CMS Oral History Project

Interviews by:
David G. Smith and Judith D. Moore, 2003 – 2006

David Smith and Judy Moore conducted a wide-ranging set of interviews with individuals knowledgeable about the Medicaid program, which form the basis for their book: Medicaid Politics and Policy 1965–2007. Interviewees include: state and federal officials who launched Medicaid in the late 1960s, wrestled over creative financing methods and program expansions in the 1980s and 1990s, and debated various block grant proposals over the years; as well as advocates who sought to expand the reach of the program to additional children and those who added home and community based services to keep elders and disabled persons out of institutions; and members of Congress and their staff who modified the underlying statute time and again. Those who agreed to make their interviews available to the public are listed in the table of contents below, followed by short biographies.

When reading the oral histories, keep in mind that each is the memory of a single individual. Read in context with other sources of information, they can add color and context, unavailable elsewhere, to important events. However, the full picture can only be seen when the perspectives of many individuals are combined into a meaningful whole.

Disclaimer: The opinions expressed in the interviews are those of the interviewee. No inference is implied nor should be inferred that they are the opinions of the Centers for Medicare and Medicaid Services or the Department of Health and Human Services.

Interviews	Date of Interview	Topics included in interview
Stuart Altman	January 8, 2003 Page 8	Nixon health reform legislation, development of HMOs and managed care
Joseph Antos	August 13, 2003	Medicare Catastrophic Coverage Act, Oregon Medicaid waiver
Edward Brandt	August 12, 2003	Early years of the HIV/AIDs epidemic, Tylenol product tampering, Public Health Service
Bruce Bullen	July 17, 2003	History of Massachusetts Medicaid program, Harvard Pilgrim HMO in Mass. Market
Sheila Burke	June 20, 2003	Senator Dole, Medicare Catastrophic Coverage Act, Congressional negotiations with the House on Medicaid
Jack Ebeler	January 22, 2003	Creation of HCFA, incremental eligibility expansions in Medicaid, Medicaid block grant
Michael Fogarty and Charles Brodt	August 11, 2003	Oklahoma Medicaid program, DSH, creation of HCFA, services for the mentally ill and mentally retarded, nursing home reform, de-institutionalization, relationship with federal government
William Fullerton	January 29, 2003	Wilbur Mills and Ways and Means committee, development of Medicare program, creation of HCFA

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Ray Hanley	July 29, 2003 Page 6	Medicaid program in Arkansas including use of data to profile physicians and expensive patients, work with disease management vendors, eligibility expansions, relationship with federal government
Robert Helms	July 31, 2003	Medicaid and OBRA '81, early years of HIV/AIDS, need for entitlement reform, reducing regulatory burden
Don Herman	July 17, 2003	Medicaid program in Iowa, role of Blue Cross and Blue Shield in early years, contracting out claims processing, developing MMIS, development of home and community based waivers
Thomas Hoyer	January 14, 2003	HMO regulations in 1970s, launch of the PSRO program, Reagan Administration regulatory reform task force, development of home and community based waivers, development of Medicare post-acute payment regulations
Julie James	May 13, 2003	Medicaid DSH, Oregon waiver, Medicaid block grant, legislative negotiations with Cong. Waxman and the House
Philip Lee	May 5, 2004	Political efforts to enact Medicare, implementation of Medicare and Medicaid, de-segregation of hospitals—role of Public Health Service and SSA, AMA opposition to Medicare, LBJ's Great Society
Patricia MacTaggart	July 15, 2003	Medicaid program in Minnesota, developing home and community

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		based care waivers and managed care waivers from Minnesota, role of not-for-profit health care in Minnesota, technology in health care, North Carolina Medicaid program.
J. Patrick McCarthy	May 25, 2004	West Virginia Medicaid program, early years of Medicaid at HEW, claims processing technical assistance with states
Don Moran	October 16, 2003	Work with David Stockman at OMB to centralize executive control over government spending, Reagan Administration proposals to change Medicaid, OMB established budget neutrality and OMB review requirement for demonstrations, future of Medicaid.
Robert Myers	April 15, 2004	Medicaid spending growth projections in the early years, requests from Congressional staff, difficulties in actuarial estimates of public assistance programs.
Christina Nye	August 8, 2003	Wisconsin Medicaid program, creation of Medicaid Bureau in HCFA, improving the relationship between states and federal government, managed care
Janet Lee Partridge	May 12, 2003	Medicaid Director in D.C., experience with waivers and cost growth, work with the National Association of Medicaid Directors after retiring from DC, relationship between federal and state

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		governments.
Gerald Radke	June 17, 2003	Medicaid Director in Pennsylvania, moved claims payment from manual to a computer process, Medicaid mills in Philadelphia, fraud and abuse, managed mental health care, DSH
Mark Reynolds	August 21, 2003	Massachusetts Medicaid program—reforming provider payments and DSH, competition and regulation as strategies for controlling costs, TennCare waiver in Tennessee Medicaid program
Sara Rosenbaum	May 6, 2003	Children's defense fund, EPSDT amendments, Clinton health reform, Medicaid managed care contract study, future of Medicaid.
Diane Rowland	September 30, 2003	Child health expansion proposals in the Carter Administration, launch of the Kaiser Commission on Medicaid and the Uninsured, potential future expansions of Medicaid for low income populations
Andreas Schneider	May 22, 2003	Medicaid waivers and how they changed over time (Arizona, Georgia, Oregon, Tennessee), Medicaid DSH payments to public hospitals, nature of the Medicaid entitlement
Sarah Shuptrine	July 16, 2003	Southern Governor's Association task force on infant mortality, Medicaid expansions for children and working families in the 1980s,

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		role of SCHIP and Medicaid in covering the uninsured
George Silver	May 19, 2004	Medicaid and civil rights, neighborhood health centers and delivery system issues
David Barton Smith	August 16, 2006	Quality of care in nursing homes, need to collect race data for research, writing Health Divided which tells the story of Medicare's implementation in 1966 and the de-segregation of hospitals.
Elmer Smith	May 26, 2004	Medicaid's inception, early years of Medicaid in New York from a HCFA regional office perspective, Medicaid eligibility policy.
Vern Smith	June 5, 2003	Launch of Medicaid in Michigan in the 1960s, role of Blue Cross and Blue Shield in early years, tensions with public health, role of federal and state governments
Mary Tierney	July 17, 2003	Developing EPSDT regulation during Carter Administration, Medicaid waivers, medical home for children with primary care pediatrians, work in DC in various roles with children, pediatric work in Russia.
Bruce Vladeck	July 7, 2003	Medicaid waivers in Clinton Administration: Oregon, Tenneessee, Hawaii, Massachusetts; DSH, donations and taxes; Medicaid block grant proposal from Congress; role of federal and state governments in Medicaid

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Henry Waxman	January 25, 2005	Medicaid eligibility expansions in the 1980s, Medicaid block grant, HIV/AIDS, legislative negotiations with Senate, Oregon waiver
Alan Weil	July 2, 2003	Medicaid block grant proposal, Colorado Medicaid program, growth in Medicaid spending over time, proposals to reallocate federal and state roles in covering the uninsured.
Marina Weiss	May 2, 2003	Senator Bentsen as Chair of the Senate Finance committee in the late1980s/early 90s, EPSDT expansion, enactment of Medicare Catastrophic Coverage Act, importance of Medicaid to very sick children.
Karl Yordy	October 28, 2004	NIH growth in the 1950s, early Medicaid growth, PHS agencies, IOM and nursing home reform

Stuart H. Altman, Ph.D. is Dean and Sol C. Chaikin Professor of National Health Policy at the Heller School, Brandeis University. Among other positions, Dr. Altman served as Deputy Assistant Secretary for Health Policy at the Department of Health Education and Welfare in the 1970s and was the founding chair of the Prospective Payment Assessment Commission, serving from 1984-1996.

Joseph Antos, Ph.D. is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute for Public Policy Research. Dr. Antos served in several senior management positions at the Health Care Financing Administration (now Centers for Medicare and Medicaid Services) and at the Congressional Budget Office.

Edward N. Brandt, Jr., M.D., Ph.D. served as Assistant Secretary for Health at the Department of Health and Human Services from 1981—1984. He later served as Professor and Director of the Center for Health Policy at the University of Oklahoma's Health Science Center and was a member of the Kaiser Commission on the Future of Medicaid. Dr. Brandt passed away in 2007.

Charles Brodt is Deputy Director, Oklahoma Health Care Authority and a long-time state employee. Mr. Brodt began his career as an Oklahoma welfare caseworker and has continued his state employment in welfare, social service, and Medicaid programs for over 35 years.

Bruce Bullen is Senior Vice President and Chief Operating Officer of Harvard Pilgrim Health Care in Wellesley, Massachusetts. Prior to joining Harvard Pilgrim in 1999, Mr. Bullen served for ten years as Massachusetts' Medicaid Director; he also served as Chairman of the National Association of State Medicaid Directors.

Sheila Burke worked for former Senate Majority Leader Robert Dole in a variety of roles including legislative analyst, Finance committee staff, and culminating in Chief of Staff over the period from 1977-1996. She was Secretary of the Senate from 1995-96.

Jack Ebeler is a private health care consultant. He began his career in health policy in the 1970's in the Department of Health Education and Welfare Medicaid Bureau and later worked for the Health Subcommittee of the House Commerce Committee, the Health Care Financing Administration, and the Department of Health and Human Services.

Mike Fogarty is Chief Executive Officer of the Oklahoma Health Care Authority, the agency which directs the state Medicaid program. He began his career as a human services social worker in Oklahoma, served as legislative assistant to Senator David Boren, and has directed the Health Care Authority and the state Medicaid program since 1995.

William Fullerton was the first Deputy Administrator of the Health Care Financing Administration. He had previously worked for the Social Security Administration, the Congressional Research Service, and the House Ways and Means Committee Staff.

Ray Hanley is Client Industry Executive with EDS, where he works with state Medicaid agencies across the Southeastern U.S. Before joining EDS in

2002, he served for 16 years as Arkansas Medicaid Director and was Chair of the National Association of State Medicaid Directors.

Robert Helms, Ph.D. is Resident Scholar at the American Enterprise Institute. He previously served as Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services from 1984-89 and was a member of the Medicaid Commission from 2005 to 2007.

Don Herman was Iowa's Medicaid Director from 1984 to 1999. He began his career in the Iowa Medicaid program as an auditor in 1971.

Thomas E. Hoyer, Jr., who retired from CMS in 2003, served as a senior executive with responsibility for a wide range of issues in both Medicare and Medicaid regulatory coverage and reimbursement policy.

Julie James, currently a private health policy consultant, worked in the U.S. Senate and served on the Senate Finance Committee staff from 1991—1998.

Phillip R Lee, M.D. is a consulting Professor at Stanford University. He served as the first Assistant Secretary for Health in the Department of Health, Education and Welfare from 1965-67 and then held that post again in the Department of Health and Human Services from 1993-97.

J. Patrick McCarthy was a staff member in the Welfare Administration of the Department of Health and Human Services at the beginning of the Medicaid program in 1965. He had earlier worked on health care vendor payment programs in West Virginia's public assistance and Kerr-Mills programs. Mr. McCarthy passed away in 2006.

Patricia MacTaggart is a research scientist at George Washington University. She worked in several positions in the state human services and Medicaid agency in Minnesota, and served as Medicaid Director there from 1995-1997. She also worked in federal service in HCFA/CMS in both the Medicare and Medicaid programs.

Donald W. Moran is President of The Moran Company. From 1982-1985 he was Executive Associate Director of the federal Office of Management and Budget.

Robert Myers was Chief Actuary, Social Security Administration, from 1947-1970. He is the author of hundreds of articles on actuarial science and social insurance programs.

Christine Nye is Vice President of ACS Government Solutions. She was Medicaid Director in Wisconsin from 1987 to 1990 and director of HCFA's Medicaid Bureau from 1990-1993.

Janet Lee Partridge is currently a consultant to the Partnership for Women and Families. She served as the Washington D.C. Medicaid director from 1983-1992 and as executive Director of the National Association of State Medicaid Directors from 1992-2003.

Gerald Radke was Medicaid Director in Pennsylvania on two separate occasions and also served as Mental Health Director in that state. He worked in private sector insurance and pharmacy benefit programs.

Mark Reynolds served as director of TennCare in Tennessee and as deputy director of the Massachusetts Medicaid program. He currently runs Neighborhood Health Plan of Rhode Island.

Sara Rosenbaum, J.D. is founder and Chair of the Department of Health Policy, and Hirsh Professor of Health Law and Policy, at the George Washington University. A national expert in Medicaid law and policy, Ms Rosenbaum has written widely on health care policy. She was a member of the White House Domestic Policy Council in the Clinton Administration.

Diane Rowland, ScD. is Executive Vice President, Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. Prior to joining the foundation, Dr. Rowland worked in Medicaid and health programs at the Health Care Financing Administration and Department of Health and Human Services, and taught at Johns Hopkins University.

Andreas Schneider, J.D. is Chief Health Counsel for the Committee on Oversight and Government Reform, U.S. House of Representatives. He previously practiced law, worked with the Kaiser Commission on Medicaid and the Uninsured, and served for many years as Counsel to the House Subcommittee on Health and the Environment.

Sarah Shuptrine founded the Southern Institute on Children and Families where she served as President and CEO for 17 years. The Institute, a non-

profit public policy organization, works primarily with 17 Southern states on issues related to health and social service coverage for families. Ms Shuptrine served as chief policy advisor to South Carolina Governor Riley from 1979-1986.

George Silver, M.D., M.P.H was Professor Emeritus at Yale University School of Public Health. He served as Deputy Assistant Secretary for Health and Scientific Affairs at the Department of Health Education and Welfare from 1965-1968. Dr. Silver passed away in 2005.

David Barton Smith, Ph.D. is Professor Emeritus of Risk, Insurance, and Health Care Management at the Fox School of Business, Temple University. Dr. Smith has written extensively on health management and policy and has particular expertise on the history and legacy of segregation on health care in the U.S.

Elmer Smith is a career federal employee who served in headquarters and regional office positions in the Health Care Financing Administration, Social Security Administration, Social and Rehabilitation Service, and Welfare Administration before his retirement in 1996.

Vernon K. Smith, Ph.D. is a Principal, Health Management Associates. He retired after more than 30 years in staff and management positions in the Michigan Medicaid program, serving as Policy Director from 1978-91 and Director from 1991 to 1996. He chaired the HCFA Maternal and Child Health Technical Advisory Group for 14 years and was Vice-Chair of the National Association of State Medicaid Directors.

Mary Tierney, M.D. is a pediatrician affiliated with the American Institutes for Research; her work involves pediatrics and primary care policy and advocacy with emphasis on children with special needs. She worked at the Department of Health, Education and Welfare on Medicaid and EPSDT programs in the 1970s.

Bruce Vladeck, Ph.D. is Executive Director with Health Sciences Advisory Services, Ernst and Young. He served as Administrator of the Health Care Financing Administration from 1993-1998, as Assistant Commissioner for Health in New Jersey, and President of the United Hospital Fund in New York City. He published Unloving Care, a seminal study of problems in the nursing home industry.

Henry Waxman is Chair, Committee on Oversight and Government Reform, U.S. House of Representatives. He has represented the 30th District of California since 1974 and chaired the Health Subcommittee of the House Committee on Energy and Commerce from 1979-94.

Karen Nelson is Health Policy Director with the House Committee on Oversight and Government Reform. She has worked with Congressman Waxman since 1978. Before that, served on the staff of the Senate Finance Committee and worked in the executive branch of government in the Department of Health Education and Welfare and the Bureau of the Budget.

Marina Weiss, Ph.D. is Senior Vice President, Public Policy and Government Affairs, March of Dimes. She served in the U.S. Senate as advisor to Senate Lloyd Bentsen and was chief counsel for Health, Income Security and Budget for the staff of the Senate Finance Committee; she later was Deputy Assistant Secretary for Economic Policy at the Department of the Treasury.

Alan Weil, J.D. M.P.P is executive director of the National Academy for State Health Policy. He previously directed the Assessing the New Federalism project at the Urban Institute and served in health policy positions in Colorado and Massachusetts state government.

Karl Yordy worked in legislative liaison, health policy, and management at the National Institutes of Health and in Health Services Administration from 1957-1972. He later was founding executive director at the National Academy of Science Institute of Medicine.

INTERVIEW WITH STUART ALTMAN
JUDY MOORE AND DAVID SMITH – JANUARY 8, 2003

SMITH: This is an interview by David Smith and Judy Moore with Stuart Altman on January 8, 2003 at the National Health Policy Forum office in Washington. Tell us about how you began in health care.

ALTMAN: I didn't know too much about health care when I went into the Department. I had written a book on nurses. And I didn't know Medicare. I didn't know Medicaid. I mean, this may be a very short interview. But I learned a lot—

MOORE: Very quickly.

ALTMAN: Over 30 years, that's right.

SMITH: But you were in the DOD for a while?

ALTMAN: Yes.

SMITH: And could you fill us in a little bit on how you got to DOD and from there into health care.

ALTMAN: Great story. I came to Washington in '63–'64 to finish my dissertation—I was at UCLA and wound up at the Federal Reserve Board because they were interested in unemployment. And some guy heard me give a talk on my dissertation topic "Unemployed Married Women" at a conference at Goucher College (a woman's college), of all places.

And I wound up working for a fellow by the name of Murray Wernick in the Federal Reserve Board. And he gave me a year to write my dissertation. And while I was there, out of the blue, towards the end of that year, as I was getting my degree, I got a call from the Defense Department. I had never been in the military. I even flunked Boy Scouts, but like most people I was sort of both awed and intimidated by the Pentagon and the Department of Defense. Anyway, he called me up and he said, "We are preparing a working group to look at whether we can create an all-volunteer military. And we heard that you're a labor economist, would you be interested? I wound up being intrigued by the issue and joined the group. That was the Whiz Kid era.

SMITH: You were a Whiz Kid.

ALTMAN: No, I was only a Junior Whiz Kid. I never quite made it to the Whiz Kid category. And I worked for a man named Bill Gorham. Bill Gorham was at that point Deputy Assistant Secretary of Defense. Bill recruited a number of great people many of whom were economists like myself. Even though the Vietnam War ended the study after about a year I stayed at the Pentagon for two years. During that period of time, Secretary McNamara recruited a young fellow by the name of Joe Califano to be his assistant. And Califano convinced McNamara that DOD should have an Assistant Secretary for Planning and Evaluation. Ultimately Califano went to the White House and convinced President Johnson that every federal department should have such an Assistant Secretary for Planning and Evaluation. Bill Gorham was recruited to be the first Assistant Secretary for Planning and Evaluation at HEW. Most of the task force team went with him but not me.

MOORE: Oh, you didn't go?

ALTMAN: I didn't go. I decided that I wanted to be an academic, so I left and went to Brown, in the economics department. After about six months I got this call from one of my friends, who said, "We are having a problem with nurses. And we don't know anything about nurses. And you know all about women—In the labor force."

SMITH: That's wonderful.

ALTMAN: "Why don't you come down and help us." So I did a typical academic thing and I said, "Well, yeah, it's a serious problem. I need a grant." I learned fast. I was, what, all of maybe 28 years old. And I ultimately wrote a book on the supply of registered nurses. At that point, Alice Rivlin became the Assistant Secretary and she actually offered me the Deputy Assistant Secretaryship. And I said no because I just had gotten to Brown. So I didn't do it and continued to stay at Brown. And then in 1970, I came to Washington for a year, to the Urban Institute.

MOORE: Oh, were you at Urban?

ALTMAN: I created the health group at the Urban Institute. So anyway, I got to the Urban Institute in 1970 to finish my book on nurses. I was there on sabbatical from Brown. And there was no health group at the Urban Institute. I kept trying to convince Bill Gorham and Worth Bateman, who

was his deputy, that they really should have a health group. All of a sudden I met this young, very pregnant woman. She was being recruited to work on welfare reform. And I said to her, "No, you're making a mistake. You should get involved in health care." It was like plastics, you know. Health care. And they need somebody here to worry about health care. Now, guess who she was? Probably as well known a woman health economist as you know. Gail Wilensky. And she was commuting back and forth to Baltimore because her husband was in residency training to be a plastic surgeon. She had just received her degree from the University of Michigan. And she'll tell you it's true. Then the fluke of all flukes in life happened. All the people who had been part of Bill Gorham's group were essentially moved out of HEW when Nixon won the presidency. You know this better than I.

MOORE: Lou Butler from California was named Assistant Secretary for Planning and Evaluation.

ALTMAN: At that time there was a huge fight about who should be the Assistant Secretary for Health. This was before Dr. Monte Duval and before Dr. Roger Egeberg. In the interim, Lou Butler became the de facto health policy leader because there was no Assistant Secretary for Health. And he had no Deputy for Health. He had two or three health people, but none of them could pass the political process. There was one analyst left from the old Gorham group who was actually in education, Mike Timpane.

And he said to Lou Butler, "I know somebody who you should meet, he knows a little about health care and he has a great sense of humor. You'll have a great time." So he called me up and he said, "Would you come and talk to Butler?" So we talked for an hour, two hours, and we had just absolutely a great time. And he says to me, "By the way," he says, "is there any chance you are a Republican?" I said, "No," I said, "I'm not anything. I'm an economist." You may find that hard to believe now, but I was very apolitical, a typical graduate student. Actually, I had been trained in a very conservative economics department where everyone believed in the "market." And I was a believer. He said, "Well, gee, I'd like to call you back. And maybe, you know, there is some way we can work you in. I would love to have you come and work with me and become my Deputy Assistant Secretary for Health Care." Six months went by and I didn't hear from him. Then Lou Butler decided to leave. And Larry Lynn was selected as the Assistant Secretary. Larry Lynn had been in the defense department when I was there. He was much closer to being a Whiz Kid. He worked on the strategic side. We're exactly the same age. He graduated from Yale when I graduated from UCLA but he had been much more involved in

defense policy.After DOD he worked closely with Elliot Richardson at the National Security Council.

And Elliot liked him. Larry also worked closely with Henry Kissinger. And so even though he wasn't a Republican he had very good credentials. Elliot Richardson by this time had become Secretary of HEW. So, Larry Lynn called me up and said Lou Butler had recommended you. While it was not easy for me to get political clearance from the White House given my relationship with the McNamara DOD or the Urban Institute I did have a friend in high places of the Republican Party of Rhode Island who helped me. It was the attorney general. And his daughter and my daughter played with each other.

So there I was, Deputy Assistant Secretary for Planning and Evolution of Health and to say the least I didn't know very much. If truth be told, I didn't know anything about the health care system. I couldn't even tell the difference between Medicare and Medicaid. So, I had to learn. Then, a month after I joined the Department, the President imposed wage and price controls on the total economy. And I and a small group of analysts from HEW were asked to staff the group responsible for controlling the health sector. This position allowed me to learn a great deal about our health system. I mean, you knew much more than you thought you knew. This town was much smaller then. There were far fewer people playing in the health field. And after two days you were an expert. So anyway, that's the long and the short of how I became a health expert. And I actually worked very well with the Administration for over five years. And it was a great experience.

SMITH: People of literally all political stripes, without exception, have said, including liberal Democrats, that the top tier of the health staff in the Nixon Administration were the best people they had ever worked with. They were interested in what made sense programmatically.

ALTMAN: Well, I mean, to the extent that I was in that group, and I guess I was, that's nice to hear.

MOORE: Oh, absolutely, you were.

ALTMAN: I didn't have many political instincts. I had economic instincts and, sure, I was supportive of the marketplace and believed in it. And I was willing to be supportive of states' rights and that kind of stuff. And working for Elliot Richardson was wonderful. And then when Casper Weinberger

came over, he was great. It was really a pleasure. We had a small staff, but very good people like Peter Fox and Stan Wallack. And I met other really good, and dedicated people. Frank Samuels over at legislation. And then Paul O'Neill who was at OMB. And we had a small, really quality group. And there wasn't the level of antagonism between the Administration and the Congress. And the political in fighting hadn't reached the level that it has reached today.

SMITH: Was Veneman still Under-Secretary?

ALTMAN: Yes.

SMITH: Everybody I have heard speaks well of him as being person who could orchestrate the efforts of others and go along with them and—

ALTMAN: But you had, you know, within HEW a group of, let's face it, liberal Republicans. There were these two sides of the California Republicans. This included Veneman, Lou Butler and Secretary Robert Finch. And they were just absolutely wonderful people.

SMITH: Yes.

ALTMAN: Their instincts were positive. They wanted to do the right thing. So it was really a wonderful experience.

MOORE: Well, and Richardson brought in some unbelievably great people as well. I mean, Dick Darman was there then and Jonathan Moore.

ALTMAN: Jonathan Moore. Well, yes. Darman worked with us in our department. And Larry Lynn, who replaced Lou Butler, was a very talented individual.

SMITH: Very much the policy wonk; his stuff on policy analysis is still great.

ALTMAN: Absolutely. When I look back over our staff, while the office got a lot bigger, I think analytically we were really good.

SMITH: Yes.

ALTMAN: You know, Karen Davis came after me. Then the health group at ASPE got a lot bigger. And, you know, Karen is an extremely competent

person and her people were very good. But I think even though we were much smaller, we could hold our own.

SMITH: Were you involved in the first Nixon health plan, that is the—

ALTMAN: I was involved in all of them.

SMITH: Oh, you were involved in the earlier one as well...

ALTMAN: FHIP AND FAP. I came to the Department as FHIP and FAP were being put together. So, I was involved towards the end. The big issue we were facing when I got there was, given the fact that we were going to essentially mandate the expansion of private insurance, what kind of regulation should we impose on the insurance industry. Although Larry Lynn was my immediate supervisor, he was much more interested in welfare reform and he left health care to me. This allowed me to work directly with the Secretary and the White House on all the important health issues of the day.

SMITH: CHIP, right. Well, and of course the whole thing of FHIP and FAP fell by the wayside.

ALTMAN: At the end, FHIP never went anywhere. It was too little, too late. And the timing wasn't right.

MOORE: FHIP was too little, too late? Yes. But there were many hearings on FHIP and how to eliminate the uninsured. Several years later we (the Nixon Administration) produced a much more ambitious plan called “The Comprehensive Health Insurance Plan” (CHIP). And credit for this plan should go to Cap Weinberger. When he came over as Secretary from OMB, he had a nickname “Cap the Knife.” But he was nothing like that when it came to national health insurance. From day one, he said, "I want to look at all alternatives. I'm even willing to look at totally government financed programs." After reviewing all the alternatives, we created CHIP.

SMITH: In retrospect, what is your feeling about it? Because I have heard many people like my good friend Lynn Etheredge who said, "I don't think we ever had a better proposal."

ALTMAN: Well, I still am a strong advocate for the employer mandate approach, which was the centerpiece of CHIP. I think ultimately if we are going to cover all Americans with some form of health coverage it's going to

be based on an employer mandate. We're not going to destroy the employer-based system. And that gets me to Medicaid because I do believe CHIP built on Medicaid, as opposed to destroying it.

SMITH: Most people don't make that observation. But it's very important, I think.

ALTMAN: I think it is important and I think the discussion I'm having now with some members of Congress in terms of what you do with the poor is very important. What do you do with Medicaid? Do you destroy it for the good of the poor? Do you build on it and make it better? I think the issue that ultimately will be fairly critical, I mean, the decision on the children's health insurance was related to this issue. You know, the children's health initiative builds on Medicaid. And we built on it in CHIP.

SMITH: It's been characteristic of some of the things you have worked for and some of the things you have written that you believe institutions are part of how we've got to run Medicare and Medicaid.

ALTMAN: Yes.

SMITH: Unlike a great many economists whom I know.

ALTMAN: Yes. As a matter of fact, without naming the people, there is a serious discussion among this group on how you cover the uninsured. Do you build on Medicaid? Or, do you tear down Medicaid and create a new form of insurance for the poor and uninsured. I do believe that Medicaid has some very important features for the uninsured and for low-income people. While it is not a strict advocacy agency and it depends on what part of the country you're in, there are people who really understand the special problems of our low-income, immigrant, and disabled population and the special health care needs that these populations have. Simply giving them $5,000 to go out and buy an insurance plan, while it might appear to be the right thing to do—

SMITH: We would like to get a little bit later into some of this stuff you've been doing on the safety net and things like that.
But back then at the time of—well, not so much FHIP/FAP but—

MOORE: CHIP.

SMITH: HMOs played a big role in the thinking of people. I mean, it was an employer mandate but there was very much a thought that we were going to push HMOs. And I had thought you were a pretty strong advocate for HMOs at that stage.

ALTMAN: Yes and no. I cannot, truth be told, take credit—that was the time when Paul Ellwood came into the Department and convinced people that there was this market-oriented approach.

SMITH: And Veneman was from California, too.

ALTMAN: Yes. Well, Ellwood was not.

SMITH: No, Ellwood was not. But, I mean, Butler and others knew HMOs.

ALTMAN: He did know Kaiser. And, you know, and he became infatuated with that. And the first Nixon health message promoted the concept as prepaid health care. They weren't called HMOs. They were called prepaid group practices and later they were renamed HMOs. So if you go back to that first health message, and that was before me—

MOORE: That would have been in '70, I think.

ALTMAN: '70. That's exactly right. I came in June of '71. And so I don't think either FHIP or CHIP really overplayed HMOs. The essential part of CHIP was not HMOs.

SMITH: Well, it wasn't the centerpiece.

ALTMAN: No, not at all. It was just one of the possible financing options. The HMO Act of '73, which occurred just a little later, we had a lot to do with writing that legislation. When I say we, the office I was in, and a young fellow there by the name of Bill Kopit who has become a quite successful lawyer here in town. He was the person responsible in my group for working on the HMO legislation. We got into all these discussions and battles with the Congress about what an HMO would look like and how much restriction there would be for a plan to qualify for federal support and what kind of services would be required. It almost died because there were too many mandates on it.

SMITH: Yes.

ALTMAN: But that's a long story. So I would put almost all those things on overlapping but related tracks.

SMITH: Okay.

ALTMAN: I think when all is said and done, CHIP was a straight employer mandate. And as I said, you had this parallel track of HMOs, but there was nothing inconsistent within CHIP for HMOs. But unlike, say, the Clinton plan of 20-some years later, which essentially was wrapped around HMOs, this one wasn't. But it did have the requirement that employers had to provide health insurance. And if they couldn't provide it, people could go into this other insurance.

SMITH: Well, now, we both know you—especially through PROPAC, which is regulating on the hospital side especially. Did your thinking on HMOs undergo an evolution where you at one point became disenchanted or—

ALTMAN: No. Well, I would not categorize myself as being either starry-eyed or strongly supportive—I mean, I didn't see the full potential of HMOs or that it would dominate the health insurance market in the mid 1990's. I didn't see HMOs as taking off immediately and pulling in a large percentage of the population—and in fact, they didn't. I mean, if you look at it, from '73 to almost '92. You have almost 20 years after the legislation before a sizeable proportion of the work force is covered by an HMO. And a lot of things happened to make it that way.

SMITH: Yes.

ALTMAN: But I was never against them. I thought they were an interesting idea. I saw them as a small but growing component that would be of interest to some people. So I wasn't a true Ellwood disciple. Nor was I a critic. And I helped him along but the HMO plan concept was not the centerpiece of CHIP.

SMITH: What about HMOs as a vehicle or a service delivery vehicle for Medicaid as opposed to Medicare?

ALTMAN: It wasn't even discussed.

SMITH: Didn't even think of it at that stage, right?

ALTMAN: Did not even think of it—it wasn't discussed—nothing, I mean.

SMITH: Because there is now in the last 10 years quite a school of thought saying HMOs really—make a lot of sense for Medicaid.

ALTMAN: Well, I think that they make sense for a lot of people. And I'm more of an advocate for HMOs today. By the way, my Web-based article came out today on health care costs.

MOORE: Is this the Health Affairs?

ALTMAN: Yeah, Health Affairs. And in it, I argue for the insurance companies to return to some form of managed care. I think we're heading down some really tough road here. And, yeah, there are excesses with HMOs and, you know mistakes were made. But the truth of the matter is that HMOs, I think, during the '90s did some very positive things. And just like Medicare, managed care turns out to be very valuable for many people who like one-stop shopping, who like the idea of organized care. No one likes to be told “no” for something they believe they need, whether they need it or not. But a lot of people like the idea of group practice medicine. Some of the finest health care in this country is designed around group practices. I mean, they may not be HMOs, whether it's The Mayo Clinic or Cleveland Clinic or something like that. So that was the original HMO model. Then it morphed into these very loose organizations—and that was part of the debate in '73, whether we should essentially adopt only the closed-panel Kaiser model, or let many different types of organizations be considered as a qualified HMO.

SMITH: Did Jay Constantine give you fits on HMOs? I heard from Henry Aaron and various other people that time and time again Constantine would block them on HMOs.

ALTMAN: Yes. He was very much against HMOs. He was very much against comprehensive insurance. His boss was totally in favor of a catastrophic plan. He said that we would never get anything through the Senate, even if we got the House to pass it. And we keep talking about if Wilbur Mills had survived and if Nixon had only stayed in power a little longer. You know, I'm one of the few people that said, "God damn Watergate. Why couldn't we just leave it alone?" I mean, we might have gotten true national health insurance legislation. And Jay Constantine said, "You're smoking stuff, because, you know, we would have just killed it." He was against a lot of things. He was big on PSROs. That was his thing. Senate Finance people were real advocates for PSROs, you know, because they had seen this type of program working in Utah, using small groups from

the medical society to do utilization review. But the other big issue, which could have affected Medicaid in a very big way—was to change the formula for allocating Medicaid funding.

MOORE: Oh, an FMAP change.

ALTMAN: Yes. I worked on that a long time. And it had to do with if you were going to reallocate a substantial amount of money to the states to expand health care, how would you do it? We created several different formulas that were similar to FAP and FHIP. But the question was: Does a state do better or worse? And do we hold harmless any state that would lose money. Jay was absolutely furious because of the formula—So we were trying to tweak the formula so that it didn't hurt any state. But there was no way you could create a new formula that didn't—didn't wind up hurting at least one state. Clearly, Louisiana was getting so much money out of the existing Medicaid formula that it stood to lose. And, of course, you know—there was Jay. So, oh, he was just beside himself.

MOORE: So what is your memory of how CHIP approached Medicaid at that point?

ALTMAN: Well, Medicaid was not as much an afterthought in CHIP as it seemed to have been in Title 18 and 19. Or in the Clinton health proposal. Basically what the situation was, you created the employer mandate for all people who were working and then you created what we called the Family Health Insurance Plan (FHIP), which included Medicaid for people who were uninsured but not working. But it had all the characteristics of Medicaid in the sense that it was state-administered, and in so doing incorporated Medicaid into a larger unit that included many more of the uninsured.

SMITH: And it wouldn't be categorical. There wouldn't be categorically needy. And that piece of it survives in SSI.

ALTMAN: That's right. SSI was part of HR-1, wasn't it?

MOORE: Right.

SMITH: CHIP had subsidies for small employers.

ALTMAN: Yes, it did. But that was on the employer mandate side. Of course, we did not realize how powerful the small employer lobby would become. We weren't anti-business and we weren't anti-small businesses.

And we were trying to work with the Chamber of Commerce and others to make this palatable to them. They were very nervous about it then and of course; they have continued to be very nervous about any employer mandate.

SMITH: Well, was that NFIB at that point or was that just small employers? Because later, almost any time NFIB would decide to get up on its hind legs and bark, you just had to pay attention. They were so powerful.

ALTMAN: Well, they were powerful.

MOORE: How about the insurance agents, the independent insurance agents? They are a real force to be reckoned with now, too.

ALTMAN: I remember learning a lot about insurance. Boy, that's where I learned a lot. You know, I was having people come down from Aetna and from Prudential, Hancock. I had a guy working for me who was an intern from Hancock. And of course the big insurance companies stood to gain tremendously from CHIP.

But the small insurance companies were at a disadvantage—you really needed to be bigger. Now, it didn't destroy the brokers or the agents because you still could get insurance through them. You had to get insurance. But it didn't tell you where to get it. It wasn't like the Clinton plan where you had HSA's—

SMITH: Yes, health systems agencies.

ALTMAN: The other thing about CHIP is that you have to appreciate the timing of it and that we did a lot of this in semi-secret. And then we had this, and Watergate issue swirling around. And Nixon essentially overrode his cabinet and made it clear that he wanted CHIP to come about. What is surprising to me even though it wasn't passed, it sort of stood the test of time. It was written by a few of us. People like Peter Fox had a lot to do with it. At the end there were just a half a dozen of us that just wrote the proposal.

The president had made it very clear that he wanted it on his desk by early January. The people at OMB and the Treasury and Labor Departments who might have stood in the way—you know, we had to clear it through all the agencies. They could not stop it. They could modify it a little bit here and there, but they couldn't stop it. Then there's a separate story around CHIP

because once it went over to the Congress it got modified. And Bill Fullerton? Remember Bill Fullerton?

MOORE: Yes, we talked to Stan Jones about the Congressional activity and he talked about all those meetings you had, the famous meetings you had at the church—You and Bill and he and who else? There was one other person.

ALTMAN: Well, there actually were three of us, Ted Cooper and Frank Samuels and I represented the administration. And then Bill Fullerton represented the Ways and Means Committee. I can remember working to find a compromise, in one of those tramcars, up above Albuquerque—and we actually thought we had it. But then we threw it all in the trash.

SMITH: Did you get involved much with fraud and abuse?

ALTMAN: I did work some on fraud and abuse, but not much. We could never get our hands on it. We put some numbers in the budget, but they were estimates.

SMITH: After that, what did you do?

ALTMAN: When I left government, I went briefly to Aaron Wildavsky's shop—in Berkeley, California. Then I went to Brandeis, to be Dean of the School of Public Policy [Florence Heller School].

SMITH: You are known as a person who has a sense for institutions, both the market and institutions. Could you comment on that?

ALTMAN: Well, I think of myself as a radical pragmatist. Some people say all we need to do is "just give them dollars." A popular view then, that they would be better off. I didn't agree. People stay with their local hospitals, they stay in their neighborhoods. So we need to preserve the safety net, be conscious of this. As they in Massachusetts—they use their safety-net providers. Other states say that's not our job. But a lot of managed care is making it worse for safety-net providers.

SMITH: What is your thinking at this point about the future of S/HMOs?

ALTMAN: You have to remember that S/HMOs grew out of a background when there was no managed care—back in the 1980's, all they had was block grants. There was a need for more integrated care and an awareness of the trade-offs. Now much of this has been built into Medicaid managed

care—for example, home health care, home and community based waivers, Medicaid managed care. The S/HMOs didn't really integrate—they were taken over by the acute care people. They could provide non-acute care for less, but they didn't really re-define the system. But I'm still proud of On Lok—people love it, speak of it with tears in their eyes.

SMITH: What has happened with the hybrid version of a risk-adjuster that you and Henry Aaron proposed.

ALTMAN: Henry has gone off on some new track. I remain fearful about cutting spending too much and the side effect of that. Mark Pauly says just adjust the wages. I doubt that the poor can ever get enough clout to defend themselves. Though Medicaid as a program has some clout and might be able to buy at negotiated prices. Could probably do a lot piecemeal.

SMITH: What thoughts do you have about the RWJ Community Access Program?

ALTMAN: I like it. But it must have a core of financing—in the battle to survive, grants aren't enough. Medicaid isn't a grant—it's an on-going program, has an independent floor of funding—that's a big difference.

MOORE: We want to thank you for taking this time with us. It has been a pleasure and we're most grateful.

ALTMAN: It was a pleasure—good to see you again.

SMITH: Thanks, it was fun for us.

INTERVIEW WITH JOE ANTOS

JUDY MOORE AND DAVID SMITH – AUGUST 13, 2003

SMITH: This is an interview with Joe Antos with David Smith and Judy Moore doing the interview. It is August 13, 2003. And we wanted to start a little bit about your early experience when you first got into the Office of Research and Demonstrations at HCFA or OR, whichever it was.

ANTOS: Okay, sure. Actually, I'll start with my first health policy involvement because it turns out that it was closely related to HCFA. In 1985, fall of '85, I was a senior staff economist at the Council of Economic Advisers. And since I was in that position I got to go to meetings that normally you wouldn't get to go to.

Bill Roper was the White House health policy adviser at the time and he was running a health policy-working group. It consisted of people from all sorts of different Departments, including Departments that I wouldn't have thought had a direct involvement with health policy of any sort, and then Departments that clearly did.

And they were DOD, VA, and the civilian-oriented health agencies, but also the Department of Justice, the Department of Commerce. Of course that does make sense if you think very broadly.

I don't know that we had anybody from Agriculture, but it's entirely possible. Around that time in 1985 there was a real push that people hadn't realized yet out in the public for the Medicare fee schedule.

And this was being pushed by people in ORD and HCFA. I think Bill Roper, being a pediatrician, thought that was a good idea, too.

One of the objectives which I think has failed miserably was to change the relative payments of the hands-on specialties—primary care physicians versus the guys with knives. Cognitive versus procedural.

It was an interesting and complicated—what turned out to be really an experiment, but in fact that part of it didn't work. Other things did, but that didn't. Anyway, Bill felt that some rebalancing should be done. We all felt that putting more of an emphasis on primary care makes sense.

That was the context. And so I went to my first meeting of this group and there was one Al Dobson, who you probably should interview if you are not

already planning to. Al was giving this presentation on RBRVS, and Al speaks a mile a minute.

I knew Al—I had known Al a little bit on and off for quite some time before that in a non-health capacity. And I'm not sure that he actually recognized me. But in any event, he gave his presentation and it was breath-taking, literally. And there were all these people sitting there, not really absorbing it because it went by so fast and it's so complicated.

I got to ask a question when Al took a breath. My question more or less was along the lines of, "Well, how does this promote managed care?" since that was the Reagan Administration's viewpoint—at least so it seemed. That single question ended up creating a process that actually derailed the physician fee schedule for a couple of years.

I never liked the physician fee schedule as a policy. I have to admit this. I am an economist and economists tend not to like these sorts of things.

That was my introduction to real health policy. I peculiarly got thrown into the deep end of the pool.

Luckily there were people I knew at the deep end of the pool. It was a kind of issue that I had thought about—not necessarily in that context. So that was fortunate for me that I didn't completely blow everything. Probably on the basis of that and suddenly becoming known in the Department when Margaret Heckler moved on—and I never met the lady—

Otis Bowen was coming on board. I got a call from somebody saying, "How would you like to come over and help us deal with—what was it—the Gramm-Rudman bill?" Gramm-Rudman. That was the first year that there was supposed to be a sequester. And whoever it was that called me said, "You know all about that. You were at OMB, right? You know all about that."

I said, sure. Nobody knew anything about that. I came to the Department but I actually didn't end up in HCFA right away. I was in an unnamed position in the Office of the Secretary for a while, waiting for the paperwork to catch up. That happens almost invariably for anybody who is above a GS-12.

Eventually I moved into the Management and Budget shop. I was a Deputy Assistant Secretary there but I never really did any of their work because

catastrophic coverage grabbed a hold of the whole department. This was clearly going to be the Secretary's most important initiative.

Everybody in the Department knew it and every division, every major division in the Department was asked—and were eager, actually—to get involved with this because this was going to put HHS health policy on the map in a more positive light, we all hoped. Well, of course that didn't quite work out.

I don't know how much more detail you want me to give on that. Probably not much more. But then—

SMITH: No, we are really very interested in catastrophic because it sets the background for so much that later develops in Medicaid.

ANTOS: Okay. Well, with catastrophic the Department took a very expansive view of these things. The bill that eventually emerged in Congress initially didn't take a very expansive view, but then expanded in certain directions that we are living with today.

So from the Department's standpoint, the various experts got together thinking about, well, what are the major components of all this. Of course, there is acute care. So we had part of our report, which was never actually made public as far as I know, part of our report was on acute care. Part of it was on long-term care, part of it was on prescription drugs. I remember there were three parts. I hope I got the parts right. I think—

SMITH: Sounds reasonable.

ANTOS: Right. So everybody worked away, worked very hard. It was a really great effort, I thought. I would say that it must have been hundreds of people working on it in some capacity or another and quite a few people working on it full-time for about a year. We produced the report within the Department. We gave it to the Secretary.

There was a process of arguing it out with the Assistant Secretaries that was actually a very useful process because what we had done was so massive that you couldn't expect anybody to actually read it. This was a way of getting the Assistant Secretaries and the Secretary to give them a forum to say what they liked and what they didn't like and to make it possible for them to ask questions, given that it was so complicated.

And it wasn't just the health–oriented people in the Department. It was really, I think—as I remembered it, every Assistant Secretary was invited to these meetings and I think most of them showed up. So the Administration for Children, Youth and Family or whatever it used to be called then, you know, that person came.

People came from all parts of the Department to participate in this. And I thought it was a pretty useful thing. However, that was the end of it. It died. Kind of remarkable. There was a lot of resistance, political resistance, within the administration as I remember it, especially the conservatives. And it was never well articulated in my presence exactly what their problem was.

SMITH: Initially, we heard that it's just a thing he wanted from President Reagan and Reagan said go do it.

ANTOS: Well, see, I think that what happened is the classic staff versus boss problem in the White House. The boss said, you know, "Otis Bowen is my man." Otis Bowen said, "This is what I care about." Ronald Reagan said, "That makes sense to me. Go ahead and do it."
Well, unfortunately, these two guys didn't happen to consult with their staff. Had they, they would have had a different view. I think that's what it was.

MOORE: And so what year was it this report was produced? Do you remember?

ANTOS: This was—I got to HHS in '86, in January of '86. The report process started soon thereafter and the report was—everything was finished by—certainly by early '87. But I think what stopped it temporarily was the concern from staunch conservatives mainly elsewhere in the government, but at very high levels, who felt that this was just an expansion of a government health insurance program.

We were just very concerned about it.

They didn't want to touch it. Then, of course, we had the guy who I think—I always tell people this and they always laugh at me but I believe this. There is one person who is really responsible for the catastrophic coverage act and it is nobody that anybody ever mentions. It's Ollie North. If it hadn't been for Ollie North—

And the reason I say that is we had the Iran-Contra scandal. Donald Regan was trying to find some good news.

There was very little good news to be had. And I have always thought—although again, nobody has ever told me this—I have always thought that since suddenly there was positive interest, abrupt, after basically being told no, go away. There was suddenly very positive interest from the White House.

Well, the only thing that had happened was this public relations fiasco. I think the question really was, "Okay, what do we have on the shelf?" What do we have that is ready to go? Well, this was the "ready to go" that wasn't foreign policy. And so from something that looked completely dead that rose to astonishing heights by this time I had moved over to—this was in—I'm not sure. I can't remember exactly when it was revived.

But I do know that I moved back, I moved to HCFA, to the Office of Research and Demonstrations in April, I think it was, of '87. So what I'm about to say about catastrophic then occurred after that. I think it was in the fall of '87 but I don't really remember.

This had been taken up and it was now being pushed hard in the Congress. And of course initially it didn't have prescription drugs in it. And it never had long-term care in it because I thought a reasonable decision had been made when it was still alive in the Department the first time that this was too big a nut to crack.

SMITH: Yeah, yeah.

ANTOS: And I think everybody felt that for better or worse, Medicaid was stuck with it.

SMITH: Uh-huh. Right.

ANTOS: And so let's not expand the—and I think whatever anybody might think about rational politics, I think the argument was that what we are talking about is protecting people within the Medicare context against high cost and making that part of it look like real insurance. And it really was true and it still is true that you don't see health insurance that ties itself in the commercial market for the under-65s to long-term care.

So everything added up to we're not going to add long-term care to this bill. However, of course, prescription drug coverage was known in 1987 and that was not the original position of the Department or the Administration to have the prescription drug benefit. And there were other things because people were worried about long-term care. I forgot to mention this.

There was some brouhaha about either home health or SNFs. I can't remember what it was anymore. But there was an expansion of probably both home health and SNF benefits in the Medicare catastrophic coverage act. And that was—I think that was early, early in the legislative process. But this prescription drug stuff came a little later and it was considered fiscally dangerous.

MOORE: By the administration it was considered.

ANTOS: By everybody, really.

MOORE: By everybody.

ANTOS: Because of the financial aspects to it. Remember that the idea behind the catastrophic coverage act as far as Otis Bowen was he wanted to protect people against high costs associated with the Medicare program. I think he would have supported—he probably would support in concept a prescription drug coverage. But his big issue was a low, affordable monthly amount, or some phrase like that we repeated when we got up every morning.

The number I remember was, it was going to be seven dollars a month. That was going to be it. Now, keep in mind that we are talking 1987–1988. So seven dollars a month—I'm not sure what seven dollars would be today but—

SMITH: It would be an incremental add-on to your—

ANTOS: Yeah. It was not something that would make you suck your breath in and say, "I don't want to do this." Okay, so then this was a big concern because if you added a drug benefit you were potentially adding a big cost.

SMITH: Uh-huh.

MOORE: Uh-huh.

ANTOS: And not only that, but OMB had imposed an additional requirement that the whole bill had to be self-funding. And—

SMITH: Now, tell us a little bit about the history. This doesn't just come out of the blue, does it?

ANTOS: What?

SMITH: OMB saying it has to be self-funded.

ANTOS: Oh, no. OMB has said that ever since OMB was created. And before that it was the Bureau of the Budget.

I worked there and I can assure you that everything has to be self-funded. And self-funding is a pretty strong term, depending on the administration.

SMITH: So this is like an article of faith.

ANTOS: Well, it is, if you are worried about deficits.

And remember the context, the macro context. We were still in serious economic trouble even that far into the '80s. You know, we had gotten past the 15-percent per year inflation rates that we saw in the early '80s. But we had a tremendously large deficit.

And so the self-funding. I had come because of Gramm-Rudman which was motivated by trying to keep a lid on excessive spending, not stop spending altogether but if goes too high, do something to slow it down. So that context was very strongly there. And so, if we are going to expand this Medicare program then the beneficiaries are going to have to pay for it themselves.

SMITH: Right.

ANTOS: Well, had it just been Otis Bowen's simplest idea it probably would have worked out okay. But people might not have been happy paying seven or eight dollars a month extra for a kind of coverage that people fundamentally don't understand.
But it's not much money, okay. By the time we actually got to the bill, people—the Medicare beneficiaries were going to pick up the drug costs. They were going to pick up the extra home health and SNF costs, other

program expansions that may have been there. I don't remember what they were anymore. All this was going to be involuntary.

Everyone had to take it. No choice. Second of all, there was going to be an income- related premium. Now, actually the term wasn't income-related premium. There was a—I think it was called the supplemental premium or something like that. It was a tax and it was as much as—oh, as I remember it, several hundred dollars.

SMITH: For the high end I think they could—they could be out 800 bucks, I believe.

ANTOS: It was a very large amount of money. And of course this was politically—somebody was tone-deaf on this one because when you think about it, 1988, most people—most retirees had good retiree drug coverage. At least most of the active voters who were in the Medicare program had good retiree drug coverage. And good meant they had better drug coverage than was being offered by this program.

SMITH: Oh, really? I didn't know that.

ANTOS: Basically what Congress was saying to these voters was, we are going to make you take something that is worse than you have so it will not benefit you. You will get nothing out of it and you will pay $800 a year for nothing. And also you will have to pay the premium, which I think escalated above seven dollars a month.

I don't know what it turned out to be. And so now I have to say I had one of my more interesting experiences in the early goings there. Somebody said, "Well, you know a lot about this. We would like you to go down to Clay Shaw's district in Florida. He is holding a town meeting."

"And we want you to just explain what this bill is all about."

SMITH: And take along your bulletproof vest.

ANTOS: You know, he is in Florida. It was in a rec center somewhere and there were about 100 older people. This was in the middle of the day, on a weekday. So you got people who were intensely interested in this. And so Clay Shaw magnanimously said, "Well, we have got this bill up there in Washington and I'm not so sure about it. And here is the guy, you know, here is the guy who really thinks this is a good idea."

I let that go and I gave whatever my straight presentation was. And then what were all the questions? All long-term care. They didn't care about prescription drugs.

SMITH: Oh, really.

ANTOS: They didn't know about insurance protection. They didn't care about that. They wanted long-term care. Well, you know, that was just the most graphic time. I felt that. But we knew this all along.

Because when you thought about it, in 1988 there were no wonder prescription drugs. They weren't so great, you know? And nobody thought that they were going to be great and nobody spent much money on them. And most of these people had drug coverage. And why did they? Because it didn't cost General Motors anything anyway.

So they didn't care about that. What they cared about was, well, who is going to take care of the nursing home expenses? And I don't want to be in a nursing home. Good points. Well, it wasn't the catastrophic coverage act. But the Congress passed this. And of course we know what happened subsequently. So that was my involvement with catastrophic.

MOORE: Were you involved in the aftermath and the repeal, because the part of the aftermath that is important to us is the QMB–SLMB, the stuff that was maintained during the repeal that was then turned over to the states, basically, and started this horrible feeling on the part of the states that the feds—that the federal government was mandating all of these problems and services and expenses that they hadn't counted on. And in fact, they had counted on a lessening of their financial responsibility because of the catastrophic drug benefit that had been passed that Medicare was supposed to take over.

ANTOS: Right, exactly. No, actually by this time I was deeply enmeshed in RBRVS again. So, shortly after my going to HCFA that was sort of it for me on this. I wasn't actually involved at all with Catastrophic—except for one little detail with the struggle on the Hill that actually emerged after I got to HCFA.

The one thing that I was involved in, you may remember, was a report that was supposed to be made to Congress about how the drug benefit would work and what the costs would be. I never quite knew who was responsible

for this. But NCHSR, which is I think the name it went by at that time, generated a report.

This was not something that the Secretary's office knew anything about. This is also not something that HCFA knew anything about. Suddenly a report emerged and landed on somebody's desk for clearance somewhere. I don't know who, actually, in the Secretary's office. Whoever it was realized that nobody in HCFA had ever seen this report.

And it purported to say what the real cost of the drug benefit was going to be. I don't remember exactly why this was. I think I was actually temporarily the Associate Administrator for Management. The Actuary's Office was theoretically reporting to me at that time.

And so, I was one of the people who got a copy of the report when it finally was revealed that the thing existed. Dan Waldo was involved with it, and Guy King, and I think several other people. Not a huge crowd. But we read this thing and we all agreed that it was not a good report, that we wouldn't agree with the optimism of this report.

And so we had a meeting with whoever it was. I don't remember anymore who they were at NCHSR, I mean, with the Department people and so on. We made the point that we didn't agree with it. We thought it was too optimistic and we were concerned about it. And so there was an interesting little political dilemma because, well, you know, they had actually produced this report.

And so the resolution I think was probably over Labor Day weekend. It was over some weekend that I didn't want to come to work—that was sort of the case—that Dan and I and Guy King and one other person were going to write a report. And so we wrote a report. The NCHSR report was the appendix.

And the appendix—we, of course, did not refer to the appendix and we made it clear that these were our cost estimates and this is how we thought it would go. I have to say that probably we were also too optimistic but we were nowhere near as wild-eyed as those folks over there in the other agency.

So that was my last little bit of exposure. This was actually one of the bureaucratic triumphs of all time because everybody was very concerned about all of this. We figured out a good solution to a little messy problem.

And this was a report that—actually, it was very clever. This is a report that I got cleared through OMB and on the street in one day. It was an emergency. We needed to do it. Steve Lieberman was the guy who had to clear it, and of course I knew Steve and we all agreed that our goal was to get this report to Congress. Don't fool around. We didn't have time.

I can now tell you that, like many a good HCFA person, I know darn little about the Medicaid program.

I now realize from what you said, Judy, that I could have learned more about the Medicaid program had I stayed with the catastrophic stuff. But, I went on to other things.

SMITH: Did you work at any point on the Oregon waiver?

ANTOS: Oh, yes, indeed.

SMITH: We were particularly interested in that experience and what you were going to say about the Oregon waiver. But also one of the things that has been concerning us is really in a way what value do waivers—or for that matter, demonstrations—have for pushing policy in directions that you would like to see it go?

ANTOS: I think tremendous—they are tremendous opportunities to push something in some direction. Sometimes you don't know what direction you end up with. But I think the lowest value of a demonstration project is to actually learn anything about the behavior of patients or the behavior of doctors.

You know, this is usually the reason that is given in waiver approvals for why you are doing a project. These kinds of things are experimental. I am not talking about the standard adjustments to the Medicaid—what is it called? The state plan.

I am not talking about those more routine kinds of waivers. I'm talking about the one—the waivers, the 1115s, the demonstration waivers.

They were usually justified on the grounds that we were going to learn something about how the system would operate if you did something new. But of course that rarely happened because these things were known to be temporary. People did not wait as if the demonstration was permanent.

You get a different behavioral result if everybody is paying attention to something new. If its just part of the normal daily way you operate in the health system you don't pay so much attention to it, and therefore your behavior is going to be different. I think we never learned a great deal about behavioral responses to policy.

However, we did learn a great deal about how you got something to actually work within the program. It's amazingly difficult in the Medicare program to pay a bill.

SMITH: Right.

ANTOS: That or the Medicaid program. So, you know, getting the mechanics right is really very important. Then to be able to say that you've got something in the field that does this is incredibly important. The hospital payment system, the PPS system, exists to this day because somebody could say, well, we've got a demonstration in—I think it was New Jersey.

Well, you know, the heck of it is, that demonstration hadn't gotten off the ground. But it was in there. It was in the field.

SMITH: As long as the question was it wasn't...proved.

ANTOS: Well, I would say it proved that you can move on to policy. So I think that, you know, that demonstrates the value of demonstrations. There is another important role for demonstrations, and that is legitimately to get around the rules.

So that if it is a Medicaid demonstration, the states can actually do something that you might think was worthwhile. Or in the case of Medicare, again, not to test something new but to just get around a problem of some sort.

The Arizona Medicaid program is a great example. They waited until the early '80s. I think the combination of some long-term care issues and realizing that there was money to be had and they were passing it up for more than 15 years, so they finally brought themselves to say, well, we would be willing to do a Medicaid program but on our terms.
I wasn't there at the time. They used the demonstration waiver program for a capitated system. Okay, that's fine with us. But, it got to be annoying.

When I was there, every couple years we had to think of a new reason why we could extend the waiver because at that time it wasn't fully accepted that we could just extend the waiver. This was again an OMB game. We constantly went through this routine of proving to them that this adjustment was going to be yet another opportunity to learn great things. It was going to be budget-neutral and we could do it for a limited time only.

Well, never a limited time in fact. Never budget-neutral. And I think we did actually in the case of Arizona, we did learn a few things that were quite useful. But, those other two criteria are rarely feasible because of unforeseen circumstances that just had to be dealt with.

When people present themselves for service you are going to pay for it. I don't think there is anything wrong with that. Now, Oregon. I really liked the Oregon project. I thought that the people in Oregon were very gutsy. I think they were not very good at public relations. I think the Department was terrible at it and the whole thing was misconstrued in the press.

I took the Oregon project to be a way of calculating a capitation rate for Medicaid HMOs, not a way of excluding services if services were necessary. That was in fact what they said if you read the documents.

Well, why not try a different way for establishing a payment rate for a health plan in Medicaid that might be based on getting the health plans to come to grips a little more directly, with the idea that there are some things that you do that aren't so efficient. And have the population come to grips with the idea that, yes, we know this program is expensive and we know you are complaining about your taxes. But, look, there might be a way to cope with this problem and we are going to try to do it in a way that is fair to everybody. But that doesn't mean it was going to be a success, and I don't think it was.

Nonetheless I thought that there were some pretty good principles to date. This thing was treated as the hot potato that it was. There were major, major problems. And the federal government, through my office, meddled constantly to get them to change sometimes important details.

There were treatments to promote fertility and child-bearing, for example. And, you know, that category of service they were prepared to have low on the list but it became close to number one, right up there with saving somebody from a heart attack in the emergency room. I've got to say that

that suggests that maybe the process didn't go too well. But that was the federal government. That was the Americans—

SMITH: A wonderful experiment in the American character, isn't it? I mean, really strange responses. And it shows what happens when these issues become highly public.

ANTOS: Well, that and also when you have other laws that were never intended to apply to this. The Americans With Disabilities Act was the leverage against some policy in this case. It seemed to me that all we were doing was helping them find a new way to set a capitation rate, not telling any physician in Oregon what they could or couldn't do.

But the way it became construed and therefore politically the way it had to come out was, this was a list of things you could and couldn't do. Therefore, anything that was politically correct was going to be on that list. If you go back and look at the list, the original list, for things that were below line, not much was below the line.

The list was hard to interpret. I think you have to be a physician to actually have any sense of it. But just on the face of it a lay person would say, "They pay for that?" It hardly seemed like a very binding list.

Okay, so political hot potato. I can't remember what year it first came up but it was during the George Herbert Walker Bush administration. And Lou Sullivan was the Secretary, right? So I remember that we had only infrequent meetings discussing what was going to be done with this project. And no decision was ever made.

The Secretary got to the end of his term and left, and I think had breathed a sigh of relief that we hadn't done anything. I felt very strongly that that was a miscarriage of justice for Oregon and for the country.

When the Clinton Administration came in it took a while for Donna Shalala to get around to HCFA. But eventually she did. And one of the first meetings that involved staff was on Oregon. It was an interesting meeting because Donna Shalala wanted it off the table as quickly as possible.

The problem was that nobody had given any signal that the roadblocks from OMB or anyplace else had been cleared away. In fact, I knew they hadn't been cleared away.

All right, so it took a few months more of constant aggravation to resolve all this. But it was eventually approved. It was approved in a way to absolutely minimize Federal involvement. So there was—I don't know that no data were collected but I know that we were prohibited from asking for anything that wasn't given voluntarily.

That was a path-breaking decision on the part of Donna Shalala that set the pattern in her administration for many of these 1115 projects. She was not interested in data collection, but was driven by politics.

In the case of Oregon, the whole point was we have to get this approved and we don't want Kaiser Portland or some other plan complaining because they don't want to invest some money in a data system that would actually help them manage their patients. They just didn't want to spend the money. So, okay, we were going to dispense with that, and other things of that ilk.

MOORE: That's an interesting thought, that it set the stage for the remaining and much more expansive 1115s.

ANTOS: Maybe she came with that in mind but it was certainly different to have this gigantic thorn in your side. Inserted there—well, inserted there by the previous administration. And I'm sure their thought was, oh, well, damned Republicans. Of course they put it off on us. We can't avoid it. We've got at least four years. We can't just look at it for four years. They only had to look at it for probably a year and a half or so.

We can't look at it for that long and so we are going to get stuck with all the bad publicity. That might have been part of it. But I think it was an honest human emotion: fear. Yeah, nobody wanted to be stuck with this one.

SMITH: And you said apparently you didn't even want to get close enough to it to worry about data collection.

ANTOS: Well, we had been running along this path that had been set for us by the previous Administration that we were going to collect data and we were going to verify until everyone was blue in the face. So that's the direction we had been given. And maybe with a little less rigor it made sense. Here was a truly new idea.

Most of these demonstration projects that I saw in my tenure were not new ideas, they were trying to adapt an idea that somebody already knew about

and had already tried into either Medicaid or Medicare, or even more trivially—although important—let's just take something that some state did and adjust it so it will work in this other state. Well, those aren't new ideas.

This one gets right at the heart of the major ethical dilemma of health care in this country. And we did what we could to avoid it.

SMITH: Which in itself is an interesting comment, isn't it?

ANTOS: Well, you know, we do what we can—to avoid big issues like that.

SMITH: One of the big beefs in the popular literature was that this so-called rationing plan was being applied to Medicaid patients. And of course then people said, "Well, this is just genocide," and all that kind of stuff.

It was true, was it not, that this was a scheme for managing care that applied to Medicaid patients. And it had in it this notion that we're going to discriminate between procedures.

ANTOS: Well, I would disagree with that. I go back to what they originally proposed to do, which is this was a scheme for setting a capitation payment in Medicaid.

SMITH: Right. But it was never discussed as that in the popular press.

ANTOS: Absolutely. Because that's one syllable too complicated. Whereas, rational rationing, you know, whoever came up with that one, I'm afraid that maybe the Oregon people did themselves in because they thought this is a way to sell it.

Then they fell right into it because the political sensitivities, the cultural sensitivities were all right there. If only they had kept it dull and gray.

Although I think that was probably impossible. But if they had tried to keep it dull and gray they might have been a little bit more successful.

SMITH: Had they gone in and said this is simply a way for us to try to sort out managed care rates.

ANTOS: Yeah. But they would have been bowled over. A good newspaper reporter would have read the proposal, saw we're going to create a list, we're going to have a process that involves panels of physicians and citizens

making rankings. And as soon as you see that then it's rationing and it's a funny process, too. So it had to attract attention but at least within, Washington circles. Serious circles. We could have talked about it in a legitimate way. But we never did.

MOORE: Were there other states coming in for kind of major reform, 1115s that you recall at that same time?

ANTOS: You know, I was so involved with—yeah, there were but I can't remember who they were. I remember we had a meeting with Governor Dean. And when would that have been? I sure wish I could remember. Seems like only yesterday. But this was later, obviously, after we got Oregon out of our system. After that, there were a series of state initiatives.

However, we were also in the throes of the Clinton health reform—or maybe in the early throes. I don't remember exactly. But all the states had gotten the message: Okay, this is an administration that is willing to work with you. And it turned out that there was pent-up demand to do various things. But I can't remember the details.

I strongly suspect that most of the states who were coming forward were not coming forward with what one would call a major reform. But there were some states. And I'm sure that Dean was coming—I don't remember the name of his plan, but whatever it became—I can remember he made us a visit.

It was a short and interesting visit. He wasn't the only governor, but he is the only person I remember distinctly. New Jersey came in. There were a series of states and they just—

SMITH: Tennessee came in shortly.

ANTOS: Oh, Tennessee. Thank you for reminding me. TennCare. Ned McWhorter.

Uhhh. Let's see, the administrator was Bruce Vladeck—yeah, okay.
The process came from the Secretary's office, as opposed to the way that it was in the preceding administration where they tended actually to come in more at the HCFA level. They were now coming through the Secretary's office. That, of course—that had to be it. That's why we saw Governor Dean. And that's why we saw Governor McWhorter and we saw other people in similar mode. In fact, we must have seen Whitman from New Jersey.

Because I think she was the governor of New Jersey at that time. And anyway, the word filtered down to us that, "Hurry up. Even though you don't have a complete proposal yet we've got to approve this right away." Which is kind of an interesting experience compared to the preceding several administrations of where it was. You know, torment yourself with details and keep going back.

SMITH: Do you think a lot of this was that you had a president up there that was much more amenable to listening to governors and also wanted to change Medicaid?

ANTOS: I always thought it was Governor Clinton. So, yeah. And by the way, it's Governor Bush now.

So—no, absolutely, that's it. He had wanted to do something in Arkansas, have some problem resolved. Judy, you may remember this. There was some problem with the—

MOORE: ...with the folklore.

ANTOS: Yeah, there was some problem with the regional office that controlled Arkansas. Whatever it was, the problem wasn't resolved satisfactorily. So when he became President years later he remembered that. And one of his objectives that was articulated right off the bat—not to the press—was to get those people out of the way. So that's what we were trying to do.

Now TennCare. There was a lot of nervousness about TennCare. Not only were they talking about something far more complicated than even Oregon. In Oregon they weren't talking about creating a new health system. All they were talking about was a complicated, consensus-building process to make a list, essentially. But they weren't creating health systems. That's a whole new order of problems.

And it must have been—must have been an election coming up in Tennessee, is all I can think of. I don't remember precisely. But there was a great desire to have this thing active on certain dates. But, the technical people who were looking at this basically all came to the same conclusion.

They can't do it. They don't know what they're doing. They don't have all the elements lined up. They don't even have a list of names of people—of

the beneficiaries who they must contact. They didn't have a good process for enrolling people. And what about the default? There had to be a default health plan of some sort. How were they going to do that?

Well, this was early on. They never really did resolve most of these problems, as far as I could tell. And the ugly specter was that, you know, when the calendar turned to the appointed day there would be people who couldn't go to their local emergency room for the care they were supposed to get because they were now assigned to a health plan. And that health plan—well, you might have to get on a bus. And we knew that wasn't going to work.

We did approve that waiver mighty quickly. And then it kept being massaged for years to come. After it was approved I basically didn't have to work on it anymore. But I did follow it in the newspapers and in the health press. And all of the bad things that people had feared—and worse—materialized.

SMITH: What was the incentive? My vague understanding was that a large part of the incentive was that Tennessee had a big problem with the finances of the Medicaid program and wanted to get a lot of people in there up to umpteen percent of poverty to earn those Medicaid dollars.

ANTOS: Right. There was a combination of—well, they had a lot of problems. They had big public hospitals that were losing money hand over fist, as big public hospitals do. They, of course, had a lot of people who didn't have coverage and they wanted to do something about that. That was a big—big health delivery problem and a big political problem.

Everybody had rising costs. And so they were hoping that there was some managed care magic bullet where they could just contract out on a risk basis and say, "See you later, guys. That's your problem now. You figure out how to live within your capitation rate."

And they were hoping to kill all those birds with one stone. Well, it turns out that the health plans weren't so dumb and they weren't so eager to jump into this. There were border-crossing problems that they hadn't really taken into account. I wish I had a map. Is it Memphis? People were coming into Tennessee...

MOORE: It's actually just the delta. It's a big area. And everybody goes to Memphis from three or four other states.

ANTOS: Right, exactly. Well, their problem is that none of these people had any money. Just because you had invented TennCare didn't mean they weren't going to keep coming.

So people in other states suffered by this, in addition to the people in Tennessee. But, you can't stop somebody who is an emergency, you are going to deal with them and you're going to spend a lot of money doing it.

And you're not going to just ship them out once you stop the bleeding either. They are going to be in your hospital. Okay, so that problem didn't go away. I don't remember enough more about it other than what we all know, which is none of the goals that you would think they would have were achieved.

As far as I can tell the program is still a disaster. But probably better than it was the first couple years.

MOORE: They have cut back on their coverage a lot.

ANTOS: That's what you have to do.

MOORE: But their health plans are working a lot better.

ANTOS: Well, I think those two things go together.

MOORE: And they have preserved their DSH money, which was going to go away. That was the other thing they wanted to do.

ANTOS: Well, DSH is a very important way to fund all sorts of things.

SMITH: What years were you at CBO?

ANTOS: It was '94 to 2001. I started in '94 and this coincided with the change in directorship. Bob Reischauer had been director, followed by June O'Neill. June knew me and knew they were going to have trouble with health.

CBO had done a lot of work on the Clinton health reform and this was after the Clinton health reform.

The context wasn't health reform, it was the bread and butter issues of Medicare and Medicaid and the uninsured.

SMITH: Well, one of the questions that pops up that you hear this from both sides. A lot of people say that CBO numbers are somewhere between guesstimates and conditional or iffy estimates. Do we put too much credence in them?

And of course other people, including Bob Reischauer, for that matter, said, "Well, I agree with most of those things. There is a large amount of truth in that. But it's better than letting liars get away with saying anything they want to about what their programs will do."

ANTOS: Yeah, I agree with that. I wouldn't be so cruel in the characterization. This is the human condition. We are not very good at predicting anything, you know. I have always said that economists are really presumptuous if they think they can make 10-year forecasts of anything because we really have a hard time predicting what happened last year. That is not really a joke, you know. The data—the data are always more than a year old. So we really do have to predict what happened last year. And we're not good at it.

The Medicare–Plus–Choice program is proof of that. But the other—or an additional—perspective which I know Bob shared with you is that you need discipline in the legislative process. Unfortunately it looks like it's accounting. It's as if accountants do this work. Budget numbers are very exact. They are right down to numbers that end in something other than a zero.

The people who do this work realize that there is a tremendous margin of error. But the political process is—the Congress is filled with people who never took a math course in their life.

So you are dealing with verbal people and you need to get a numerical concept across. Don't give them two numbers, give them one. And I don't think there is any—solution to this obvious problem. There's guesswork here but I would say it's informed guesswork.

And the problem with the estimates that come out, first of all from an understandability standpoint, most of the time CBO will generate a table without any explanation at all. And a big problem that I think the people on

the Hill have is—here's a number that I didn't expect. Now what do I do? What was wrong with what I proposed?

Sometimes you can find out, sometimes you can't. That is a CBO staffing problem, but it's a real problem. The ideal I think would be a process that also got everybody to understand what's behind the estimate. CBO can give an informed opinion insight about how a policy might work.

A high cost estimate is telling me that there is a mechanism that I have put in here that isn't working, at least according to what I want. So explain to me. Maybe I can figure out a way to solve the problem. On really big bills I think CBO is pretty good at explaining their logic. But, you know, most things aren't really big bills.

SMITH: One of the things that interests me is the fact that CBO, unlike OMB, has managed to stay relatively unpoliticized. And the second thing is that you say that Congress—I think you have said rightly is full of people who never took a math course, but that CBO numbers have the credibility and the kind of leverage on the legislative process that they do.

ANTOS: Well, it's hard to know whether the egg or the chicken arrived first. After all, Congress set its own budget rules that created that leverage. It transformed the legislative process.

And so it revolutionized the way—the whole way policy is done in Congress. So the credibility comes from two sources. One is because the process requires a number. So you get tremendous credibility if the process requires a number.

You get additional credibility if the number has face validity, and even better if, when you write an explanation people read the explanation and a light bulb turns on. So it's technical but it's also political. And that has as an accident of history worked out. Didn't have to.

You know, you can have great analysts producing great stuff. But if you don't have that political acceptance, then it won't make any difference.

SMITH: You could also say it was an invention that was born out of hard and arduous struggle.

ANTOS: Yeah.

SMITH: And sometimes that sort of thing sharpens the mind. That's what Samuel Johnson said of hanging.

ANTOS: Yeah, hanging. I wish you wouldn't bring that up in this context. I mean, I was involved with a few estimates. Well, there's—eventually there is a statute of limitations on prosecutions, isn't there?

SMITH: In your time at CBO did you work on any Medicaid issues particularly?

MOORE: Were you involved at all with the block grant, for example?

ANTOS: Only a little bit. Linda Bilheimer really handled that. That's seriously a very, very difficult area and the formula fights over the block grant is what did it in.

And I thought that Linda did superhuman work to try to bring reality to that highly political process. But in the end, analysis doesn't do it, of course. You are deciding which state gets what in the end, a political question.

Recently someone proposed—something that would change some balance in the Medicaid program. It was—a reaction to the GAO or some report that looked at the FMAP, that said that California doesn't get as much per person as another state or, you know, its ability to spend is lower.

And so Rep. Pelosi said, "Oh, we're going to look into this." Good luck. I would say it's a great issue to look into as long as you don't try to actually change anything.

But it was great to see that.

SMITH: Well, we had a long, very interesting interview with Howard Cohen and I think he will never in his life forget his experience with the block grant.

ANTOS: Absolutely. Howard was responsible for one of the great moments in CBO history. It was at a hearing. I think it was the year before I got to CBO, in the Energy and Commerce, the Health Subcommittee. I don't know what the issue was but Howard unfurled a banner that went across behind the members' chairs saying, "Bad numbers drive bad policy."

And I have since told Howard that that is true. But good numbers drive bad policy, too.

SMITH: Well, this has been remarkably enlightening, I must say, and extremely useful to us.

ANTOS: Well, good. My pleasure.

SMITH: Thank you very much.

SMITH: —Department of Health Administration and Policy at the University of Oklahoma Health Sciences Center. And it is August 12th, 2003. And David Smith is conducting the interview. One of the things I wanted to ask you, I notice that you got an M.D., and right on top of that you got a Ph.D. What prompted you to do that and in what field?

BRANDT: Well, I was actually working on a Ph.D. in math when I decided to go to medical school and I decided to go to medical school because, in the interim, I had gotten married and my wife's father was a G.P. in Marietta, Oklahoma. I got fascinated by it, decided I would go into practice with him. That was my goal when I went to medical school.

I got turned off during medical school to doing general practice, or what is now known as family practice, and decided to stay in academics. So I went ahead and finished my Ph.D. in statistics and biostatistics and did part of a residency and then quit and decided I was going to be a researcher.

Then I got into administration through a kind of a fluke and spent my—almost my entire career as an administrator.

SMITH: Well, of course, one obvious question is: How did you come to be Assistant Secretary for Health? What was the history—

BRANDT: Yeah, that's a very interesting question. When it looked like President Reagan was going to win the election I had worked in both the AMA and the AAMC and testified before Congress representing one or the other of them. I had been involved in developing the section on medical schools of the AMA and was chairman of it.

They both asked me if they could nominate me. I was vice chancellor for health affairs for the University of Texas system at the time. So I said, "Fine. It's okay with me." And then I forgot all about it, to be brutally honest.

Then one day Secretary Schweiker called me on the telephone. I didn't know him but I knew who he was and knew of him and his work in the Senate. He asked me to come up and be interviewed. So I went up and had a truly in-depth interview by him.

SMITH: By that do you mean he went into your medical background or he was concerned about your views?

BRANDT: No, he went—he didn't push me on political views very much, he pushed me on sort of values and what he was looking for and that kind of stuff.

SMITH: He was a pretty engaging fellow, as I remember. I interviewed him and he was very lively.

BRANDT: I like him a lot. I have dealt with him quite a bit, of course, during the two years he was the Secretary, particularly. I mean, he made it sound very interesting and I had, you know, worked with NIH and CDC and all those and I really thought I understood the Public Health Service. I was shocked how little I really knew.

Anyway, I went home and he called me the next day. And I had gotten home late at night and I get up and go to work early in the morning, as I still do. So I hadn't even talked to my wife. And he called me and said he had a meeting with the President in a couple hours and I was his man and would I accept the job.

And I said, "Wait a minute, wait a minute, wait a minute."
So that was on a Friday. I remember it very well. And then, to make a long story short, I went up and talked to the hierarchy of the University of Texas system and the University of Texas system at that time had believed very strongly in faculty serving in government positions, state and national.

So they were perfectly happy with me doing it. And then on Friday, February 13, 1981, we had a regents' meeting. And in the middle of it I got called out because the President was on the telephone, which was announced at the meeting.

So I went in and he asked me if I would take the job and I said “yes.” I had already told Schweiker in the interim that I would. So March 1st I climbed aboard an airplane at Austin, Texas and flew to Washington and went to work. Rented a little apartment not very far away and started in on that unbelievable briefing system for the Senate confirmation. And by then I was getting dozens of calls every day wanting me to speak, wanting me to do this, congratulating me. One of the things about the Assistant Secretaries for Health is that we are all very close.

SMITH: Uh-huh. You mean former Assistant Secretaries?

BRANDT: Yeah, has-beens, as I refer to us but—not officially. As a matter of fact, most of the time we have been called together to give advice or other kinds of things. And it is interesting because even though politically we range all the way from the right to the left, I don't think anybody would consider us at the extremes.

SMITH: Phil Lee is pretty liberal.
BRANDT: Phil Lee is liberal, for sure. There are a couple of them that are reasonably liberal. There are a couple of them that are fairly conservative, one of whom is dead now—two of them are dead so far. And so anyway, they started calling me and offering advice and help.

And Monte Duval, who is the former Assistant Secretary was one of my teachers in medical school, used to be on the faculty here. As a matter of fact, OU is the only medical school that has had two members of its faculty serve as Assistant Secretary, although several went to Harvard afterwards and things like that.

SMITH: At this point, how was the office conceived? You know, when it was originally established one of its main functions seemed to be to reassure the AMA. But then later it becomes more of an advocate for general health concerns but without much ever, as I remember, in the way of staff. Because you had staff but you weren't staffed like ASPE or anything of that sort.

BRANDT: Oh, actually I was. At that time it was a line position, one of four line positions in the department: Social Security, HCFA, Public Health Service, and I have forgotten the name of the other one, but dealt with a hodgepodge of—

SMITH: The HRSA?

BRANDT: No, no. HRSA was an agency that reported to me. This was human development services. That was the name of it, and it included such things as the administration on aging and all that kind of stuff. It was kind of a welfare-oriented agency and I was line officer and had reporting to me the Public Health Service, ADAMHA, NIH—I mean, all the Public Health Service agencies.

I merged the Health Services Administration and the Health Resources Administration into HRSA as a part of a reorganization that we went through, CDC, NIH, FDA, HRSA, ADAMHA. And I'm missing one. But anyway, that—and then several others.

Health statistics reported to me, and so forth. So it was a pretty powerful position in the usual sense. And when I started I had 55,000 employees, so it was a pretty good-sized outfit.

So I went up there and of course finally got confirmed by the Senate on a voice vote, which made me very happy. And because C. Everett Koop had been nominated to be Surgeon General and he was—I think it's an understatement to say very controversial.

So I was Acting Surgeon General for nine months until he was confirmed finally. And the reason I mentioned voice vote, because he was confirmed roughly 52 to 48 or something like that. Very close. Turned out to be a great Surgeon General, in my view. But he was—

SMITH: Yes, I think greatly surprised us that he wasn't the kind of Surgeon General Reagan was expecting.

BRANDT: I think that's probably correct. But early on he spent a lot of time on his anti-abortion efforts and things of that sort. Koop is one of the most honest people I have ever met. When he says something you can be sure that is what he believes. But the point of it is, he also learns and changes when the data is there to convince him. So I think you're probably right that he wasn't exactly what everybody expected him to be. You know, the public health association APHA labeled him Dr. Kook, K-O-O-K. Various other names like that. I think he was unfairly attacked, particularly by the women's groups. He had trained more women pediatric surgeons than anybody else, trained the first one and all that kind of stuff. But he was still labeled a chauvinist and, you know, et cetera.

SMITH: Well, he comes from my part of the country; everybody locally had heard of Chick Koop.

And everybody I knew, and I knew a lot of people in the medical trade, said, "Sure, he's got these views." And many pediatricians do, as a matter of fact.

BRANDT: Yes.

SMITH: But he's a fine doctor and he's a very square shooter.

BRANDT: He's absolutely square. I mean, there is no question about it. And anyway, we got started. And of course during the briefings I learned that we had three very interesting cases out in L.A. from three young men with immune deficiency of unknown cause, gay, et cetera.

SMITH: This would have been when? Was this the first time the CDC turned them up?

BRANDT: This was April, yeah. April of 1981. Then they got two more and in June of '81 we put an article in the MMWR describing this strange new syndrome. Then cases started pouring in, particularly of Kaposi's sarcoma, in some cases a pneumocystis. So that got us started. And the controversy was unreal.

SMITH: Well, you say got us started. Was this kind of all the windchimes started tinkling, that is, the CDC and NIH?

BRANDT: Well, it was CDC and NIH primarily that were involved early on. We put Jim Curran in charge at CDC to handle the epidemiology and Anthony Fauci now the director of NIH, The National Institutes of Health.

Yeah. But anyway, Dr. Fauci at the NIH actually started admitting patients by September of '81. We called together a big conference on the issue in the fall of '81, a big scientific conference to try to decide which way to go, you know. Cases were starting to pile up.

It was controversial for two big reasons. One was the people with the illness who were gays or IV drug users, neither one of which ranked high in our society at the time.

I was accused of everything. Of course, there were editorials written about me being, on the one hand, a homophobe, on the other hand trying to advance the homosexual agenda, and et cetera. So that occupied a huge amount of my time and effort dealing with that issue.

SMITH: You seldom hear people say what was motivating them at this point and tend to infer this from reading between the lines. For example, I had the sense that Koop felt it's a doctor's duty. These people are sick and you move in on this. You, on the other hand, had not been a practicing

physician particularly. But you had done a residency. So what was moving you?

BRANDT: Well, two things moved me about it. One was that I saw it as a true public health problem. That was one issue. And the second issue was it was an intriguing problem, intriguing scientific problem and one that needed to be dealt with. The big shock to me was I thought that I made the assumption, of course, that the United States government and the Public Health Service had always dealt with epidemics like this. And in fact, they hadn't. This was the first time that we had dealt with a major epidemic.

SMITH: Is that a fact?

BRANDT: I went back and reviewed the polio material because I thought, well, this is similar. Well, the March of Dimes did all the polio work, not the U.S. Public Health Service. The government didn't get involved until they sponsored some of Ender's research when they isolated the polio virus, and then the vaccines—the Salk vaccine in particular, to a lesser extent the Sabin. So here I was with no real path to follow on a complex illness like this. It had many of the characteristics of polio. The big difference between it and polio, of course, was that polio tended to affect kids who are high in our society and this affected gays, who aren't high—or weren't high in our society.

SMITH: You are saying that then very, very early a lot of this got defined in terms of pro/anti-gay?

BRANDT: Oh, boy, did it ever. No question about it. As a matter of fact, that was the biggest issue of the whole thing in the early years. I mean, I got letters saying, you know, you are spending way too much time and effort on this instead of legitimate diseases like heart disease and cancer and things of that sort.

The other thing I learned though was the real importance of basic research. Because quite frankly, we would have been way behind the 8-ball if we hadn't had all this work on immune systems that had no direct application.

SMITH: Right.

BRANDT: It was fundamentally research for...

SMITH: If you hadn't had Gallo and that Montagnier in France, where would you have been?

BRANDT: Well, it wasn't so much them, it was the basic understanding of the T-cell/B-cell phenomenon and the way in which the immune system responds, and so forth. Some of that had been used in the early days of liver transplantation. But not much. And it was later—and of course Gallo, with the retroviruses which he had worked on. Of course, at that time retroviruses were not known to cause human disease except on one small disease in an isolated area of Japan. And nobody tumbled to retroviruses.

We were studying every known organism that had ever caused human disease and looking at variants of various things. As a matter of fact, it was a veterinarian at Harvard who likened feline leukemia to AIDS. And feline leukemia was a retrovirus and that kicked off the retroviral stuff. Now, Gallo, of course, had a huge knowledge of retroviruses.

That was what he did. And therefore it was just tailor-made for him to get into.

SMITH: But he wound up barking up the wrong tree.

BRANDT: For a while. And Luke Montagnier I didn't know, of course, and as a matter of fact had never heard of. But that's not too surprising considering everything. But everything that happened of course—it's kind of an intriguing little story—was when we realized the blood supply was contaminated, which occurred because of a preemie that had been born and had been transfused and promptly died of AIDS. It's not too hard to figure out that that kid wasn't gay or using IV drugs.

SMITH: And the point was made, as I remember.

BRANDT: Yeah. And so then, of course, the real problem was: What do you do now? And that was a really terrifying experience. But the story I wanted to tell was, I was on the board of the World Health Organization at the time and I was on the so-called executive committee of the board, which was really a program committee and planned the agenda.

So in '82, later in '82 when we had a meeting, I brought up the issue of putting AIDS on the agenda. We had named it by then. And it was vetoed by—guess what—France and Russia.

They said it was an American problem and not—you know, they didn't have that problem. I got long lectures about communistic societies and socialistic societies. France was socialistic at the time, and et cetera.

SMITH: Now, who was giving you these lectures?

BRANDT: The ministers of health of the two countries. So, you know, they didn't take a real position on AIDS till '87. '85 was the first time anything from the World Health Organization ever mentioned the word

AIDS. And of course by then it was devastating Africa.

SMITH: That's interesting because if you read some of these well-known accounts back there like Randy Shilts and so forth, you get the sense that the United States was dragging its feet and scientific progress is being obstructed and people are trying to shut down inquiry. And I am sure there were certain groups that sought to do that.

But from other accounts I get the sense that scientific inquiry was going ahead as fast as it could possibly go and these people were doing their darndest to find out what this thing was. And you were doing the best you could to get the thing on the agenda.

BRANDT: There were two scientific issues that came up early on. One was that there was a feeling—and I must admit that I shared that feeling early on—that this was going to turn out to have a very simple cause. That we would find it pretty quickly and everything would be great. And there were a lot in the scientific community that felt that way.

The second issue was the fact that it was so controversial. And in my opinion there were very good scientists who wouldn't touch it simply because of the controversy associated with all of this. And that, of course, I understand, but I didn't think much of it.

SMITH: Right. Well, there was one guy [Peter Duesberg] whose name I now forget who led a whole counter-movement.

BRANDT: Yeah, there was. There were several like that, as a matter of fact. I appeared on more talk shows than you can believe. And the most common things that came forth from the public calling into these various radio talk shows was, one, that this was God's will and I was interfering with punishing evil. And the second was that this was part of what we would now

call bioterrorism—that the germ warfare research that the United States was allegedly carrying on during that time, which I knew nothing about, had somehow or other come up with this virus and it had either escaped or was being deliberately used to wipe out gay people.

SMITH: Some of that certainly circulated in some of the radical gay newspapers.

BRANDT: Oh, boy, sure did! No question about that. And that became a—you know, as we tried to look at standard public health measures that one might take, some of the more radical people in the gay movement saw this as a move against gays. This particularly became an issue at the bath houses.

And so it was a kind of a fine line to walk all the time, to try to say, you know, my thoughts about sexual orientation phenomena aren't an issue. These are sick people. And your thoughts about the rightness or wrongness of their sexual behavior is not an issue. This is a public health problem. These people are suffering and dying and we need to do something about it.

SMITH: That gets you into another issue. I remember talking with people who were involved in the movement and said there were three phases. There was a fairly long phase identifying HIV and the connection with AIDS and all of this and there was a kind of a counter-movement that was even to some extent political and in the streets challenging that interpretation.

BRANDT: Yes.

SMITH: But there became a second big phase that involved a lot of the gay community which was—even though AZT is not particularly working there are all these other things that need treatment that we may be able to palliate and do something about and do research on, such as what you might be able to do about KS and so forth.

BRANDT: That mostly occurred after I left, but I got involved in it because when I moved to Maryland to become president of the campus at Baltimore, the health campus up there, the governor set up a task force on AIDS and made me chairman. So I couldn't escape the issue.

You did mention something earlier and that was the question of physicians and nurses refusing to take care of people.

And I spoke out on that pretty strongly. And there was a big storm created when Johns Hopkins fired a group of nurses because they refused to serve on a unit where gay people were being admitted, or people with AIDS were being admitted. And at that time, remember, we only knew it when they got frank AIDS.

I came out publicly and supported that move because I felt that through the years health professionals have exposed themselves to illness in order to fulfill their needs. And I wasn't very sympathetic. And when I moved to Maryland, for example, there wasn't a single dentist that we could identify that would take care of an AIDS patient.

And we finally convinced some of the dentists who were gay to begin to do that pretty soon. But we had beauty shops refusing to take care of—and barber shops and all kinds of people getting fired, et cetera. So it was really amazing. And people who were scared of touching doorknobs in public places and going to the john in a public place—and all that kind of stuff. The fear was understandable but absolutely unbelievably screwy. And there is no question there were a lot of people out there spreading that. There was also the problem of two other aspects of it, and one was the question of medical care and the second was the aspect of social services.

And those in '83 and '84 became the big controversies. And, you know, I could only say to them that, I mean, it sounds bureaucratic but that is not the responsibility of the Public Health Service.

I mean, go talk to HCFA and go talk to Human Development Services. There was a big need of that, I knew, but how to deal with it was another issue. And many of these people were extremely expensive to take care of because they were very sick, had these strange, bizarre infections, and so on. And then of course in the middle of all this we have the Tylenol poisonings occur.

SMITH: I had forgotten. I had totally forgotten about that.

BRANDT: Yeah, I got home, I guess it was close to 7 o'clock in the evening and the phone almost immediately rang to tell me of one, two, three—four cases in Chicago. Fortunately—I guess fortunately from the standpoint of the epidemiology—all of them went to the same hospital and saw the same doctor and he diagnosed cyanide poisoning.

And it was pretty easy to—I mean, the one thing they all shared in common was that they had all taken Tylenol that had been purchased within 24 hours of the time they showed up. And they all had gone to the same drugstore, all of which was useful.

So we immediately set in motion stuff. We sent people to Chicago and Johnson & Johnson was just magnificent because my biggest fear was that we had some nut loose in the factory who was just randomly scattering cyanide crystals in Tylenol capsules. And we set inspectors up and they went to the factory. All of these had come from a factory in Pennsylvania. There was only one other one that made Tylenol capsules down in Texas and none of the contaminated stuff had come from there. So I learned a lot about cyanide.

One of the interesting characteristics, by the way, is that of the manufacturers of cyanide—which is still used in gardening, apparently and that kind of stuff—each of them uses a slightly different crystalline structure. So by looking at the crystalline structure of the cyanide that was in those capsules or in other capsules in the bottle you could find out who the manufacturer was. The police then found out all of the outlets in the Chicago area. And you had to sign at that time. You had to sign a document when you bought cyanide, so they were able to find out everybody that had bought that particular brand of cyanide in the Chicago area. Within about 72 hours they had all that.

SMITH: Seventy-two hours?

BRANDT: Yeah, I think it was about that. Turned out not too many places sold that particular kind of cyanide so that allowed them to begin to focus. I wasn't involved in that aspect. I was trying to deal with the other. And then after we got through the early part of the problem I sort of turned it over to the commissioner of the FDA...And then every day we talked twice a day to figure out where everything was.

SMITH: In attempting to get people concerned about the AIDS problem, to move on some of these fronts, there was a lot of talk about being obstructed in efforts to get something done or about HHS not being cooperative.

And yet, when I look for instances of that I don't see very many, except one particular account I remember when you tried to put out an information booklet. And that got vetoed at the White House level, I guess at the behest

of some radical right religious groups. Were there other cases in which you were either personally blocked or efforts you sought to make?

BRANDT: Only one, really, only one time. And that was when in the early days we were attempting to do the necessary research. And I had a meeting with three big agency heads, NIH, CDC and FDA, to examine needs and that kind of stuff. And so we came up with a proposal to fund the research.

And that got turned down by OMB and became a big political battle because Henry Waxman's office got a copy of the memo from me to Secretary Heckler before I had seen the memo. He called up and said, "I wanted to talk to you about this memo you have written to Secretary Heckler asking for a supplemental appropriation."

SMITH: Before you had even had a chance to sign it or anything.

BRANDT: And I said, "What memo?" And Mr. Waxman and I were pretty good friends in spite of battling periodically in public. So that was when I sent out a famous memo that said, "In the future if you are going to leak something, at least let me see it first." Anyway, that got turned down by OMB.

And that led to a bit of a battle with the gay community because I went through the Public Health Service books and we had money in various programs that we weren't going to spend. I mean, it was clear we weren't going to spend it. So I got permission from the Congress to redirect that money and I was accused of robbing Peter to pay Paul and depriving other programs.

I wasn't depriving any other program. I told every agency head, "Look, if you think you have got a reasonable use for it, don't tell me, go ahead and use it."

So we used the money and the other—

SMITH: You used it, but I thought you said it was turned down.

BRANDT: No, I used the money that I had sitting in accounts already. I didn't go for a supplemental.

But because that memo got leaked and Tim Westmoreland—you know Tim?

SMITH: Yes.

BRANDT: He is still convinced that I leaked it in spite of my denial numerous times in private and publicly. I didn't leak it. The Congress passed a supplemental.

SMITH: The Congress what?

BRANDT: Passed a supplemental without an official request, actually passed it for more than I had asked for or more than I was going to ask for had I had permission to ask for it. So that was seen by many of the anti-administration folks as that, as interference, and so forth.

Now, two things that are important. One is that with Schweiker's permission and later Heckler's permission, I really asked the White House to stay out of the whole thing and for a whole lot of reasons. One is, I had read about the swine flu fiasco and I had read the Harvard account of that.

And so I knew that White Houses are by their very nature political. So it doesn't really make any difference whether you are to the left or to the right or someplace in between, it is still going to become a political issue—which I was trying to avoid, keep it as a basically scientific issue.

Now, the President got heavily criticized for never speaking out about this issue. And I was sent several speeches, draft speeches that he was going to make to various groups in which they had put something in there about AIDS. And I asked them at the White House to take it out; and they did.

So I think he was unfairly criticized, but I didn't want the politicians and the White House—and I'm not talking necessarily about the President, but all the other people who were there—just please let me deal with this as a major public health problem and a major issue.

So that, of course, became a problem. Now, I know of 13 histories that have been written during that period of time. Only one author has ever talked to me.

SMITH: Really? Isn't that astonishing?

BRANDT: Which I found to be interesting.

SMITH: Who is the one author that talked to you?

BRANDT: A gal who wrote a book called The AIDS Bureaucracy by the Harvard University Press. I can't think of her name...[Sandra Panem]

She must have interviewed me for—over time—24 or 30 hours of interviews. Now, Randy Shilts when he was working for the San Francisco newspaper, had interviewed me at various times during the early stages of the epidemic about various aspects of it. I never met the man. He was bright. He always asked the right questions, I thought.

And he was always very friendly and wrote what I thought were fairly sympathetic type articles. But in that book there are a lot of things that never happened that are in there. I mean, he has me—for example, on the blood sisters issue which became a big controversy, unfortunately. Do you know that story?

SMITH: The blood sisters?

BRANDT: When the blood supply became contaminated—when I came out and asked gays to voluntarily not donate rather than get into the issue of making it a crime or forcing the blood banks to take a sexual history, which of course they didn't like, the blood supply dropped rather dramatically.

And there was a lady who was a lesbian out in California who organized lesbians around the country with their—one thing I learned, by the way, is there is a very active gay network. Boy, did I learn that—quickly. And I learned that I could put stuff out on that network and it would get out quicker than publishing it or anything else. And she got them to donate blood. And as it was explained to me, lesbians do not have sexually transmitted diseases.

SMITH: Oh, I see.

BRANDT: And therefore they have pure blood. And brought the blood supply up. Well, the gay organization in New York decided to give her an award and they invited me to present the award to her, which I was perfectly willing to do. The large group of conservatives—unfortunately, they advertised it pretty widely. I was going to fly to New York. They made arrangements with the New York police to get me to the airport to make a flight that would get me to Miami or wherever I was going the next morning.

Well, it soon became clear that my presence was the drawing card and I was told by NBC, ABC, CBS, New York Times, The Wall Street Journal—

everything that you can think of—that they were all going to be there. So I sat down with myself one evening and I said, "This is crazy. I'll be the story. She's the hero, but I will be the story. It will be all over: Reagan official goes to gay dinner or something.

And so I said, "This is really nuts." And so I called them the next morning and said I'm not coming. This was about two days before. One of the histories of the time says that I should have gone. Randy Shilts says that I was ordered not to go. Nobody ordered me not to go.

And he says that Mrs. Heckler called me down and ordered me not to go. Mrs. Heckler wasn't even in the country and I had not talked to her. I talked to her about it afterwards. Some of the more radical gay groups interpreted that as me not wanting to associate with these people.

SMITH: I got the impression, that on the whole Shilts saw you as a pretty stand-up guy.

BRANDT: Oh, he did. There's no question about it. No, I came out very fair in that deal. I mean, I'm not arguing with that and I'm not arguing with—I do argue with some of the others. There is this gal wrote The Coming Plague. And she talked about my views about sexually transmitted diseases, which I found to be intriguing since—

SMITH: You didn't express your views, did you?

BRANDT: Well, not only that, I didn't even have those views. But she says that I did. The only good thing about it is she says that I was thinking, which I thought was kind of interesting.
But there are other books like that and they—

SMITH: Is there any book that you thought was really a good book in this area? I mean, I have read one that—it was kind of academic, but seems not bad in some ways.

BRANDT: What's that?

SMITH: I think his name is Steve Epstein and it's called Impure Science. He talks about how it got politicized. I think it's not bad.

BRANDT: Yeah. My view about it—and I haven't seen one yet, is that I would like to see a really objective study of that period of time. I think it

would be helpful now that people are worried about bioterrorism and other kinds of things to be able to say here are problems you can expect to occur. I think the one thing about AIDS in a way is that it's unique primarily because of who it affected.

And today it probably wouldn't be nearly as controversial because even though homosexuality is still a controversial area of debate—just look at the Episcopal Church today, for example—I think it is—it would be more widely appreciated that these people were sick and they needed help. And that it was appropriate for the U.S. Public Health Service to get involved. In 1981, that certainly wasn't true.

So in that sense an objective study of the period might not be as useful. But on the other hand, it might keep future people in my position or some other responsible position like that from making similar mistakes.

The one thing about that job—which, by the way I had not appreciated very well when I took it—was all this controversy you do get into.

Because—and let me just give you a very good example of that. When we sat down and said, "What are we going to do to prevent future Tylenol poisonings?" And we came up along with OTC manufacturers, over-the-counter manufacturers, on the issue of the tamper-proof packaging. And put that into effect. Boy, did I get hate mail. From elderly groups and groups for the disabled that said, "These people can't open those packages." Well, you know, it was sort of a toss-up. Do you want to be able to open a package that is contaminated or do you want to be able to—

Well, even today when I go to speak sometimes and people know about this story they will bring some of this tamper-proof packaging up and ask me to open it. I have trouble opening some of it. And my standard line is, "With a pocket knife and a pair of pliers I can do it."

Because some of it is pretty tough to open, in my opinion. But of course by now I have trifocals and not nearly the flexibility, you know, of being 70 years old. But that brought to mind the fact that the old maxim: No good deed goes unpunished.

SMITH: That is certainly true.

BRANDT: And I don't think I had appreciated early on everything you do or say is going to be controversial. And I guess I just had ignored it in the past.

SMITH: Well, in an academic setting you don't expect it and—

BRANDT: But I knew some of the people that had been in that position. I got a piece of advice early on that really turned out to be true. One of the old hands in the Public Health Service—two pieces of advice, actually.

One was: It's your friends, not your enemies that cause you the most trouble. And that's really true. Because of my AMA work and my AAMC work and having been a dean of a medical school and stuff like that, I was besieged by all my old buddies to do this, that or the other thing, you know. And I would have to say no—or yes, as the case may be.

The second piece of advice came when one evening after long briefings I was sitting in the office that they had given me and reading a briefing book. And one of the old-timers came by. And I said, "Come in. Have a cup of coffee." He said okay. So he came in and I said, "You have been around here for a long time. Tell me what this job is really like."

And he said—he thought for a moment and he said, "Well, let me tell you, it's a wonderful opportunity to make an ass of yourself." And those two lessons really showed up because ambush interviews were something that I was totally unaware of. Having to deal with things like 20/20 and some of those whose primary purpose is to show how stupid and ignorant and uncaring you are.

That kind of stuff really surprised me. Now, overall I would say, overall my press wasn't that bad. And I got to know many, many of the reporters. But the dilemma was that a lot of the people shoved the more controversial stuff up to me.

For example, Mr. Hinkley—Mr. Hinkley, you remember, who shot the president was sentenced to St. Elizabeth's Hospital, which at that time was a Public Health Service Hospital.

So that every time something went on out there that involved Hinkley, I got called to make a decision. I mean, that was nuts, you know. But it was controversial and so when he tried to commit suicide and pulling the oldest trick in the book. And other things would leak out about him. And

subsequently, many years later, a reporter one time asked me if I thought he should be released.

And I said, "How do I know? I'm not taking care of him, you know." But anyway, I got labeled by one reporter as Mr. Hinkley's doctor. But the other thing was that the FDA kicked a lot of stuff up to me.

SMITH: The FDA what?

BRANDT: Kicked a lot of controversial stuff up to me, which I was perfectly willing to make decisions about it if it was ultimately my place to do it. But—just take some things like the contraceptive sponge.

And, you know, what else could you do? It met all the criteria of the law. It needed to be approved. As far as I was concerned, the science was solid. The approval process had been followed absolutely to the letter. So I signed it.

And of course the concept of—as one reporter said to me—jokingly, fortunately—that I had done more for backseat sex than any Assistant Secretary in history. I said, "Oh, for God's sake, don't let that get around." But it did get around. But not from him, I'm convinced.

But some of the religious organizations got, you know, heavily involved.

SMITH: One other thing you were, I thought, pretty much involved in was pushing for children's health.

BRANDT: Yes.

SMITH: This being in the area before the various kind of Waxman Medicaid reforms came on line. But this was a period in which there was a lot of noise, as I remember, about infant mortality and a good bit of concern that this be given a top priority. And I don't know the ways that you were involved in that or—

BRANDT: I was involved. There were two—there were several places that we got involved. In the first place, remember that Julie Richmond in his tenure—by the way is another liberal but only about children.

Julie had set up an agenda for 1990. And I decided to implement it. I read it one night, that report, and decided to implement that. I set up all the

task forces. Well, one of them was to reduce infant mortality. And another one was, you know, the increased immunizations and much of the standard stuff.

And because of that, and getting heavily involved in it and trying to meet those priorities and meet those objectives, we did do that. And I made people in preparing for their fiscal '83 budget justify any budgetary changes on the basis of the objectives for the nation. In the interim I also set up a procedure for developing the 2000 objectives. So infant mortality became an issue. We also had all the vaccine flareup during this period of time.

This was the issue about—it was a group called Disappointed Parents Together, DPT, who were arguing that the required vaccines caused neurologic disorders.

BRANDT: And so that became a big controversy that led to the so-called vaccine—I have forgotten the exact name of it now—but it was Waxman's bill to set up this vaccine compensation system for people who really are injured by vaccines and can demonstrate that.

But we did a fair amount of work on vaccines to try to really see (a) is there—because the problem is that you are vaccinating kids at a time in their life where you start picking these defects up anyway. So the question was: Is it the vaccine or is it something else?

And frankly, I am not convinced there is any really good way to sort that out. But since then the molecular biologists and others have pretty well, to my satisfaction, demonstrated that if the vaccines are given properly that the risk is trivial. And this became a big issue later with autism, DPT, and others. By the way, another controversy during this period of time was the cancer chemotherapeutic trials in which a reporter for the Washington Post quoted various people saying that the NCI was killing people by their trials.

And it's age-old issue that at that time the standard cancer chemotherapeutic trials were in people who had exhausted everything else and were dying. And so the question of sorting out was it the chemotherapy that was killing them, either directly or indirectly, or was it their disease or was it some kind of interaction between the two?

So that took a while to sort through. Anyway, we finally worked out some kind of peaceable arrangement where we could have some assurance. But part of the controversy came about because of the question of how much

evidence does the FDA need to have in the treatment of cancer to approve a drug, NIH taking one position and then the FDA taking another position.

And then we finally set up a task force and worked through all of that. We also ran into part of that when we were setting up the testing mechanism for HIV after the test had been developed. I won't get into the debate about who developed it. Because I don't know the answer to that. But the one in the United States was clearly developed in the United States. And we were going to license companies to do that and we made them bid to do it. And I signed those contracts—

Oh, the Reyes syndrome. That was the other big battle, the Reyes syndrome.

SMITH: Did you get into any of the efforts to broaden coverage for children, pregnant women, or was that a—that pretty much a HCFA initiative?

BRANDT: That was pretty much HCFA. I was only asked in various senior staff meetings to make comments. All their regulations went through me. And, you know, we would read them and comment on them, and so forth. I did get involved in the liver transplant issue. That's where I got overruled by the President himself...and they told me I was being way too rigid.

SMITH: Well, in way of summary, it seems to me that there was very little effort to block you in the efforts that you were making in this AIDS area and that I don't get any indication that anybody ever said to you, "You can't do this, you can't do that."

BRANDT: Well, the only real thing, the only place had to do with the money side of it. That's really the only place that I ran into any what I would consider active interference. Now—by the administration, I'm talking about. Now, on the other hand we had plenty of battles with the Congress during this period of time over a whole lot of issues, not the least, of which was the priorities for distribution of money.

I should point out to you that during the period of time that I was Assistant Secretary we got the biggest increases in the history of the NIH, excepting the period of time when Shannon was there and really putting the heat on. We got up to 5,000 new and competing renewal grants during the period of time I was there, and so forth. But with the Congress and with others, we were constantly getting into debates about where the priorities ought to be

for the expenditure of those monies. And in that sense AIDS and some other things became big issues. But by and large, the real controversies came from outside.

And I should say that I did show up at a number of gay events. I mean, the blood sisters was an exception to the rule. But, for example, I went out to L.A. to—they had a clinic that was run by the local association of gay and lesbian people out in that area and they were opening an AIDS thing that was being staffed by UCLA docs on a volunteer basis.

And I went out and got a little bit shanghaied, I must admit, but I got out there because I was going to do this ribbon-cutting and everything. And I thought this was going to be people from UCLA and the hierarchy of the gays' association. It turned out they had invited the press. So it turned out to be a press conference and, you know, that kind of stuff.

SMITH: Certainly any account you read makes it clear that one of the things very important about the gay campaign was that they were using publicity. And they got very good at that.

BRANDT: Oh, they are very good at it.

There were sort of three schools of gays, I would say, during that. And I got to know those people pretty dadgum well. And I would like to point out to you when I got out there I was very naive about that whole business. I knew nothing about it except the usual sort of stuff that gets tossed around in dressing rooms and so forth.

A group of them really decided to educate me. And I was perfectly willing to be educated because I didn't know very much about it, to be brutally honest. I have at home 20-some-odd books on the issue that were sort of hand-picked by various members of the leadership. The three schools, I think there was one group of homosexual people, both gays and lesbians, who frankly just wanted to live their life and didn't want to be involved in all this stuff.

There was—and I have no idea how big that group was but I did meet some of them. There was a group of what I called the more radical gays who felt like any move to constrain or be critical of their behavior was an attack on them.

And then there was the vast majority who really saw this as—well, some of them saw this as an issue to advance some other kind of agenda. An acceptance agenda is the way I would put it. But the biggest group of them really saw this as their brothers and sisters suffering and that it was the responsibility of the government to deal with this like the government would deal with any other epidemic. Now, the problem was, the government didn't deal with any other epidemic.

Or hadn't at that time. But other than that—and I was very sympathetic with that. I mean, I would have felt that I don't care whether you're—you know, whether you have been divorced 18 times or cheat on your spouse or anything else...But if you are threatened it becomes a public health issue that needs to be addressed.

I feel the same way, by the way, about violence. I mean, violence is a public health question, in my opinion, because it is amenable, it costs a lot of money. A lot of people suffer as a result of it. And I don't get into the issue of innocent versus guilty and all that kind of stuff.

You know, the newspapers used to describe people who—well, like Arthur Ashe and others as innocent victims, which suggests that everybody else is some kind of guilty victim.

You know, that's just the way it is. I don't want to get involved in it. I don't still get involved in it. I stay away from it. We had a guy here in town, a gay man who was also a psychiatrist, who really created an enormous backlash because he felt and said that gays are very creative people and we don't give them enough respect and we need to have et cetera, et cetera, et cetera. You know, in a conservative state like Oklahoma that really hurt their image.

SMITH: It did. It did not advance the cause.

BRANDT: So I learned a lot and as I look back on it I don't feel ashamed of anything that we did. There are some things I would have done different had I known about it. But I know a lot more now than I did then.

SMITH: Well, I have talked with a lot of people and I must say that your reputation is good, is solid here. People say that they thought you dealt with this as a responsible doctor should have done and as a responsible public servant should have done.

BRANDT: I mean, that's all I really wanted to do was to deal with it as a problem that threatened a lot of people. I felt that so much of this was tied up in other issues. And I have to admit there is the issue of serving in a politically and socially conservative administration. And it wasn't the latter nearly as much as everybody plays it up to be, that people had an expectation that I would behave in a certain way and that I would come out and condemn all these people and all that kind of stuff.

And I think in part people were surprised that I didn't do that—because, you know, I'm not pure. I mean, I saw no reason to—to take positions like that; and I didn't. And I think there were people out there who were doing that. The other interesting thing was that the so-called Moral Majority never really bothered me. They sort of left me alone in this battle.

The ones who caused me—I shouldn't say caused me trouble—but that I met with and were very critical were the conservative Jewish and the conservative Catholic groups. They came to see me on a number of occasions. Indeed, I will never forget the rabbi—Levin was his name—who looked like the classic image of a rabbi, long—all dressed in black.

And we had met several times. And I actually liked him even though we disagreed on this issue. And he called me up one morning. It was about 10 o'clock or so. And he said, "Doctor," he said, "you and I are friends, so I just wanted to advise you that at noon we are calling a press conference."

And I said, "Oh, that's interesting, Rabbi."

And he said, "Yes, and we are going to demand that the President fire you." And he said, "I want you to know that this is not personal. This has to do with your dealing with the AIDS thing."

And I said, "Rabbi, I hope you are successful." It was one of those days when I was hoping I would get fired or something. But there were a lot of times I thought about quitting and getting out of there, I've got to tell you. But on the other hand—and it's interesting because when I went—the group of us, former Assistant Secretaries met with the secretary, Thompson, shortly after he took over and so forth.

And we went in the secretary's conference room. For reasons that are beyond me—matter of fact, Phil Lee got to deliver the message. He called me up and he said—we had developed these points that we wanted to make,

I think, through conference calls, et cetera. And he said, "Oh, by the way, we have decided that you are to be the spokesman."

You, chairing it. And I said, "Who is we that decided?"

He said, "Oh, all the rest of us." I said okay. So I was up at the head of the table with this—and somebody, in introducing me to the Secretary, said that AIDS had been discovered and I had to deal with the Tylenol poisonings. And Secretary Thompson took one look at me. He said, "Will you go to the other end of the table. Whatever you've got may be catching."

And—so anyway, it was an interesting time. As a consequence of that I should say that I didn't get so heavily involved in the Medicare or Medicaid issues except for the transplant questions where I was asked by Carolyn, who was Administrator of HCFA at the time to address—to come up with recommendations on whether or not liver transplants for children should be covered by Medicaid.

It was no longer experimental but now it should be considered standard therapy. The consensus of the experts that I called together was that so little was known about cyclosporin A at that time, which was the anti-immune drug, and its effect on the developing renal system in these infants—because these were only infants that we were dealing with, with biliary atresia—was not known. And therefore it would be a mistake.

So I said “no,” and that's what got me called to the White House to meet with the President and a group of others in which at the end of all this—he asked lots of questions and he told me that I was overly rigid and I should go back and approve it as a standard therapy; so I did.

SMITH: Said you should go back and what?

BRANDT: And approve it as a standard therapy to be covered by Medicaid. The other place that I got into it a little bit with Medicaid was over the vaccine issue and over Reyes syndrome, which still was hanging around as a controversial area. Anyhow I got involved in the Medicare issue because we were trying to push for some preventive steps, in particular vaccines coverage, and it got turned down by the Congress because it was going to cost too much—pneumococcal vaccine, specifically.

And I also got tangentially involved in the Katy Becket phenomenon. For some reason, the White House sent me that request to reexamine the Katy Becket. You know the Katy Becket story?

SMITH: Oh, sure. Yeah, we've been all through Katy Becket.

BRANDT: That was a HCFA story, not I. And that was one that Koop worked on, of course. And so I just let him handle it with HCFA. But the original note came to me.

I'm glad I did it and I learned an enormous amount and I studied more than I had ever studied in medical school. I mean, every night there was something because we dealt all the way from molecular biology to issues of cyanide poisoning in Tylenol.

It was a really intriguing experience. And I tried to avoid a lot of the social scene. I would occasionally get ordered to go to this, that or the other, but I didn't particularly care for all that stuff.

SMITH: But in its way challenging and fascinating, but not necessarily something you would want to repeat.

BRANDT: Oh, I—you know, I have to tell you I never was on active duty in the service. If we got a Secretary some day who had so little wisdom that they would call upon me to come and do it again, I probably just would go.

And I worked for every administration that has been in since I have been there except this one. I have done projects for every one of them on various and sundry topics, and enjoyed it and learned a lot from every one of them because I went into every one of them without knowing anything about the topic, particularly. And it was worth doing.

If I could make that kind of a contribution and really felt like it was going to influence the public health in some way, I would do it again. And every report and every federal recommendation that I have ever given to an administration has been implemented.

Now, a couple of them because of the passage of time turned out to be sort of stupid as we learn more. But, you know, so what?

SMITH: Well, I'm glad to end on that note because some people that will read this should get that message.

INTERVIEW WITH BRUCE BULLEN
JUDY MOORE AND DAVID SMITH – JULY 17, 2003

SMITH: Today we are interviewing Bruce Bullen of the Harvard Pilgrim program. Judy Moore and David Smith interviewing and it is July 17, 2003. We thought it might be useful to start by asking you how you became a Medicaid director, how and when, and what were some of the main items on your plate when you got there?

BULLEN: Well, I became the Massachusetts Medicaid director in 1989 and served in that capacity until 1999. Just prior to becoming Medicaid director, I had been the budget director for the Senate Ways and Means committee in Massachusetts. And Medicaid of course was a significant budget conundrum.

When I took over, the program was running what was considered to be a massive deficit of about $400 or $500 million in a program of probably $2.5 billion in combined state and federal funding.

SMITH: Was that an annual or total deficit?

BULLEN: That was the annual deficit.

SMITH: So that could be a bit alarming?

BULLEN: That was alarming, yes. There were many problems in the program. The program couldn't pay claims. It had outsourced to Unisys and had some serious systems problems. It had backlogs in payment and outstanding settlements owed to hospitals and nursing homes, both of which were on retrospective rate-setting systems that involved multi-year retroactive settlements. It had angry providers, angry advocates, budgetary overruns. It was the kind of thing that a number of Medicaid programs in the late 1980s were facing. A lot needed to be done.

SMITH: What were the roots of this situation—was it the economy? Was it systematic bingeing? Was it years of not administering tightly; or all of the above?

BULLEN: Well, it was a number of things. In Massachusetts the recession happened quicker than it did elsewhere, as I recall. That was immediately following the Dukakis run for President, when they were touting the Massachusetts Miracle and all of a sudden the state went into a recession.

There were serious economic problems; downturns similar to what is happening now, and systems in place that were not working well, particularly the rate-setting system. Massachusetts had an independent rate-setting authority and very complicated hospital and nursing home reimbursement systems that were an accountant's and lawyer's dream.

We spent a lot of time just fighting off huge bills submitted for prior year services that needed to be reconciled. There was a general sense that the program was beyond the control of the Medicaid administration. The people who were paying the bills were not necessarily making the decisions on contracts and rates of payment.

It was a very heavily regulated program. There was no proactive purchasing agenda. Nor were we using the waiver programs very well. There wasn't enough administrative flexibility to gain purchasing leverage from the huge appropriation, all the Medicaid money going into the health care system. It was a reactive program.

SMITH: So they came to you and said we really have a challenge for you?

BULLEN: They did. And I knew exactly what the challenge was. Before I came to Harvard Pilgrim I spent 23 years with the state and had various jobs, one of which was at the Executive Office of Human Services, an umbrella agency over Medicaid and other health and human services programs.

I knew Medicaid well. I had not worked in the program, but had been either responsible for it at the cabinet level or through the Ways and Means committees that funded it.

MOORE: The best person at the right time.

BULLEN: I guess. I went in with my eyes open. Let me put it that way.

SMITH: Well, it would be kind of interesting to know what you set as your one, two, three priorities and how you thought you were going to take hold of this—

BULLEN: Right. It was very interesting. I came in with two years left in the second Dukakis term. He had just lost the race for President, and it was a down time. They were not interested in doing much other than holding things together.

I had spent a lot of time thinking about what would I do and how I would do it. I prepared a set of initiatives, which they weren't too interested in doing. But a new administration came in. This was Governor Weld, who was a Republican. And they didn't know very much about Medicaid.

They brought in Charlie Baker, who is now the CEO here. I'm the COO. We worked together for the remaining time that I was Medicaid director. He was very flexible, had ideas that were consistent with mine about how to go at the Medicaid problems, and gave me a lot of latitude.

We both agreed that this was not a problem that could be solved overnight. It wasn't a one-year effort. It was perhaps a four-year effort, which happened to end when the governor would be running for re-election.

We agreed when we first met that we would put an agenda together that would target, four years hence, a complete turn around of the program. We thought it would probably take that long to get there, and it turned out, in fact, to take that long.

MOORE: And what was that agenda?

BULLEN: Well, the agenda was now, you have to remember that this was 1989. The agenda was taking advantage of the growing managed care industry in Massachusetts because, as you know, Massachusetts had a strong HMO presence in the 1980s, and HMOs were growing. They were having great success.

SMITH: Can I ask you a quick kind of preliminary question? With the HMOs what kind of balance did you have or anticipate with respect to profit/not-for-profit, which often turns out to be a significant variable?

BULLEN: Well, that's another thing to realize about the Massachusetts marketplace. It is almost exclusively not-for-profit HMOs. The for-profits have never gained a foothold here. So Blue Cross, Tufts, and Harvard are the main players.

SMITH: Well, I think you are fortunate.

BULLEN: Well, it didn't save us. We have done a good job of crippling our homegrown HMO industry here, when the backlash hit everybody—us, as well as the national for-profits. But, it made it easier then to think about

using the HMO system to solve the Medicaid problem than it otherwise would have been.

That was one approach. Another was to use waiver flexibility that had never been taken advantage of by the administration. Yet another was to completely revamp the reimbursement systems for hospitals and nursing homes and focus on prospective payment systems; to give more control to Medicaid and not have an independent entity, the rate-setting commission, setting rates for Medicaid; but to refocus Medicaid as a purchaser of care with the tools to be able to take advantage of the leverage in the marketplace that its huge appropriation gives Medicaid.

Another component of our plan was to employ utilization control and management to take advantage of a well-developed community system of care in Massachusetts that the rigidity of the Medicaid program prevented us from exploiting.

In other words, the program was tilted wildly towards institutional care and needed to offer a spectrum of care with lower unit costs as well as higher quality services.

SMITH: Was the heavy emphasis on institutional care, was that the natural inheritance of the Medicaid program or were there unique features in Massachusetts? It occurs to me you've got a lot of big hospitals and medical schools and things of that sort. I don't know whether that was an influence.

BULLEN: We have a heavily institutional service system to begin with, although that cuts both ways. We actually have competition in some areas if you're free to use it. We have competing teaching hospitals, for instance.

But there was a "perfect storm" of things that you wouldn't want simultaneously. You know, a service system that is institutionally weighted and all of the incentives that exist in the Medicaid program to institutionalize people.

For instance, the eligibility system in long-term care virtually prevents a low-income senior or disabled person who isn't categorically eligible from receiving Medicaid services in the community. But the minute the person applies to a nursing home he or she is automatically Medicaid eligible. We also had a reimbursement system in nursing homes that created a huge administrative day problem in the hospitals. Medicaid-eligible people were backing up in the hospital because there was no nursing home bed available.

But we had a payment system that rewarded nursing homes for taking a very low-level admission. Nursing homes made a lot of money on Level 3's, but not on the SNF level patients. We completely reversed the incentive by instituting a prospective case mix system of reimbursement that paid in blocks that increased as the acuity level of the admission increased.

Instead of fighting over low acuity admissions the homes all of a sudden started fighting over high acuity admissions, because they were making more money there. And we had no administrative day problem in our hospitals.

They all got admitted. An ancillary result was that the demand for community services rose, because the people who used to go into nursing homes as Level 3's started requiring a lot of community support. We put in utilization management systems and started using our elder affairs agency more and began to develop a community system for seniors.

We did something similar with hospitals by changing the retrospective system to a prospective DRG-like system that operates today, although it's very controversial. We put it in place to complement the move to managed care, to reward community hospitals, and to get some of the volume, the routine volume, out of the downtown teaching hospitals into community hospitals. We designed a reimbursement system specifically to try to support that move.

MOORE: Did you do all of this at once or did you try to stage it in some way?

BULLEN: We had to stage it. I would say putting all of this in place, including filing for a 1915B waiver, all happened in the first two years. And then it took two years for it to kick in.

MOORE: Uh-huh.

SMITH: So you were on target for the four years?

BULLEN: Yes. We were explicitly doing that.

Charlie said: I'll support you for the four years you're doing this, but at the end of the four years we have to see demonstrable improvement. The Medicaid program has to be under control, because the governor is going to

run for re-election and wants to say that we solved the Medicaid problem. Which he was able to do.

MOORE: And when did the managed care initiative begin? Did that start in that first four years or was that a little bit later?

BULLEN: We got our 1915B waiver in 1992.

MOORE: Okay.

BULLEN: Now, one of the things that we decided to do there which turned out to be a good decision was—we didn't have a primary care, lock-in managed care waiver.

SMITH: Do you have any problem with the balance between safety net hospitals and your HMOs? You've got a heavy emphasis on HMOs and I know IOM just put out a report about how the safety net hospitals are being both neglected and in some ways encroached upon by HMOs. Was that an issue in Massachusetts? And if so, how did you resolve it?

BULLEN: It could have been an issue. It hasn't been an issue. All you have to do is go look at Boston Medical Center to see whether it's an issue or not. They're booming down there.

There are a couple of reasons why safety net providers were not neglected in Massachusetts. One is a Medicaid created HMO which started before I got there although I continued to build it. It is a disproportionate-share, community health center-based HMO called Neighborhood Health Plan.

Neighborhood is the preferred payer for health centers and for disproportionate-share hospitals. It enabled us to avoid the kind of pitched battle that a lot of Medicaid programs had with their public health authorities over whether or not the Medicaid managed care initiative was disadvantageous to the safety net hospitals and the community health centers.

We were able to enroll people in Neighborhood Health Plan and therefore in a lot of the health centers and the hospitals that participate through them.

We also decided that instead of enrolling our Medicaid recipients in private HMOs exclusively, we would provide a choice: either enrollment in a capitated HMO or participation in a Medicaid-administered IPA called the

Primary Care Clinician program, which contracted directly with primary care doctors and used the Medicaid service system. We managed it as if it were a large IPA.

MOORE: That's like kind of a PCCM system that is actually managed by state employees, right?

BULLEN: Yes, and it competes with the HMOs. We actually subjected it to the HEDIS system. It gets scored by NCQA.

And it turned out to be a wonderful safety net. First, it guaranteed choice for people and was viewed as managed care "light." In some ways it was and in other ways it wasn't, because its HEDIS scores are pretty good.

Over the years we developed all the managed care features. For instance, the behavioral health carve-out is a piece of the primary care clinician plan. What we said to people was—you can't just use straight Medicaid fee-for-service anymore. You have to enroll in our managed care system.

But our managed care system involves a choice of HMOs or the primary care clinician program, which is a lot like traditional Medicaid except that there are a variety of new rules and requirements and some new benefits. For instance, you will have a 24-hour physician on call because the contract requires it.

And that turned out to be a really good safety valve. It enabled us to deal with the disabled issues better. It enabled us to deal with the disproportionate-share hospital issues better. The advocates loved it. We actually got advocates to support our managed care system because of it, and so it turned out to be really good.

SMITH: When you say "managed care light" that means that an individual would have a considerable amount of choice of doctors or in what sense is it managed care light?

BULLEN: Yes, at least at that time. Now it isn't "managed care light" really. It is probably more a managed care system than our commercial marketplace is. But at that time the HMOs were very tightly run with limited networks. The Harvard Community Health Plan, for instance, had physical health centers sites, like Kaiser.

Relative to what you would expect if you enrolled in an HMO and the kinds of restrictions you would live with, the PCP program looked like it offered broader choice. You could self-refer into the behavioral health system, for instance.

There were flexible pieces that people liked. You could choose your own primary care doctor, as long as that doctor was contracted with us. And that was a big issue: to make sure that our network of primary care doctors was sufficient.

We decided to reimburse them using the existing fee-for-service reimbursement system but pay them a $10 supplement to their fee-for-service reimbursement for an office visit whenever an enrollee came to the office and received services.

It was also an incentive to get people to go to the doctor. One of the big problems in Medicaid is that people don't go to the doctor. But it was also very attractive to doctors, who signed up in droves for the program. They had to sign contracts with us that required them to do things for Medicaid enrollees that they had never done before, like ensure 24-hour response capacity. The medical society loved it because doctors self-selected in or self-selected out.

We weren't trying to create a selective network of physicians. What I loved about it was that in the first year we put it in place our overall physician spending went down. The primary care dollars increased, but the specialty dollars decreased because the primary care doctors were rationalizing the use of specialists through gate-keeping controls. So it worked on all accounts.

MOORE: Bruce, did you have the disabled in from the beginning?

BULLEN: Yes.

MOORE: So you started with all Medicaid eligibles? You didn't distinguish between moms and kids and disabled when you started this?

BULLEN: We started with everyone under 65. Again, the PCP program enabled us to do that. If we had been enrolling only in capitated HMOs we would not have been able to do that.

MOORE: Did you have particular problems with that, with the disabled I mean particularly?

BULLEN: Oh, yes. There are a set of specific issues with the disabled that need to be addressed. One thing we did that, I think, we were the first state in the country to do, was to have a separate contract for enrollment.

We had a contractor whose job was to administer enrollment, provide educational materials, and manage the choice that we were offering people. That worked well and enabled us to tailor the connection between PCPs and disabled persons.

SMITH: What led you to—to use a modern term—outsource that? I mean it strikes me that it is quite imaginative but considerably ahead of the pack.

BULLEN: Yes, and expensive. It is funny, the Medicaid situation was so bad that we put in a radical plan that the Democratic legislature—you've got to remember: this is Weld, a Republican, and the entire legislature is Democratic—we put in a plan and an accompanying appropriation and said we think we can make this work if you give us the authority to do the following. They didn't want anything to do with it, but when they got it they decided that it was politically best for them to hand everything over to Weld and not to tamper with it at all.

Okay, you say you can do this? Go do it. So they gave us the authority to do everything, including spending money in anticipation of savings. I'm sure they expected us to fall flat on our faces with it.

You need to take risks to do something like this, and you need to think about what the dynamics are going to be. The reason we outsourced that function is we viewed it as critical to the success of the program. If we tried to shoehorn people into PCP relationships, we were going to have a lot of disasters on our hands. The program would never get started.

SMITH: So was it your thought that you were buying a sophisticated kind of expertise here that you might try to equal but you probably wouldn't? Or that there was
some—

BULLEN: It wasn't so much the expertise but the resources to handle the—

SMITH: Just a question of resources?

BULLEN: Yes, the process itself. Medicaid programs are chronically under-funded programs. The legislators get so mad at the medical spending that they hammer away at administrative costs because they think they should get some sort of payback, you know, or return on investment. And of course it makes matters worse in a lot of cases.

We knew we weren't going to get a big request for new state employees. And we didn't even want new state employees. I mean, it was a Republican administration. They were much more amenable to outsourcing than they were to building up the state work force. So we carved out behavioral health and created a fully capitated program of behavioral health services.

MOORE: Was that the first in the country or just the first that was pretty big?

BULLEN: I think it was the first of its size. There were some little ones around, but there was nothing as comprehensive.

SMITH: Was that really what they thought of as an HMO? That is, you contracted directly with a major provider—it wasn't an HMO, but it was a contract with this person who provided the whole thing?

BULLEN: Yes, there's a Medicaid law that permits you to enter under certain circumstances into risk-sharing arrangements with entities that are not HMOs on a capitated basis. It has to be for a specialized service. It can't be for comprehensive health coverage like what HMOs provide. That's what we did it under, that authority and the 1915B waiver.

SMITH: How has it worked out? I mean, there have been mixed reviews on managed care and behavioral health.

BULLEN: We think it has worked well. The Massachusetts Behavioral Health Partnership that Value Options runs is one of the more successful in the country still. They have broad-based support from advocates, and they do a lot of innovative things.

For instance, their consumer satisfaction survey is administered by the Alliance for the Mentally Ill. They have strong connections with the advocacy community and with other state agencies, like social services, the mental health authority and so on.

It's been a bumpy ride, but over the years everyone has come to recognize the value of having it, and it has become a responsive and flexible vehicle for the various state agencies responsible for mental health services.

SMITH: Well, now, another thing which occurs and maybe you've really already answered this, if not explicitly at least implicitly. Mental health is one form of the disabled but it's of course often the case that you, you are on touchy grounds when you try to get HMOs to take on the acute care of disabled and the various things like that. You've got a lot of high-cost cases there. Has that been a problem in Massachusetts?

BULLEN: Well, again that's where the PCP program really helped us. The behavioral health carve-out, as part of the PCP program, serves the vast majority of the chronically mentally ill. And it has a very close relationship with the Department of Mental Health. We don't have the problems that a lot of states have had that put the mentally ill into a commercial HMO. I work for a commercial HMO, and I'd be the first to say that commercial HMOs' behavioral health services are not necessarily the best for the chronically ill.

SMITH: So part of your success here was that you were largely working with not-for-profit entities?

BULLEN: Yes, either not-for-profit or specialty entities—the behavioral health carve out is a for-profit entity, but by and large, the components were not-for-profit or directly state-administered. Another thing that the PCP program did was enable my staff to learn a lot about managing care. Some states handed over the program to commercial HMOs and then didn't know how to manage the relationships, how to manage the contracts, what expectations to have.

My staff got good at understanding what the dynamics of managed care were and could therefore manage the HMO contracts better.

MOORE: Bruce, as your tenure went on you became more involved in the National Association of State Medicaid Directors?

BULLEN: Yes.

MOORE: What did you see at that time and what do you see today as the primary issues to be addressed in the Medicaid Program? There's a tiny question for you.

BULLEN: There are lots of them. The first major problem is how badly misunderstood Medicaid is. It looks like an insurance program, but it isn't because the rules of insurance are not followed. There is no risk selection. Selection bias is built into the program.

MOORE: Right.

BULLEN: The medically needy program is an adverse selection machine. It pours in people who will spend lots of money.

MOORE: As is SSI.

BULLEN: As is SSI, right. So, you've got huge segments of the population coming to you because they need to spend lots of your money. And there are no tools Medicaid can use to prevent that. Medicaid is legally required to enroll these people, and that's the purpose of the program. So thinking in insurance terms is not necessarily the right thing.

Secondly, it is unbelievably broad and flexible, at least in the big programs that have been established in the Northeast, in some of the Central states, California and others. The range of coverage is unbelievable. I used to say that Massachusetts Medicaid offered the best coverage on the face of the earth.

There is almost nothing you can't cover under Medicaid. Not just health, but a variety of human services and health services that specific populations require in order to remain healthy and live lives that have any quality to them. I think it needs to be recognized that that is what Medicaid does. Another problem is that the complexity of the dual administration of the program needs to be addressed somehow. Things go back and forth. Sometimes, like under the current administration, they hand everything over to the states, and the states do everything, and the states call the shots.

The Clinton administration became more and more interested in spinning dials themselves, treating Medicaid as if it were Medicare, a federally administered program. It goes back and forth, and Medicaid directors are whipsawed by some new surprise. Either the state legislature wants to take on the feds, or the feds want to run the program more. It's a confusing management challenge because, depending on the situation, the feds or the state or both think that they are running the program under very different rules, different expectations. That's a big problem.

Yet another problem is long-term care. Long-term care is uniquely a Medicaid problem. It's the only health program in the country that recognizes it fully in its coverage. Medicaid *is* the long-term care system, by and large, particularly as Medicare tries to get out of the business. Medicaid picks more of it up, not only for seniors but also for the disabled. And it's critical for the disabled. Medicare people always get mad when I say this, but I think Medicare is becoming increasingly irrelevant in the service mix for seniors and disabled, as Medicaid becomes more relevant. Medicaid is offering what seniors and disabled need, not Medicare. An instance, pharmacy, the home and community based services, the therapies, the PCAs, the support services, assisted living, etc. You name it, it's Medicaid, not Medicare, that's funding it.

The service system of the future for disabled and seniors is likely to look like Medicaid, not Medicare. I think some people think that's a joke or something, but it's happening. Policy-makers in Washington need to realize that's what is happening. So that's a big long-term issue.

There is also a structural problem in Medicaid—Medicaid law is health care as it was delivered in the 1960s. Except for the waivers, but we're in danger of having a program that runs exclusively on waivers. The old rules don't work anymore in the kind of health care world that we live in now. Somebody needs to take a look at that, and there needs to be a radical revamping of the legal structure of the program.

SMITH: But you're implicitly saying that you don't think it's healthy just to go on with the waivering everything when it gets to be convenient?

BULLEN: I think it's better than nothing, but it's going to be counterproductive at some point when it's a program without a core and there isn't any integrity in the program because everybody is one-offing some kind of system, a different system per administration. It certainly makes it harder for the feds to figure out what's going on.

SMITH: In my own thinking I often go back to the Mental Health Systems Act of 1980 in which they spent several years really trying to think about not only therapeutically how this program ought to be run, what were the key items, but beyond that how they would set about trying to redistribute the functions between the feds and the states and to set up a piece of legislation that would help to ensure better balance federal, state and local.

And though there might not be some overall kind of answer to your tension between the feds and the states I just wonder if sector-wise maybe one of the things we need to do is to work on this. What do we need for mental health? What do we need in the M.R. field? What do we need in the nursing home area, et cetera?

BULLEN: I think there is a variety of creative ways of thinking about how the responsibilities and functions could be allocated differently between the feds and the states. But that discussion tends to stall over the long-term care issue. Because realistically, long-term care should be a federal, not a state responsibility. State revenues are wildly variable and long-term care makes a continuing demand. To support a long-term care system requires a very stable, steady funding source. People are in nursing homes for 365 days a year.

There is nothing variable about long-term care services. And it's a real mismatch at the state level. But the minute the feds look at the long-term care tab they don't want anything to do with it. And reasonably so. It's a big, big expense. In some ways I think the long-term care problem needs to be carved out and dealt with as a separate issue, with some kind of allocation of responsibility between feds and states over what remains that isn't long-term care. That might be a more profitable way of going at that whole question.

A revamping of Medicaid that would start with a change in the enabling legislation to reflect the realities of 21st century medicine as opposed to the 1960s, then a restructuring of the financial and management responsibilities between the feds and states to rationalize it so there is not so much overlap affecting the individual Medicaid director, who is whipsawed by the dual management system—that would be a start.

MOORE: Bruce, I don't know whether you were—when you started in the state or where you were. But we were talking to Don Herman a little earlier today about the very early years of Medicaid in Iowa and the fact that for a long time the state basically contracted everything out and didn't really do policy, didn't run the program at all and then when MMIS came along they got much more involved.

Do you know much about the early history of the Medicaid Program in Massachusetts and whether the state processed its own claims or how much hands-on policy and administration the state was involved in?

BULLEN: I do. That history is a very interesting feature of Medicaid. Medicaid started in most states as a small program and as an adjunct to the welfare system because it was essentially health services for AFDC. And in most states, including Massachusetts, the program was placed in the welfare department. The welfare department had a network of local eligibility offices that were used to enroll. That was the practical reason. And it was a small program, like one of those ancillary welfare programs, say housing or homeless services.

What that meant was that the Medicaid program was kind of lost in the welfare department and was assumed to be a welfare program. But it was, in fact, a health program and a welfare program and had different dynamics from welfare—it didn't provide cash to individuals, for instance. It contracted with providers to provide services to individuals.

So it had infrastructure needs and a focus that was very different from the welfare focus. Then all of a sudden it started to explode. When I got started as Medicaid Director in Massachusetts, I was an associate commissioner of the welfare department.

While I was there, we created a new state agency, the division of medical assistance, and I became the first commissioner of an independent state agency that ran Medicaid, and it was pulled out of the welfare department entirely. When I left the welfare department, Medicaid accounted for almost three-quarters of the spending in the welfare department.

Yet I was one of five assistant commissioners reporting to the commissioner of welfare whose interest was the welfare laws, not Medicaid.

In a lot of states that's what happened. The Medicaid programs would have to scramble for administrative resources as well. You know, when I started in 1989 I didn't have a general counsel. I had a staff lawyer, who later became my general counsel, who reported to the general counsel of welfare and who was one of a large number of lawyers, most of them working on welfare matters.

That was replicated across other administrative units. A lot of states handled this not by building up their state work force but by contracting—that's what that HIO thing was. Some states like Indiana and Texas originally, and I think Iowa maybe, contracted everything on a kind of capitation basis.

MOORE: They even put the contractor at risk, I think.

BULLEN: And the contractor was responsible for absolutely everything: the administration of the program, the enrollment, contract payments, claims processing, utilization management, everything. That was the way some states handled it. Others tried to make do with whatever resources they could get from the welfare department, or wherever they had been placed.

So, yes, I think the history is a history of trying to make do in a rapidly growing program that never received the respect that it should have from day one and was viewed as an ancillary piece of the welfare agenda, which hurt the program. I thought welfare reform was a good thing because it broke the tie between welfare and Medicaid.

SMITH: Yeah, I think there were quite a number of people that felt that way. At what point did you begin to develop your own capabilities for the claims processing and all that, or did you develop that pretty much in the beginning? In other words, did you contract it out?

BULLEN: No, originally the state processed its own claims internally. That was in the welfare department. But it became such a huge problem that the first out-sourcing contract occurred. I think that was in the late 1970s or early 1980s, and the contract went I believe to UNISYS or a company that UNISYS later acquired or merged with.

I can't remember exactly, but UNISYS had the contract for a long time, until the late 1980s when we made the decision to bring the entire thing back in house. The state data center still processes claims for Massachusetts Medicaid now.

SMITH: But the kinds of things that you would want in a software system you were able to contract with UNISYS to get them? Or was it your feeling that you really needed something that had more bells and whistles that suited you and therefore you wanted to take it in house?

BULLEN: You mean in the late 1990s?

SMITH: During the period when you were dealing with UNISYS were you able to say to them, "Look we want certain kinds of audits in this. We want certain things to be flagged. We want more that helps us with utilization review or quality assurance or whatever"? Could you build these wrinkles into the system? Get them from UNISYS—

BULLEN: When the program was first implemented until the late 1970s, in Massachusetts the Medicaid program was a small piece of the welfare department with its own claims processing, okay? But it didn't have anything like a sophisticated claims processing system. And the volume started to overwhelm us. The reason for outsourcing to UNISYS in the late 1970s/early 1980s was strictly to be able to handle accurately the volume of claims activity occurring in Medicaid. There had been an MMIS system, software that had grown up with the Medicaid program. It was to deploy the MMIS system that was the incentive for out-sourcing. They hoped to get a lot of bells and whistles but they didn't ever really get it.

It really was for the entire time, as far as I'm concerned, a high-volume claims processing system that didn't give you much in the way of analytical help or utilization management. You could put prior approval edits in place, but you had to do other things to make it work.

Part of the reason for bringing it back in house in the 1990s was that the state had developed the capacity to deal more fully with high volume of claims activities, and we were able to customize more of what we wanted.

MOORE: Okay, I think that's probably it unless you have final thoughts or you think we haven't covered something that's interesting or was one of your priorities that you need to mention.

BULLEN: Well, from a historical point of view—the program has evolved from a program that was believed to be a small health benefit for welfare mothers, with the majority of the enrollees on welfare, to a program that is now much, much broader in focus. It's more generally a low-income health and human services program, with the majority of the spending going to seniors and disabled and not to welfare recipients.

It calls for a different approach, a different management structure, a different kind of enabling legislation and a different set of policies than have been there in the past. We're still suffering a bit from a misconception of what the current Medicaid program is.
MOORE: A good sum-up.

SMITH: Yes. Just one other slight little question, another unrelated to Medicaid but I just wanted to ask it anyway as someone who was involved in the history of an HMO myself. HMOs like Pilgrim Plan and so forth to an outsider have always seemed to me almost too good to be true. And I

wonder how they manage to exist. I mean, they give excellent care. They give very high quality care but—

BULLEN: You're talking about Harvard Pilgrim now?

SMITH: Yeah, but then aren't they in danger of flat going broke?

BULLEN: We almost did. That's why I'm here, you know. Charlie and I came here in the middle of 1999, because the place was just about to go under.

SMITH: And what was the problem? I mean, it would seem to me that the natural kind of problem here or at least from my HMO experience is that doctors want to practice good medicine but it's very expensive.

BULLEN: There are a number of problems that Harvard Pilgrim faced. One of them was that Harvard Pilgrim is a merger of Harvard Community Health Plan and Pilgrim Health Care, a separate IPA model HMO.

When we got here, they had never really merged. Instead they had embarked on an ill-conceived growth agenda designed to paper over the fact that they hadn't really made the hard decisions to merge the organization. When we got here they were the biggest HMO in the marketplace here in Massachusetts, with a million and a half members. We now have 805,000 members. In the course of about two years we lost almost half our membership.

They grew by under-pricing the product. They had also entered into very complex contracts and had one-offed everything, and their systems failed internally because they never really merged. They had a bunch of legacy systems trying to talk to one another.

It was a big mess. So we had to pull things together, simplify, merge, and make a lot of hard decisions about markets and people and all kinds of things. But we're operating well. We've maintained our very high quality scores. We made about $40 million last year in net income, and are doing okay.

It's an expensive marketplace, if you look at the premiums we're charging, they're high. The marketplace here—as are most marketplaces—experiences relentless double-digit medical cost increases every year. The big challenge for everybody is going to be avoiding large numbers of

uninsured because employers have decided not to provide minimal coverage.

I'm not sure if that answered your question.

SMITH: Well, yes...As I was listening it seemed to me that you were saying that you had something that structurally didn't make a lot of sense and in many cases they simply had postponed tough decisions, that it was a question of knocking heads together rather than it of finding economies in management and better utilization review, finding ways to save money through preventive medicine. It wasn't the latter; it was more the former.

BULLEN: Yes that's right, although they were hurt by a nationwide market trend moving away from the kinds of controls that the HMOs were able to use effectively in the 1980s. We don't even call ourselves HMOs anymore. We call ourselves health plans.

Legislation passed, and the market pushed back on select networks. Consumers don't want select networks. They want absolute freedom to choose from the full range of health care providers. All of the networks in the competing HMOs in this market look the same.

We have everybody in our network. We don't have a selective network, we have everyone. Once you have everyone in your network the providers know you have to have them in your network so the balance, the negotiating leverage shifts to the provider and away from the plan. Do you understand what I'm saying?

SMITH: Yes, I do.

BULLEN: And that has happened everywhere. One of the reasons that costs are as high as they are is that the providers are basically dictating price now. The plans are competing on a product array designed to allocate the costs of care in a way that's affordable for the employer and to affect trend by employing measures like three-tier pharmacy. Members are presented with a choice of tiered pharmacy coverage, which requires them to pay more for certain choices than for others.

But hands-on utilization review, select network and gate keeping, that's all gradually becoming a thing of the past.

SMITH: Yes, seeing what happened locally, Pennsylvania as well, there was a reality check on my part.

MOORE: Bruce, thank you so very much for your time.

BULLEN: You're welcome.

MOORE: It was very much appreciated.

SMITH: A great pleasure.

BULLEN: Good luck with your project.

MOORE: Thank you.

SMITH: Thanks so much.

INTERVIEW WITH SHEILA BURKE
JUDY MOORE AND DAVID SMITH – JUNE 20, 2003

SMITH: We are interviewing Sheila Burke in her well-appointed office. This is David Smith and Judy Moore and it is June 20th, 2003.

BURKE: And it's raining.

SMITH: It is raining, perennially raining. We went back and reviewed the interview that Ed Berkowitz did with you and got a lot of personal data but you were on Senate staff from 1977 to 1996.

SMITH: 1977 to 1981 would be one important kind of breakpoint.

BURKE: Yes.

SMITH: And then until 1986 would be another and then after that up until 1996.

BURKE: Yes.

SMITH: Now back in this period of 1977 until 1981. You don't have a Democratic president and you are in the minority.

BURKE: Yes.

SMITH: I get the sense that you worked quite closely pretty much on a bipartisan basis with people like Jay Constantine and Jim Mongan.

BURKE: Yes, John Kern, Bob Hoyer.

SMITH: And did Jay sort of see himself as the tutor or the mentor of a lot of the staff?

BURKE: Well, I think he did. Interestingly, the history of the Finance committee really up until the 1970s was a single staff. This was because of Russell Long, whose vision it was that it really ought to be a nonpartisan staff who served both sides. It was really the substance that was the issue, not the politics.

So a bipartisan staff was the history. The 1970s brought about the introduction of a divided staff. The Republican staff was originally quite small. In fact in 1977 Senator Dole was a junior member of the committee and the ranking Republican was Carl Curtis.

And it was just through a series of extraordinary events that the people preceding Dole in seniority retired. And Dole having been in the Senate for a very short period of time, since 1968, so nine years, became the ranking Republican on the Senate Finance Committee.

There were as I recall on the Republican side at that time maybe three professional staff at the most. Dave Swoap was one. And there were a couple of others but essentially there was little or no staff.

When Dole became ranking and hired his own staff he consciously made a decision to attempt to match the majority in terms of at least substantive expertise and brought me on to handle all the health issues. Jay, who had introduced me to Dole, really felt like I was one of his protégés who was coming to work, even for the Republican side, and felt very invested in my succeeding.

I remember the first couple of times I prepared amendments for Senator Dole for a committee markup I only realized after the fact how remarkable this was. I mean, Jay made damn sure that those amendments got passed and that I was not about to fail in my virgin work of the markups.

And Dole was stunned. Here he was this relatively new very conservative—relatively conservative then—member of the Finance committee and somehow Russell Long was taking his amendments, which was just sort of astounding.

But there is no question that Jay, because of his history with the programs and with the committee and with Long and Talmadge, was critical in helping to introduce me into the committee and into the sort of Byzantine world of Medicare and Medicaid politics. No question. And Jim and John and Bob were all enormously helpful and we worked extraordinarily closely together. No question about it.

SMITH: Also it seemed to me something kind of critical you said and I think we both sensed that with Jay, that it was the policy that mattered.

BURKE: Yes, absolutely.

SMITH: Right.

BURKE: Absolutely. You know it's interesting when you think back to who was on the committee at the time. It was Abe Ribicoff, Bob Dole, Jack Heinz, John Chaffee. I mean, really remarkable people in the history of the institution and notwithstanding the fact that there were very partisan Republicans and very partisan Democrats, this group of people worked together remarkably well.

And, yes, things got tough at times but on a lot of these issues as was proven time and time again, they were able to come to closure whether it was Social Security or Medicare or any number of things. So we were blessed in that respect.

SMITH: Now thinking just in the health care area because certainly you get the sense from talking with other people that even Medicare was relatively small as far as Senate Finance was concerned—

BURKE: Yes, no question.

SMITH: —in the large picture including tax and all that sort of thing. But just in this narrow area of health care, were there any particularly important priorities that Senator Dole had in this 1970 to 1981 period?

BURKE: I think again that Dole was relatively new as a senior member at that point. I think there were a couple of things. One, of course, I started on the weekend before we began hearings on the Carter Cost Containment Bill. I began the Memorial Day weekend of 1977 and the hearings began the next week.

Costs were an extraordinary issue at that point in time so the issues around the escalating cost of the program clearly drove a lot of the discussion at the time. And this was one of the things that I think that Dole was taken by—this cost issue, the shear magnitude of growth in the program.

And the question between government intervention and the operation of the market, to the extent that you could assume that a market existed with Medicare. But it was the tension between the sort of government price-setting mechanisms and the private sector that was very much on our minds at that time.

And the other issue for Dole in particular even at that point, that he began to pay close attention to, were the differences, depending on the geographic location, that is the rural issues. Kansas, at that point, had more than 50 percent of its hospitals with fewer than 50 beds.

So a lot of the challenges that were being faced by some of the big urban hospitals were very different than challenges in Kansas where we fought to keep hospitals staffed and open. So, clearly at that point and into the future, Dole was very concerned about the particular issues faced by rural providers.

The other thing I think that was interesting about the makeup of the Finance committee was, with a couple of exceptions, this was a relatively rural committee as compared to Ways and Means, which had a history of being much more urban. And you had a great sensitivity even then to the plight of the smaller, non-urban institutions.

I mean obviously over time you had Moynihan and others that came on the Committee. But this was a crowd, between Long and Talmadge and Dole and Chaffee and others, who were focused on the smaller institutions.

SMITH: Right. Small town America in many ways, right.

BURKE: Yes, and their relationship with docs. There were a lot of issues around physician reimbursement at the time. I can't remember when we did RAPS but it was all certain...

MOORE: That was an alternative, wasn't it?

BURKE: The issue at the time, as I recall, was the percentage contracts that were in place for many hospital-based physicians.

SMITH: Yes.

BURKE: On the Medicaid side, it was always sort of a second class citizen and viewed as a poverty program; as it should be. It was really about our relationships with the states. And really little attention except to the early efforts on the part of Reagan, around the capping of the program and things of that nature. But Medicaid really wasn't something around which we spent a whole lot of time.

SMITH: Right. Well, so then fraud and abuse was probably something that they were more worried about in the House I would suppose?

BURKE: Yes, yes, and that came a little bit later in the Senate. There were—and forgive me for confusing my years. I mean, there were issues around quality. In that period of time generally we did the Boren Amendments, you know, those kinds of issues. We also got very caught up in the—I'm having a senior moment—on Medigap and the Baucus Amendments. And Baucus was mid-1980s?

MOORE: Uh-huh, uh-huh. So here were a series of those kinds of issues. On the Medicaid side, you think of fraud and abuse in a broader context of cash assistance and the linkage to cash assistance, the child welfare issues, the absentee fathers. Guys like John Breaux who got in the Senate frankly running on the runaway dad stuff. And that was sort of in the mid-1980s when he replaced Long. But fraud and abuse was an issue. You heard it more out of the House side, from the real conservatives. On our side a lot of it got linked up with sort of the quality issues as well, particularly to the nursing home side.

Long's interest was clearly more on the welfare cash assistance side than it was on Medicaid. And Medicaid kind of got brought along as the sort of stepchild. Now, I don't remember when we did the 1619 waivers and all those issues but there were also issues ultimately about work and about incentives for work and what kind of inhibitions there were for people hoping to return to work.

There was at that time—and I frankly think it continues today—this misperception that Medicaid was primarily for black women with many children. And even then there wasn't the kind of understanding of the extent of the elderly and long-term care and disabled in that population because you only added the disabled in relatively late, the SSI eligibles.

So there was a real misimpression about what Medicaid did and who it served. I think we had a lot of issues around CHAP at the time that came out of the Carter administration. Now this is all vaguely coming back.

And that was this whole issue of relatively inexpensive populations, you know, targeting the kids. Was EPSDT working? Were we really getting what we were buying? You know, you had the Title 5 Maternal and Child Health programs that were serving a slightly different population—we were looking at many of these programs.

So there was a lot of confusion about who was being served and what was being provided, whether it was appropriate. But again, this paled by comparison with the cost pressures on the Medicare side, which was really what was consuming an awful lot of our time.

And we also went into a period of escalating unemployment. And so there were a lot of issues around unemployment benefits and coverage for those folks and what the right methods were. And even at the time, you know, there were early discussions about how you accessed coverage and so forth. And again, I don't think that people fully appreciated the role that Medicaid was playing.

SMITH: But you get a little bit of a sense that Senate Finance is so huge and its jurisdiction is so enormous.

BURKE: Yes, yes.

SMITH: That it takes something rather unusual to make Medicaid float up to the top, so that very frequently you would probably kind of wait to see what the House wanted to say.

BURKE: No question. But I think it's an even more complicated story than that. Finance had a very broad jurisdiction. And there is no question that the draw for a member to get on the Finance committee was the tax policy and trade policy. And you had members who had come with that expertise or had developed that expertise and who spent enormous amounts of time understanding the most arcane tax law.

The social welfare side of the committee was really secondary, although Social Security had its own life because of its impact on the elderly. By comparison, the House had its jurisdiction divided.

SMITH: Right.

BURKE: And the Commerce Committee had the capacity to focus very clearly on Medicaid. And even to this day you find there are enormous differences in the willingness of the House members to take on these very specific areas and be immersed in them.

That has never been traditionally the Senate's methods with some exceptions: Dave Durenberger on physician payment and managed care, Jack Heinz on long-term care, John Chaffee on child health issues. But even

they, at the end of the day, were never a match for a Henry Waxman or for the House guys who basically immersed themselves in these issues. And I think that is probably still true of them, although I don't follow it as closely anymore.

MOORE: Do you recall the Reagan proposals for block granting and Medicaid?

BURKE: Yes. In the early 1980s. As I mentioned, there was this whole issue around the budget. And Stockman, of course, was head of OMB at the time and Medicaid, of course, was one of the most difficult programs to predict and from the state standpoint one of the most uncontrollable expenses.

And I don't remember now what the rates of increase were but there were no questions that Medicare and Medicaid were both beginning to show some real escalation. The Reagan Medicaid cap proposal was one that there were members on the committee who were very positive about.

I remember even at the time my staff director, who was Bob Lighthiser, was quite enamoured of this cap, which was a fairly simplistic—this is how much we'll spend and we'll give it to the states and then they will have to live within the limits—and that was very much Stockman's sort of view. The members on the committee I think were—as you might imagine there were a number of former governors.

SMITH: Yes.

BURKE: And there was no question that the presence of former governors had an impact on our deliberations, members who knew very clearly what it would be like to essentially have an economy go south on them and not have any flexibility and who counted on these federal funds.

Now, this was long before all the games that we were seeing in terms of the states finding ways to increase their match with a variety of tools. But there was no question guys like Chaffee and others were very sensitive to what the impact would be on a state. So I think the governors—I'm trying to think who else was a governor.

Chaffee was a former governor, Boren was a former governor. I'm trying to think who else was on the committee at the time. I can't remember. But

there was no question but that had an impact on how people viewed it in our committee.

SMITH: Well, and again, in '81 when it was going through the House and the Senate, if you go back and read the accounts at that time you get very much the sense that an awful lot of the trench work was being done by Waxman and company.

BURKE: Yes, yes, yes.

SMITH: But that's not to say that the Senate wasn't sitting there and hoping that dogfight came out a certain way.

BURKE: Well some members of the Senate, no question.

SMITH: Yes.

BURKE: Obviously the conservative members, people like Bill Armstrong and others who were on the committee were very much in favor of those kinds of constraints. But the real battle—I mean the battle was clearly going to be engaged by the House guys, no question.

And, I mean, our guys had other fish to fry and they were caught up in bigger issues or different issues. So clearly, it was going to be lead by the House guys.

SMITH: And it also seems to me that all you had to do was torque that thing just a little bit and you got a very different outcome. But if you said, well, we'll allow, as Waxman did, that only a certain percentage increase this year.

BURKE: Sure.

SMITH: And we'll look at these waivers and no really a way of privatizing a program, but it's a way of making it grow and so forth and so on.

BURKE: Right. Well, and again, my memory is not very good but there was no question that this was going to be a bargaining chip. If anything, I might suggest that Medicaid often became a chip in the bargaining. But remember in the broader context we also didn't conference against Waxman on the other issues we cared about.

We didn't conference against him on Part A Medicare. We didn't conference against him on taxes and we didn't conference against him on trade. We were dealing with, you know, Danny Rostenkowski or Al Ulman at one point. And so it was an odd sort of conferencing, you know, in terms of how you bundled these things together.

SMITH: Right.

BURKE: But it was clear the House cared a lot more about Medicaid than the Senate did. No question.

SMITH: Well, then it's a bit further along in this that the incrementalism began.

BURKE: Right, right.

SMITH: How did the Senate and how did Senator Dole see that? Was this a good thing if it didn't go too far?

BURKE: Well, that's an interesting question and actually I sort of vaguely remember but it would be interesting to go back and look at the record. I mean, a number of these things that were really just negotiated agreements: You take this and I'll take that.

Henry Waxman, of course, is like a determined dog with a bone. Andy Schneider and Karen Nelson were steadfast in terms of these increments.

SMITH: Someone said he never seemed to have to go to the bathroom.

BURKE: No, no. But neither did Dole. That was never an issue. These were issues that on the Senate side to a certain extent got left to the staff.

SMITH: Yes.

BURKE: And on the House side were clearly member issues. I mean Henry Waxman was right there. And I think a lot of these increases, a lot of the sort of groups of kids and the age group extensions and expansions came one at a time, as I recall, in terms of the coverage of kids.

They were relatively inexpensive because the kids were generally inexpensive to treat. And I think they were more bargaining chips within the Senate rather than a substantive commitment. That doesn't mean to

suggest that the Senate doesn't care about these things. But I think at the time as I think back, the House cared deeply. We cared less but we cared about other things and these were trades.

SMITH: Someone said, and I'm not sure quite sure who it was now, but often from the Senate's point of view, you put those things in thinking well we've got to build a majority for the tax bill.

BURKE: Yes, that is correct.

SMITH: Yes, yes.

BURKE: They were trades. That's exactly right. Although again, remember we weren't negotiating these with
the tax committee.

SMITH: No.

BURKE: That was part of the bigger negotiation when we did the reconciliations. I mean, one of the strange things that occurred in this period of time were these strange bills where we would build these weird coalitions. I mean, I think one of the most well known was the bicycle parts bill and I don't know what the hell we put on there and the carillon bells I think was TEFRA or DEFRA, I don't remember.

But we would build these strange coalitions, particularly in the early 1980s when Long was still chairman where it really was a puzzle. You know, what are the pieces you need in order to get the bill done?

SMITH: Right.

BURKE: There is no doubt in my mind that is exactly how Long viewed it.

SMITH: Uh-huh. Well, then is there a point at which in the Senate, this incrementalism seems to get a little bit more alarming and things kind of come to a peak around 1989, or between 1987 and 1989, and you get the Catastrophic Coverage Act.

BURKE: Right.

SMITH: You get the nursing home standards.

BURKE: Right, right.

SMITH: Again, how were people like Senator Dole perceiving this? Too much of a good thing is too much? Or not worrying? What was his reaction to the Catastrophic bill, for example?

BURKE: Oh, that's a whole other story. The Catastrophic story is an interesting story. There were an awful lot of pieces in play. I mean, one, you had the White House, which really didn't have a domestic agenda and were focused very much, I think, on Iran Contra at that point as I recall.

There were other things that they were interested in.
Otis Bowen was HHS secretary, as I recall. And Otis had a wife who was or had been quite ill. I was not there, but it is described as Otis Bowen really coming to the President in extremis over this situation with his wife and the sort of issues that they had faced, and Bowen ultimately convinced the White House that this would be a good thing to do and it was a good domestic issue for them.

It would provide help to people who needed it. And the White House really didn't focus on it. And what then occurred was, it got quickly out of control. I think there is a lot of blame to be spread around on a lot of sides but I think there was a Secretary who was prepared to do anything to get it passed.

There was a White House that was paying absolutely no attention to what the policy was. There were Members who took the opportunity to fight a whole series of additional fights and essentially a process and a bill where there was an inability to articulate in an easy way what it is that you were doing, to a constituency who would buy in, and allowing people like Martha McSteen of Save our Security and others to essentially take the information, or the absence of information, and strike fear into hearts of everyone.

And the inability to respond to that, frankly because of deals that had been cut which made the answers in terms of what benefits you would get for what constituency for how much money and how quickly would you get the benefit.

I mean, we did everything possible wrong that we could have done. Now, along with that you had John McCain who went home and got hammered in Arizona. And McCain was again like a dog with a bone. McCain just wouldn't back off.

He wasn't a member of the committee. He was a renegade and would go to the floor and was just torturing us. Dole and Mitchell, I mean, literally held hands and jumped off that cliff together in terms of the legislation.

One of the interesting sort of side stories about the Finance committee, at the time, that would be interesting for someone to look at is the impact of having had the majority leader and the minority leader on the committee. It made an enormous difference in terms of that committee and its power and how things got brokered.

Because Mitchell and Dole had a very nice relationship they were like the 800-pound gorillas in the room with all the other members. And I think it had an enormous impact on the committee but, nonetheless, at this point in time, I mean, these are two people who had signed on, voted for the Catastrophic Act.

You could see in the conference when we were in it with the House, I will never forget having a screaming fight with Tom Burke, who was just ineptitude in all its forms, about what Bowen was prepared to sign off on, what he had signaled the House guys he would take—you know, he basically just undercut us repeatedly in the conference when we would raise issues and they would just ignore us.

So we ended up in a series of negotiations with McCain, and McCain just had no reason to back down because at that point between Roosevelt and McSteen and all the rhetoric we were quickly losing ground. And members that had signed on were just getting battered.

So it was like the perfect storm. Absence of good information, complicated story, delayed benefits, high prices—benefits that many people already had, so for them there was nothing new. I mean, it was just a disaster. So, you know, the repeal within 18 months was stunning but it was an interesting learning experience for all of us, suffice it to say. Not that I hope to repeat it! But it was not one of the prettier memories of my time in the Senate.

SMITH: Well, from the standpoint of Medicaid, of course, a very important aspect of that was the responsibility for the dual eligibles.

BURKE: Exactly, exactly. It's interesting. There were a whole series of things like the dual eligibles, the spousal impoverishment provisions, that survived and stood in their own right, having been separated from the other issues.

And again I think they were appealing. They were something that people sort of focused on. They weren't what drove the bill but they were essentially things that allowed the bill to go forward and then ultimately survived as I recall. Do I remember that right?

SMITH: Yes, yes.

BURKE: Ultimately survived, not having really been what drove it nor what brought it down. But the whole issue around spousal impoverishment, at that point in time we were also caught up in all these questions about people essentially gaming the system and spending down, all the spend-down rules and the sort of horror stories about people who were divorcing and all those kinds of things.

All those things kind of arose and I think it made a case that a lot of middle-class members could understand because it was their parents.

SMITH: Right, right.

BURKE: It was an experience that they could understand. It wasn't the mythical single woman with six kids. This was someone's parents who had a house, saved their money and now they were sick.
Russell Long was not very sympathetic, shall we say, to that constituency but Dave Boren and others were, Jack Heinz and others.

And then, of course, you also have the dual eligible issue. That whole question about essentially Medicare being the payer of first resort, but the state is essentially picking up the rest, and from the state standpoint a much cheaper deal.

SMITH: Yes.

BURKE: And a bargain in terms of being able to buy into Medicare Part B in financing Part A, and of course from the beneficiary standpoint assured them continued access to much more mainstream care. So there are a lot of things in support of that.

I do think that there was some more appreciation for that constituency perhaps than there was from what they perceived to be the other constituency in terms of a young mother with multiple kids.

SMITH: Well, I'm curious a little bit, of course, it is not too long after this or it is about that time that you begin getting a lot of noise about unfunded mandates.

BURKE: Yes.

SMITH: Then very shortly thereafter you get an eruption of the Medicaid scam. Sort of schemes.

BURKE: Creative financing.

MOORE: Creative financing.

BURKE: The State of New Hampshire was particularly skilled in that as I recall.

SMITH: Now, what kind of reaction did you get, and not so much just in the Senate Finance here I'm thinking about, but particularly from people like Senator Dole and the Republicans and so forth?

BURKE: Well, the scams of course had them outraged in the committee in terms of what the states were doing in terms of gaming us. But you also had a growing number of Republican governors and you had guys like Tommy Thompson, as I recall, and John Engler. And Voinovic—

SMITH: Voinovic, yes. Well, you had Engler.

BURKE: Yes, you had John Engler.

SMITH: That was Michigan.

BURKE: That was Michigan. Wisconsin was Thompson. Anyway, you had a bunch of very, very outspoken Republican governors who—you know, had some sway. You had Senator Dirk Kempthorn, I think at the time as I recall. I'm trying to think of who else were the big leaders in this unfunded mandate issue that were really fighting it from the Republican standpoint in terms of states' rights.

But at the same time you had Senators pushing back on some of these governors, who essentially wanted absolute flexibility and no restrictions. And there was a real tension. I mean John Chaffee was, not withstanding

having been a governor, very suspicious of what the governors ultimately would do with that kind of flexibility.

SMITH: Yes.

BURKE: Very, very resistant to the kinds of methods the states were finding to essentially increase the amount of money they were drawing down from the program. So you had a fracture within the party as well as among the conservatives and the moderates to liberals on the Republican side. So it wasn't just partisan in the sense of Democrats and Republicans, it was internally divisive.

SMITH: Yes.

BURKE: As many of these issues were in terms of Medicaid, which was sort of interesting. There was this strange kind of relationship with the governors, particularly when you get near election years. Because of course the Republicans, both Reagan and then Bush in '88, very much, were counting on the governors to develop the support they needed in those states.

So those were always very interesting times in terms of negotiating. And then in 1992, again, in 1996 it was an enormously difficult issue for us in terms of keeping the governors happy.

SMITH: Right.

BURKE: Similarly in 1992, it was very tough for Bush who very much wanted to keep those guys in line, their having supported Reagan. But we came out of these sort of series of negotiations. It was always a tension among Republicans where they very much were in favor of states' rights but reluctant to spend a lot of money.

And you had moderate Republicans who were very concerned about giving some of these governors a lot of power that would have allowed them to reduce the program.

SMITH: Yes.

BURKE: It was always something Chaffee, for example, was very much opposed to, even having been a governor.

SMITH: Right.

BURKE: He didn't want to give them that authority back. I hope I'm not completely confusing my years.

SMITH: No, no, no.

MOORE: It sounds right.

SMITH: No, that sounds exactly right. I didn't come across the attitude in the Senate at all. That is, from people you talk to in the House, particularly coming out of the Commerce Democrats, in a way, it didn't matter as long as it was legal, states were getting this money. They weren't concerned about the morality of it as long as they spent it on some form of health care.

BURKE: I think that's true.

SMITH: Yes. You didn't have that attitude among anybody in the Senate.

BURKE: No, not really. Not that I recall.

MOORE: The only thing that I would like for you to comment on is the eligibility enhancements for kids and moms for the 1980s and into the 1990s, and the extent to which that was driven. It's always seemed to me, from the Administration side, to be driven by both Finance and Waxman, that Bentsen particularly was always very much into these expansions.

BURKE: And Chaffee was.

MOORE: Yes.

BURKE: But Chaffee was as well. Chaffee was very much a proponent. Christy Ferguson obviously, I think, should get a lot of credit for that. But Bentsen was as well. And Dole was comfortable. And Packwood was certainly not adverse to expansions, although Packwood had a particular interest in long-term care issues.

But even when Packwood replaced Dole as chair there was an understanding of trying to deal with some of these blanks in the system by allowing some of these additions.

SMITH: I was curious about the ideology line behind that. For example, Chaffee made no bones of the fact that he thought too much was being spent on the elderly.

BURKE: Right.

SMITH: And not enough on the children.

BURKE: Right.

SMITH: Some of the people say, "Well, the children are our future."

BURKE: Right.

SMITH: Other people say, "Well, the children are cheap."

BURKE: Right, right, right. And Heinz, while he was still there, was more interested on the elderly side because he was with the Aging committee at the time. Bentsen had a particular interest in children. So it varied by member with the result that you ended up with this sort of odd combination of things. No question.

SMITH: There were quite a number of statewide programs that are children-oriented.

BURKE: Yes.

SMITH: And that might resonate with Senators, I would think; at least it might have more visibility for them.

BURKE: I don't know that they really ever thought about it that way frankly. I mean when you think about it, we had a whole host of the immunization programs, the Title 5 programs. Most of those were over at the Labor Committee and not with us.

SMITH: Right.

BURKE: Title Five was, of course, with us but it wasn't something that anybody spent a whole hell of a lot time on, frankly. And I don't think that they ever really thought about it in the context of Medicaid in those terms.

SMITH: There is one question about 1995 that I have always kind of wanted to clarify in my own mind. I talked with you earlier about that and you said one of the big things for Senator Dole when they came through with let's restructure Medicaid and Medicare, was that since Dole had in mind a run for the Presidency, he didn't feel that he could have any light between him and—

BURKE: And Gingrich.

SMITH: —Gingrich.

BURKE: Yes.

SMITH: Now, but other than that it seems to me that the Senate was singularly unenthusiastic about most of this.

BURKE: Yes. Well, the Senate was unenthusiastic about the Contract With America.

SMITH: Oh, yes.

BURKE: And all the sort of subsequent stuff. But, yes, the Senate was never very enamored. The other thing I think, and you're absolutely right, David. There was this great—and Dole will even talk about it, where he was terrified about allowing a great deal of light between he and Gingrich—or breaking with the governors.

SMITH: Right.

BURKE: Because they were so critical to building, particularly when he was in the primaries against Gramm and others. But at the heart of it, Dole was someone who had a keen appreciation for the role the government played and did not have what you might think to be the sort of traditional Republican abhorrence of government largess.

SMITH: Right.

BURKE: Dole wrote and handed out to his grandparents welfare checks, and had a fine appreciation for the role that some of these programs played in supporting individuals who were in periods of transition in their lives. What frustrated him was the generational aspects of some parts of welfare as we know it.

But the fundamental role of government in providing that assistance was not something that troubled Dole. So he didn't come with a sort of a resistance to Medicaid or to food stamps. He and George McGovern were, you know, critical to the development of the food stamp legislation. One could say it's because Dole represented an agricultural state and it was a big farm subsidy. But in fact he had, because of his own background, a real sensitivity to people who went through tough times. And so he did not have a knee-jerk reaction against Medicaid or Medicare. You know, granted he voted against Medicare originally and subsequently admitted that was a mistake.

SMITH: Certainly his timing was bad there.

BURKE: Yes, his timing was bad. But, I mean, he would tell you at the time there was another option which was the Medicredit Bill and lots of other things on the table. But he did not have a traditional Republican's abhorrence of government. He fundamentally thought there were things government did and did well.

And so he approached these things—notwithstanding the Gingrich challenge—he approached these things somewhat differently and with a somewhat skeptical eye to these people who said, "Get them all off the rolls and shut it down." That was not where Dole was likely to be comfortable.

SMITH: One thing that I wondered about, it seems quite logical that in a 1995 BBA campaign that Republicans would take on Medicaid first, because you have got to have some time to put together the Medicare proposal—

BURKE: Right.

SMITH: But the people who wanted to change Medicaid didn't come out very well. Did you have a sense there that, well we're bogging down in the mud here?

BURKE: No question.

SMITH: Yes.

BURKE: And here was also again this tension with the governors. I mean, it was just a fractious meeting with the governors about what the adjusters would be and how you would accommodate certain changes, you know, in the economy and everything else under the setting sun. So there was

nothing about it that was going to make it easy and there was no question we were going to get bogged down in some of that.

SMITH: I have a little bit the sense that a lot of that squabbling was kind of coming in the committee sessions. They got into a real big formula fight in the House. Now, did they have the same kind of thing in the Senate?

BURKE: Yes, yes.

SMITH: They did?

BURKE: Yes, we did indeed. I think it was '95 when we had a knock-down drag-out with Kay Hutchison in Texas and the rates for Texas. But formulas are ugly.

SMITH: Yes.

BURKE: We did cut a couple of deals at the last minute on the formula. I remember sitting in Dole's conference room—I had forgotten this—sitting around the table on the formula issue. But it was always an ugly issue.

It was always uglier in the House but it was ugly in the Senate as well and it was largely because there were states—this is an interesting issue historically in the Finance Committee because of Long.

There were multiple attempts to try and figure out how you would value the offshore assets of Louisiana and should that be considered as part of essentially the assets that they had available and how you would calculate the federal match. You can imagine what Long's view was on that.

But there was always a battle because the big states that really committed to the program—the Californias, Pennsylvanias, New Yorks—always looked on the Texases and the southern states as being miserly because they were so unwilling to commit resources.

So there was always attention and Senator Hutchison, not unreasonably given the size of Texas, always thought that the method of calculating the rates—in fact Lindy Paul, who was then Senator Packwood's staff director, and I, when I was Dole's chief of staff, had a couple of very unpleasant in-your-face screaming match sessions with Senator Hutchison about our view of what the matching rate formulas ought to take into consideration and

whether there were prior commitments and how you calculated what the states had done and what the required maintenance of effort issues were.

God, I'd forgotten all of that—gratefully. But you are correct that it was always ugly in the House but it was equally ugly in the Senate because it was the big states versus the small states. It was the more prolific programs, the California programs, versus the southern tier. That was always a huge problem.

SMITH: It sounds like it's a little different kind of a battle because in the House I remember Howard Cohen saying they must have run a couple of thousand simulations.

BURKE: We all did. Well, because you look at exactly who is going to get hit and who is not.

MOORE: The winners and the losers.

BURKE: And it's like doing DRGs.

SMITH: Yes, yes.

BURKE: I mean, or the AAPCC when you are figuring out people's ZIP codes. We ran bazillions of numbers. Both sides did. And, you know, the House had a different agenda than ours in some respects.

SMITH: Technically, how do you do that? Do you say, GAO, please run these numbers for us...

BURKE: CBO generally ran them or the Department ran them.

MOORE: The actuaries sometimes ran them.

BURKE: Yeah. It depended on the formula and what we were trying to do or what the unemployment rate was. I mean, there were every possible configuration you could imagine. And, of course, all the numbers are weird.

SMITH: This is a delicate way of putting it, but now that you're away from the fray has your philosophy toward any of these issues changed somewhat?

BURKE: Fundamentally, no. I mean, fundamentally I think Medicare and Medicaid are unbelievably critical programs which have not adjusted with

time as they should have, to the realities of practice or care, which are enormously important to the people that they serve and which have become mired in minutia because of our attempts to try and constrict or encourage certain behaviors.

I have an increased appreciation of the complexity now that I now sit on MedPAC and go through these long discussions about rates. To a certain extent, we are shooting in the dark.

The data is terrible. We create barriers to behaviors we think are inappropriate and in doing so we limit people's access, which is terrible.

SMITH: Yes.

BURKE: I think Medicaid is truly the little engine that could. It really is a remarkable success story in many respects and has been a safety net for millions.

And Medicare of course mainstreamed the elderly at a time when they were going without care. So I think that both are enormous success stories with some warts. But then again, what doesn't have a wart? But they were programs created in the 1960s for a very different environment than you find in 2004 and bureaucracy makes it tough to change and adjust, as they needed to.

SMITH: There is no doubt about that.

BURKE: But I think they are both—I've never doubted the fact that they are both critically important and serve very important groups.

SMITH: Well, there is one more question in particular. Now, particularly on these Waxman incremental reforms, you say that the House was pretty much the driver of things.

BURKE: Yes, no question.

SMITH: But there was one area in which the Senate really moved far out ahead of the House and that was in child care, and especially in 1997.

BURKE: Yes.

SMITH: Were there important historical antecedents to that?

BURKE: None that I can think of really. I'm sure there must have been and—

SMITH: Probably some personal interest. I mean, there is Kennedy and Chaffee and Long's interest.

BURKE: Yeah, and probably again people smarter than I am will remember them. I don't remember them as clearly. Chaffee's interest was also in disabled children.

SMITH: Yes, yes.

BURKE: So a lot of the attention that he gave was in mainstreaming and in dealing with those. And Dole's interest was more in the return to work issues.

SMITH: Right.

BURKE: How one enabled people to go back to work and the whole issue around substantial gainful employment and how do you give people tools so that they are encouraged to move out. But, you know, if there was any antecedent on the child care side it was Long, but that was obviously a long time away. He left in 1986 as I recall.

It was always something that he cared about and child welfare was something he cared about. Margaret Malone was the person I was trying to think of. But I don't remember one, David, but I'm sure someone else will. Nothing rings in my mind.

SMITH: Well, thank you so much. It's been great fun to see you again

INTERVIEW OF JACK EBELER, ALLIANCE OF COMMUNITY HEALTH PLANS, BY JUDITH MOORE AND DAVID SMITH – JAN 22, 2003

SMITH: It is January 22nd, 2003.

SMITH: We were saying earlier, Jack, that we are not at all clear about your history. You have been around a great deal and we are not clear when you were in different places.

EBELER: My first job in the federal government was working for the Medicaid program in the Medical Services Administration of the Social and Rehabilitation Service. I started in mid November of 1972, just after the enactment of Public Law 92-603, which was a major set of social security amendments.

In those days, Congress did its major bills on the entitlement programs as social security amendments, rather than reconciliation bills. The Medical Services Administration at that point was headed by Howard Newman. I worked as a program analyst in the office of program planning and evaluation, which was headed by Karen Nelson, who is the best Medicaid person and health policy person you will ever find.

SMITH: We have interviewed both of them.

MOORE: That is, Howard Newman and Karen Nelson.

SMITH: Howard and Karen. We had an interesting conversation with him. One has it that there was a big problem with the Medical Assistance Agency because they had all these social workers from SRS and these people didn't have a health background.

Newman said he didn't think that was very important. He thought what was really important was how smart people were. And there were all sorts. And he gave us very much the sense that the morale was very high in the MSA. And these people were trying to scale the heights.

EBELER: I was very low-level, a GS-7. I was not on the senior staff. When you joined the agency, at the next monthly, senior staff meeting in Mr. Newman's office I wouldn't have dreamed of calling him Howard at the time,

the new person got to come and sit and be introduced. I can still describe his office. I can describe where I sat at the table. I was so scared. And I did not say anything. There was very high morale, in part because there were just exceptional people there. Howard was a perfect commissioner for the program at the time. Realistically, it was probably perceived as an activist enclave in a conservative Nixon administration.

People like Karen Nelson, Joe Manes, Lucille Reifman, were just extraordinarily talented people. And the impression I got as a child there was that we were doing battle against the Social and Rehabilitation Service.

The Medicare people in the Social Security Administration were terribly off-putting, though one or two of them were very helpful in part because they believed in Medicaid. But, you would go to a meeting on physician payment policy or something, and you would go in and there would be Karen, with me sitting in back with a set of notes. And there would be seven experts from Medicare on the other side of the table.

SMITH: It's like the New York delegation moving in.

EBELER: And that is a fabulous environment to be in if you're young. I could type neatly and stay between the lines, and make the columns add up, and I got to do lots of work. It was a very motivating place to work.

SMITH: Howard told us that if they were mentored by anybody, or if they tended to take their cues from anybody, it was from Social Security, not from Ellen Winston or from SRS. That is, they were formally under SRS but it really didn't matter very much.

EBELER: I assume Howard is right; I took my cues from the senior Medicaid people.

EBELER: Again, I played in that higher level environment much later in my career. At this point, I did what I was told.

But the social worker connection is really interesting. I had the privilege of sitting in an office with one of the old time people there, a woman named Peg Adams, who was a woman attorney from an era when that was a hard thing to be.

She was part of the old school, who worked in Henry Spiegelblatt's division of policy and standards, which did the technical policy. She helped orient

me, and grounded me in history and the welfare connection, which was very strong and very important.

EBELER: And there was a passion about service in that environment that was much more paternalistic than is acceptable today. But it was there. They were there for poor people. And at this same time, Peg said, "I'm not part of this new crowd and don't like it. But if I were your age, this would be great. Go do it." It was really a wonderful environment.

SMITH: Well, it's kind of laying on of hands. It's very important. We miss that now in the civil service.

EBELER: Absolutely.

SMITH: So you would have been there when things like the McNerney Commission were beginning to break up and when they were struggling with the amendments of '68?

EBELER: No, no. The McNerney Commission was earlier.

SMITH: That was history.

EBELER: Yes. In fact, I think some of the impetus to change the Medical Services Administration and bring in someone like Howard had stemmed from the McNerney report.

MOORE: So you mostly worked on the implementation of the '72 amendments.

EBELER: Yes, and cost estimates, and issues like whether or not New York City could provide coverage to prisoners, and why Arizona wasn't in the program. And a lot of work on national health insurance, which we all assumed was going to pass.

The Nixon administration had a plan, CHIP, which was an employer mandate with low-income coverage. At that time, conservatives were for that.

And we, of course, thought that wasn't good enough. There was a lot of analytic work comparing on a state-by-state basis the then-existing Medicaid program with what CHIP would have made available: who is better off and who is worse off. It was learning how to do classic government staff level

work: preparing briefing books for Karen and Howard as they would work within the administration and go testify on Capitol Hill.

Again, it was a very small place without a lot of hierarchy, where a young person could do that. You weren't a GS-7 working for a 9, working for an 11, working for a 12. You did the work. You walked into Karen's office and she corrected it and made it right. And gave you credit for it.

There had been a lot of work done earlier by Kevin Sexton and Karen with the Ways and Means Committee in developing some national health insurance briefing material and state-by-state analyses of beneficiaries by basis of eligibility and spending by type of service.

So there were a lot of opportunities to learn the dynamics and the spending in the program.

SMITH: When we were talking with Karen about this she was saying that CHIP was sort of marching ahead. And there were a lot of assumptions about what was going to happen with this.

And much of their concern at this point was that they were really having to retrofit this with what the states were doing in terms of eligibility and seeing whether this thing was going to work.

EBELER: Yes. Oh, absolutely.

MOORE: Had you worked in health before? Or were you just right out of school?

EBELER: I got out of Dickinson College, did six months in the Naval Reserves, did eight months as a stock broker, and then worked nights in a Giant warehouse. My B.A. was in psychology.

MOORE: So you didn't have any health background?

EBELER: I had never taken a health course. I had never taken a political science course. I was just a classic example of a recent graduate walking around town with the government application form trying to find a job. I knew nothing about Medicaid or Medicare.

MOORE: And you just fell into SRS and Karen’s staff?

EBELER: I was the luckiest person on earth. I fell into that job.

MOORE: How long did you stay in MSA?

EBELER: I stayed till August of 1974. What happened was that a new SRS commissioner came in, Jim Dwight. Howard, as is normal in those situations, was getting ready to head out.

So he left to head the Dartmouth-Hitchcock Medical Center. A new Administrator came in named Keith Weikel.

EBELER: He was a very knowledgeable health care expert. I don't know him well. Karen went to the Senate Finance Committee to work on the staff. And, I was trying to figure out what to do, assuming I was going to stay. But all these people that were really smart and helpful mentors seemed to leaving although nobody ever encouraged me to leave.

SMITH: They're all leaving.

MOORE: They're going.

EBELER: I figured that there was something going on here. And I got a call from the Congressional Research Service, which is a wonderful organization. Bill Robinson, who was the head of the education and public welfare division, had worked with Howard and Karen earlier at OMB, and one of them had contacted him about me. Joe Manes, who was another division director at Medicaid, had already gone there.

SMITH: I went over and talked with Joe and you'll be happy to know that he's healthy and happy.

EBELER: So I got an opportunity to go up to CRS and work on the health staff there.

SMITH: And of course at this point, this is before you really got the Hill heavily staffed up. So they relied heavily both on the administration and on CRS.

MOORE: And did you work on Medicaid stuff or other—

EBELER: I did a lot of other things. Jennifer

O'Sullivan was there doing Medicaid at the time. Jennifer was another former MSA person who had headed out. The big advantage of going to CRS was that I got to work on a breadth of things ranging from FDA to Medicare hospital cost containment. I got to do papers on health care cost containment and national health insurance and other kinds of issues. It was a very interesting chance to branch out in that way but I was continually drawn to Medicare, Medicaid and the financing issues. They just seemed more interesting.

But it's very valuable to have spent a year trying to answer questions about the Food and Drug Administration and health manpower and public health programs.

MOORE: You stayed there until the beginning of 1977.

EBELER: There is a piece of this history that Judy is more knowledgeable about than I. But during my time at CRS, I did a lot of work with the Finance Committee. The staff director at the time was Jay Constantine. We also did a lot of work with the Ways and Means Committee; the staff director was Bill Fullerton.

A lot of the Finance Committee work was involved in restructuring the executive branch. The Talmadge bill that Jay had worked on basically created an agency that combined Medicare and Medicaid in one administration under statute.

SMITH: Now, did you work on the Talmadge bill?

EBELER: Yes, at a very junior level.

SMITH: As Chris Jennings once said, quoting a famous figure out of the past, success has many fathers. But the Talmadge bill certainly called it "HCFA."

And Jay Constantine I think, at least, Jay Constantine and others, came up with that name. But then, of course, when it got to Joe Califano, it's as though he's the first guy that ever thought of this.

EBELER: I think both those things are true.

The Talmadge bill did propose the new agency. But it didn't pass.

I think there were a lot of people at that time saying we really did need to combine these two arms of health care financing, Medicare and Medicaid.

And again, I knew as “fact,” that National health insurance was going to pass. Put it in the bank.

MOORE: Yes.

EBELER: And you had to figure out a way and place to implement it.

So Bill Fullerton went to the newly created HCFA after Secretary Califano established the agency on an administrative basis. Bill went there as the first Deputy Administrator.

EBELER: He was looking for a special assistant. And I threw my resume in and got that job. Bob Derzon was Administrator.

This would have been in the summer of 1977.

MOORE: Yes, summer of 1977.

SMITH: Did the association between Jay Constantine and Fullerton continue at full bore?

EBELER: They knew each other well. They had worked together. Bill had been at Social Security during the creation of Medicare as Irv Wolkstein's deputy. Jay was staffing, I think, the Senate Aging Committee. As with two opinionated, prominent leaders within a field, they didn't always agree, but I think they did agree on core direction. There was a genuine sense of shared values at that point. For me, Jay was always incredibly supportive of this young kid who had been sitting in meetings and taking notes on things like the Talmadge bill.

SMITH: Well, I was talking with Jay Constantine and one of the things that certainly came across was this guy had a passionate faith and commitment, not just to the program, but to the ideal of public service.

EBELER: His other interest at the time was in creating the inspector general function. And that also was established at HHS roughly at the same time, as government moved into the fraud and abuse field.

SMITH: He also had an enormous commitment, it seemed to me, to the PSRO concept. And of course I think if you could have done it the way he had in mind it might have been really an enormously good thing. But, as you know, they didn't fund it and they didn't really put much behind it.

EBELER: Yes. Jim Mongan, MD by then had joined Jay at the Senate Finance Committee staff and there were one or two people at Ways and Means and one or two people at Commerce, including Karen Nelson at that point. And they were extremely dedicated, passionate, smart, and influential people.

They were the information conduit for the members in a way that no staff person is today because of the cacophony of information available. I'm not sure we're all better off today but we sure have more staff.

So Bob Derzon was Administrator. Bill was Deputy. HCFA went through a policy process to try to come up with a long-term policy agenda. Bob Derzon was very thoughtful. And we developed that, an agenda covering physician payment and Medicaid eligibility and a lot of the changes to upgrade Medicaid and Medicare.

It was leaked and put in the National Journal. It didn't go anywhere formally within the policy process.

SMITH: This would be about—

EBELER: This was late '77, early '78. It was a very thoughtful agenda. I'm sure you [Judy] were involved in it. Diane Rowland, Peter Fox and Kevin Sexton were, along with Clif Gaus. One of the big issues at the time was taking advantage of having the two programs together.

Within HCFA, you still had separate Medicaid and Medicare bureaus at the time. They weren't organizationally merged. And it was very interesting. There were some wonderfully funny stories. I remember sitting down and trying to get the data people to put on one piece of paper the number of Medicare and Medicaid beneficiaries, although everybody insisted on calling them recipients at that point. And the amount of money Medicare and Medicaid spent on hospital care, and basically what HCFA program were. And we couldn't get people to do it because the data were different.

The reality is, they are different. The Medicare number is for a full-time, full-year beneficiary. The Medicaid number wasn't. So you just went through these huge fights.

But at the top line it's very simple. You take the Medicaid number. You add the Medicare number. And then you subtract the number of dual eligibles. That would be the number of people we serve. People finally got excited about it.

Dennis Fisher in the finance office finally produced a fabulous little laminated card that identified the number of people HCFA served, the number of providers that were involved and the amount of money spent, on hospital care, on other services.

Things like that were major accomplishments. And not because people were poorly-intended or incompetent. It was just two very different cultures. It was very interesting.

SMITH: I remember when Jay was talking about this problem. He was saying he thought you could get them unified around quality standards, research and development, and data. And that's where you should start. Then where you took it from there he didn't say. But seems to me that would make sense.

EBELER: Yes.

SMITH: We have asked this of a lot of people and they said that in spite of what one has to say about the Nixon administration—and Nixon, for that matter—that the people who were in HEW at that point, ASPE and things like that, were an astonishingly good bunch of people.

EBELER: If you go back to Nixon, again, I didn't really know the senior people; maybe if I was lucky I would be at one meeting with them.

SMITH: Right.

EBELER: But looking within Medicaid, no question. Very competent people. Stu Altman was, is and remains a very top-notch policy person.

I think Richardson had brought in some enormously competent people, like Dick Darman, who ended up running major areas of government in later years.

But, again you are way out of my league. The ASPE job, which I now have some familiarity with because of later experiences, was different before HCFA because Medicaid was in the Social and Rehabilitation Service and Medicare in Social Security. ASPE had the job to do any integrative work on health care financing. And, Stuart was there.

MOORE: So, back to the late 70's, you stayed with Bill Fullerton until he left, then...Leonard Schaeffer came in.

EBELER: Then, I transitioned in and out of HCFA a whole series of Administrators. Bill left in the summer of '78.

There was an enormous amount of tension between Bob Derzon and Joe Califano. Again, Judy is probably more privy to some of that than I was. But it was very clear. And Califano fired Bob in the late summer or early fall of 1978. It was interesting, David, because the proper Washington dance would be that Bob would resign, "to pursue other opportunities."

But Bob said, "I don't want anybody to think I left this job voluntarily. There is no shame in being fired. I'm not being fired because I have done bad things. There is a disagreement on the direction of the agency and I would never want any person working here, doing hard work for me, to think I walked."

EBELER: It was very interesting. And Califano appointed his then-Assistant Secretary for Management, Leonard Schaeffer as Administrator. At that point, Judy had moved.

MOORE: I had just left in the fall of '78, right before this happened.

EBELER: Both Kevin Sexton and I were special assistants to Leonard when he came at that point. And that was an unbelievable opportunity to work for a truly spectacular leader.

SMITH: Now, in the Carter Administration there was a big, big emphasis on fraud and abuse.

EBELER: They created the inspector general's office, headed by Tom Morris who was very close to Califano. Califano loved talking about fraud and abuse. And, HCFA created an office of program integrity.

SMITH: Well, partly I got a sense that it surfaces because it's been around a long time and it's cooking and the stench is coming out of the kitchen and people don't like it.

EBELER: Right.

SMITH: That's one thing. Also, I've been told that a big item here was that if we're going to do national health insurance we've got to clean this up.

EBELER: Right.

SMITH: And also with hospital cost containment. And the nursing home people are raising all sorts of sand about this.

EBELER: Right.

SMITH: Are there any other reasons why there would be this kind of emphasis? You said Califano was hot on it.

EBELER: I may impute things to folks in part based on later information. I had more first-hand experience with Jay's passion about it. It was, for someone like Jay, a moral issue.

SMITH: Yes.

EBELER: These were public programs, public dollars, and people shouldn't be ripping them off. I think people like Jay and Califano were also very astute politically and they knew full well that you couldn't sustain the credibility of the program, and the public support for a program, if it was perceived as fraudulent.

SMITH: Yeah.

EBELER: And, in retrospect I think they're right. That resurfaced very dramatically in the '90s and it was very much Secretary Shalala's view.

EBELER: At the same time, other people were probably going after fraud and abuse to discredit the programs. It was one of those initiatives that had multiple advocates, as successful policy issues often do, multiple and often conflicting sources.

And there were people in the policy and advocacy community who were skeptical. The concern was that if you keep talking about fraud, all it's doing is undermining the credibility of the programs, which is a classic tension.

But it was a big push.
SMITH: And then you left—

MOORE: Can I ask a question before we let him be gone? Did you work on the Carter national health insurance proposals or did you mostly work on cost containment or—

EBELER: You know, you get to do everything and nothing out of a special assistant's job. I did a lot on hospital cost containment because Bill took that over at one point with Bob O'Connor. So I did a great deal of work on that. The Secretary's office did most of the real policy work on national health insurance: Karen Davis and Jim Mongan.

HCFA got involved in how you would implement it, because of course we assumed that we were going to implement it.

But the reality is, the policy lead was in the Secretary's office. And we would kibbitz.

The big internal initiative at the time was that Leonard was brought in because Califano was passionate about, as he used to say, “smooshing” Medicare and Medicaid together.

So Leonard had to functionally reorganize the programs. HCFA created a policy bureau, a bureau of operations, etc.

Leonard led the second stage of the reorganization. Califano first put it together under one umbrella.

MOORE: It's hard to reflect back on how you might have felt about this at the time versus the intervening 20-some years. But how did you approach that reorganization with the difference in resources between the Medicaid staff, which was still very small in terms of size and expertise, and the very large Medicare staff at the time? And did you think about that?

EBELER: We thought about it a lot. The hope was to take advantage of Medicare staffing. For example there was a new Medicaid reimbursement policy office, which was always Medicare's greatest strength—at the time,

the best and the brightest in Medicare went to payment policy. And you would have people working on payment policy for both programs.

Bob Streimer who was a young star in Medicare at the time, is the classic case. He got very involved in Medicaid payment issues. It was hard though.

It would be worth talking to Kevin Sexton because he was very involved in the nuances of the reorganization. I think Califano's other purpose as a good political operative was to make it hard to undo HCFA when a new administration came in.

After Leonard's reorganization, you didn't just have to move Medicaid back to welfare. You had to reach underneath it and do this difficult reorganization again. But yes, more resources for Medicaid were important. It's just very very hard to do.

MOORE: Yeah.

SMITH: Did Califano have in mind—I know Constantine had this in mind, but did Califano have in mind that you could create a HCFA and then national health insurance would essentially build on that and use that, that that would be a core?

EBELER: Absolutely. I don't know if Leonard Schaeffer still tells the joke, but he used to always say that he wasn't involved in national health insurance policy other than, of course, that he assumed that he would be running it. HCFA was to be the platform off of which you implemented national health insurance.

Again, Bob Streimer was involved in that. But, by then, I think there was a little more skepticism about whether national health insurance was really around the corner.

MOORE: Than there had been in the early '70s?

EBELER: And again, it may just be that I had a little more of a clue at that point. I mean, I was probably at the stage of my career where I thought I really knew a lot. You know, you have this point where you peak after about six years, and you think you're really smart and then you learn more and it just all goes downhill after that.

But, I think it was clear a Carter plan wasn't going to pass.

MOORE: And when Reagan was elected you stayed. Schaeffer left immediately I think.

EBELER: No. He had left earlier.

MOORE: You stayed around for a while.

EBELER: I went to the Kennedy School in 1979 and 80. I got a year off for good behavior, which was wonderful, because I had never gone to graduate school. Leonard left in April or May of 1980, which was the election year.

MOORE: Oh, that's right.

EBELER: When Leonard was Administrator, Califano was Secretary and Hale Champion was Under Secretary. That was a fabulous period for HCFA because we were lined up with the Secretary. We were the Secretary's place, and Leonard was the Secretary's guy. We were credible. Champion was a fabulous public administrator and bureaucratically protected us. When the stars are lined up like that for an agency, it's really fun.

Then Harris came in and the stars lined up in a different way. So Leonard left in 1980. Howard Newman came in as the new HCFA Administrator in probably June or July of 1980.

So I transitioned Howard in. Then Reagan got elected. Howard was asked to leave—on Inauguration Day, basically. So we were very involved in this transition. Kevin Sexton prepared a terrific briefing book for the new team because we thought of ourselves as professional civil servants.

We were skeptical, but we were going to staff these new guys, and prepared this great briefing book about all the issues. And I'll never forget sitting down with Jack Svahn, who headed the Reagan transition team for HHS. We had all this information about cost issues and policy issues, ready to go.

And his first question was, "You can't issue the guidance you are going to issue on DME suppliers." And we just thought, "Oh, no." Not exactly big picture. Obviously, this was a very important political constituency and HCFA planned to limit payments in some ways.

Carolyne Davis came in as the first Reagan appointed Administrator. Paul Willging had been the Acting Administrator. He had been the head of Medicaid by that point and became—

MOORE: the Deputy under Carolyne.

EBELER: Carolyne Davis got appointed, and so we transitioned her in. And she is a very goodhearted person. But it was also pretty clear that OMB was calling the policy shots at that point.

While I could have stayed within the agency, I decided it would be a good time to leave. And Karen Nelson once again came to my rescue and brought me up to Henry Waxman's health subcommittee staff in November of '81.

SMITH: As a staff person, there is no question that Karen Nelson has been absolutely a standout and incredibly successful. But she is not a very public person. And it leads me to wonder what is the secret of her success.

She is very smart politically, and she is very dedicated to what she is doing and she seems to have a great interest in bringing on people and recruiting a very good staff and hanging onto them. And that may be a very big part of the success. But am I leaving anything out?

EBELER: I think all those things are true. I'm sure she would deny this at this point but she is a really spectacular analyst and staff leader. Later, when she headed the subcommittee staff and had a lot of staff whose job was to focus on analysis in their areas, she didn't do that as much.

But she is a spectacular policy analyst in her own right and political operative on the Hill. She really understands how to create a dedicated group of people: a staff, an organization that really enjoys working together.

And, she is not at all threatened by having experts working for her who are more knowledgeable on details of their program than she is.

She never felt the need to sit in front of Henry and be the most knowledgeable technical person in the room. She would always make sure the information came to him correctly and that alternative views were there. She is a very good leader. And has a sixth sense about health politics.

SMITH: Another thing you have to add is that she is clearly appreciated by the congressman.

EBELER: Yes, she and Mr. Waxman obviously have a very good relationship. It worked. And he reinforced that, very much reinforced that

staff collegiality. After all these years, we still have an annual holiday party that Mr. Waxman comes to and the entire old staff goes to it. I haven't worked there since 1983. Yet I'm still part of it.

SMITH: What did you work on primarily?

EBELER: I went up there to work on Medicare because the Commerce Committee shared jurisdiction over Part B with Ways and Means as a result of some re-organizational changes in the mid '70s.

And they had never really engaged on it. So I went to work on that. And also did a lot of work on the federal budget because the Congress had invented reconciliation and you had to grapple with that. Medicare and Medicaid were always part of that.

Andy Schneider was the Medicaid expert there. But, Andy did Medicare stuff also and I did Medicaid, too. But he was clearly the Medicaid person. The other issue that came up at that time was health care for the unemployed.

The economy was going down, unemployment was going up, with people losing their benefits. And we started the process of trying to create and finance a program to cover people while they're receiving unemployment insurance.

It didn't go anywhere, but I think it was helpful to the House democrats in the 1982 elections. It led to COBRA two or three years later. It never happens in the year you start. But you nudge issues along.

The other big issue at that time was prospective payment of hospitals. HMOs were also put into Medicare at that point.

SMITH: Right when—I guess it's the same time. It comes in with the OBRA of '81. And there is a major assault on Medicaid at that point and they want to cap it. But in exchange for this, it's almost a preview to what later happens. In exchange for this you are going to get flexibility and...and this kind of business.

EBELER: I was not there when they won that fight. It is an indication of how competent that staff was and how competent Mr. Waxman was politically.

I think it was the only amendment to that 1981 bill that passed. And instead of a Medicaid block grant they got a three-year reduction in matching rates.

SMITH: Yeah, that 3-2-1.

EBELER: Yes, with a special offset for states with high unemployment. But they retained the open-ended financing, retained the entitlement, and achieved the budget target.

SMITH: There was a lot of negotiation with this and a lot of calculation.

EBELER: Andy Schneider and Karen can explain that better than me. And flexibility on Medicaid hospital payment was included. Home and community-based care waivers were enacted. There were actually, like any situation, some good policies though it was clearly a defensive action at that time.

SMITH: But to me it's been striking how that staff and how Waxman would go into a defensive mode but out of that would come something that they really wanted.

EBELER: Paul Rettig, who was the top Ways and Means Committee staffer, used to always laugh, and say that every time we would go into conference to cut the budget, we have to walk out having increased Medicaid.

And that was exactly right. You would whittle the Medicare savings target down but it would stay relatively large. And then over the course of the 1980's, Mr. Waxman, Karen and Andy would, first, bring pregnant women and infants into Medicaid with income up to 100 percent of the poverty level and then the near poor pregnant women and then older kids.

SMITH: Where would they get the savings from?

EBELER: You need savings within the health function.

SMITH: Okay, so they would be getting stuff from Medicare and where else?

EBELER: It was Medicare savings. It was very interesting. I don't think reconciliation bills are good vehicles for public policy at all. It's a terrible way to make tax policy. And it's a terrible way to make domestic policy.

Everything is in one bill because the accountable public officials get to cast one vote and say they are for reducing the deficit. But having said that, if that is to be the policy vehicle, everybody eventually figured out that you had to deal with that. And I think Mr. Waxman and Karen figured it out a little earlier, in part because Medicaid and health programs came under attack first.

MOORE: That's a good point.

EBELER: Again, it's not a good way to make policy. But if that's the way people are going to do it then you have to learn how to play—

SMITH: There was another piece in this. One was the capping of it. And that's really where they came up with the 3-2-1 thing.

EBELER: Right.

SMITH: And the other was the block granting. And we were talking with Karen about that and it seems clear to me that they did a job of regrouping a bunch of grants.

So if you put a bunch of dogs, politically indefensible things, in one and other stuff that they really wanted in some other things—

EBELER: Yes. There was a big Public Health Service fight at the time that the committee also had jurisdiction over. I can't say I followed that as much. There was a narrowing of the categorical programs into some block grants. But they started building in pressures within those blocks for constituents. Somebody like Tim Westmoreland could tell you more about that.

SMITH: It was a pretty artful job. How quickly did the congressman get onto the AIDS issue?

EBELER: I was in the office from '81 to '83 and he was on it then. It was then called (I'm going to mispronounce it)—Kaposi's sarcoma.

MOORE: Yes.

EBELER: Both because of his public health interest and his constituency in California, we had people coming into the office. Tim Westmoreland handled the issue. And, there were incredibly passionate advocates, insistent on

doing something about this, when it was politically unpopular. I mean, this was seen as a gay person's disease in an era of bath houses before the gay community had looked at this and totally transformed themselves in one of the most amazing social movements we'll ever see.

So, you weren't defending little kids. It was the classic difficult public health issue. And the Committee really did a lot.

Again, Tim could tell you more.

SMITH: That's right because they had yet to identify AIDS and HIV.

EBELER: There were very difficult debates with CDC and the Reagan administration. I think later Surgeon General Koop came around on it in what was undoubtedly an unpopular stand within his own administration. But early on I think it was a great health and moral failure in the Reagan administration, to ignore what was obviously a real epidemic.

SMITH: And in the government Waxman is about the only guy that stands up at the plate.

EBELER: I think that's right.

SMITH: Ed Brandt does later and so forth.

EBELER: Yes, the professionals at CDC were working on everything they could because, again, they were professional epidemiologists. This was a health issue. And they are health professionals. But like I said, Tim would have to give you that.

MOORE: So '83. Where did you go then?

EBELER: In '83, I left government and went out to work for Leonard Schaeffer, who was the president of Group Health at the time (now called Health Partners.) And I went out to Minneapolis and worked there for four or five years.

MOORE: Did they have a Medicaid contract?

EBELER: They did. They had a voluntarily Medicaid program. But, I deliberately went out there to do private sector health care work. I didn't oversee the Medicaid program.

MOORE: You went to learn managed care.

EBELER: Marketing and strategic planning and all that stuff.

SMITH: This is a question out of left field, in a way. But obviously you are to some extent engaged in that now. Do you think there is a way to save the HMOs for the good of humanity?

EBELER: I do. I think the key is that our presumption in the late '80s and early '90s that this was the one and only true answer, the Enthoven model. That is nonsense. This is a big country and doctors like to provide care differently and patients like to get it differently. But I am convinced that the relatively more organized plans like those that I now work for, which are the Kaisers, Group Health Cooperatives, are a very valuable way to provide care.

It puts a lot of pressure on the rest of health care because it does certain things better. If you look at 21 HEDIS indicators, which are today's best measurements for quality, our average is better on each and every one of them than the all-plan average.

I think you are well served by having these differing models. I also think consumers and employers, as prices go back up, are going to confront choices about whether it's worthwhile to go into a more tightly organized plan.

And, to the extent you get more involved in quality measurement, which we're pushing, the simple reality is larger, more organized health care groups have an advantage over solo and small groups.

SMITH: Yeah. And then you get more of the buy-right type employers and things like that.

EBELER: Yes, and Medicare. So yes, I do think there's a future.

MOORE: And how about Medicaid with regard to HMOs and Managed Care plans? Whatever we're going to call it.

EBELER: It's hard to tie this into a specific time, but when it began, there were a couple of presumptions that I know I held. There was the 50-50 rule, which was the policy that you didn't want Medicaid-only plans. You wanted the Medicaid beneficiary in the same health care system that you and I have. And that was a very strong belief and in statute. It was deeply

felt by advocates on my side of the aisle. That was a theological principle. And the policy of no mandated enrollment.

SMITH: Yes.

EBELER: You couldn't force everybody into a plan without choice. Even from a health plan perspective, I believe in that because there is nothing worse than trying to serve a patient who didn't want to be with you.

The difficulty is with Medicaid's underlying system. And while I have and would continue to defend this program in whatever way it took, the underlying fee for service Medicaid program in many places wasn't good.

I sometimes describe it as an “unpreferred” provider organization. And what happened over time is the states kept seeking areas of flexibility through waivers and statute and regs, slowly breaching the 50-50 rule on Medicaid-only plans.

And then things changed allowing them to move people into Medicaid managed care on a mandatory basis so long as there was a choice of plans. And I still twitch over mandatory enrollment—- I think we are well-served by different models out there.

But the reality is that a lot of Medicaid-managed care is now Medicaid only and works well. The community health centers formed organizations to serve that population. And I think they served Medicaid well.

EBELER: I love going to the Kaiser North Capitol Medical Center because we are all served the same there. But in most places, in the areas where these beneficiaries live, community health centers have done a nice job in improving that program.

I hate it when I'm wrong. But, I do think there's been some progress there. Meg Murray heads a group of health center-affiliated health plans that serve about a million Medicaid beneficiaries in 17 or 18 plans. They are organizations, community health centers, mostly, who are responding to market changes and trying to keep their patients.

She's got quality data that show they do better than most others. So I actually think there have been some good changes that occurred. And in the mid '90s when we were in the next Medicaid block grant fight the issue of the 50-50 rule and mandatory enrollment came up again.

And we saw that hand writing on the wall. You have probably observed that more than I have. It may well be that the 50-50 rule was right when it was first in place, in part because the first people that tried to get into Medicaid-managed care were not in it for health care delivery reasons. But, as time went on, things may have changed with Medicaid- only plans. And, there are things to learn from those plans in chronic care.

SMITH: Well, it's kind of interesting because I was talking with Steve Davidson the other day, who I know as a former student. And he was talking about some of their data on managed care and saying much earlier than they expected they were actually finding that Medicaid-managed care plans were taking on difficult patients and were doing quite well with them. Which is counter-intuitive because we all thought they would be scanting on service and avoiding these people.

EBELER: There's a lot of good work done by those plans. Steve Somers up in Princeton has done some really nice work. And, if you are in it for the right reasons, especially local delivery systems, you had better figure out chronic care with multiple co-morbidities real fast, because you've got those patients.

MOORE: We need to finish up the sweep of your career and then we can ask you a couple more Medicaid questions if you'll give us a little more time.

EBELER: I left Group Health in 1987. I came back to work in a terrific place called Health Policy Alternatives. It is a consulting firm that Bill Fullerton had helped found when he left HCFA. I was there for about eight years, doing a breadth of consulting on federal issues which in this town focus on Medicare and Medicaid. I was there from about '87 to '95.

In '92, I got very involved in doing health policy work in the Clinton campaign. I didn't go into the first part of the Clinton administration. I didn't want to be on the health care reform task force for two reasons. One is it was never evident to me that that was a good way to make policy. Is that understated enough?

MOORE: Uh-huh.

EBELER: And second, there was no institutional job. When the health reform effort ran its course, terrific people who had gone into the administration for that and had worked 25 hours a day were just burned to a crisp by the time it ended. A lot of the people were leaving government at

the time. Judy Feder and Ken Thorpe left ASPE in 1995, and I got invited to basically replace the two of them.

In 1994, if you recall, the Republicans took control of Congress, in large part because of health reform, and came back with a very difficult agenda. Gingrich was on magazine covers as the prime minister. And our job was to play defense. The biggest issues on the health side obviously were the budget cuts in Medicare and the cuts and block grant in Medicaid. And, it seemed to me like a useful way to spend a year and go back in to government and try to help oppose that.

So I went back to government as Deputy Assistant Secretary for Planning and Evaluation (health) and was there till the end of the first term. We had the Medicare- Medicaid fight. The government shut down, and it's very interesting to be in the government when it's shut down.

The Medicare fight in many ways was easier because there's a huge constituency. The Congress passed a $270 billion Medicare savings plan. Bruce Vladeck (then HCFA Administrator) was fabulous. Bruce and I had a very clear agreement, and we just decided when I got there in 1995 that HCFA-ASPE tension can't exist when the two programs are on the line.

EBELER: And it was easy, because we agreed about policy. So we didn't allow the bureaucratic split to happen. I sort of took the lead on Medicaid with his staff. To the extent that there were major policy decisions to be made, he would be involved. But the basic decision was simple: we're not going to block grant Medicaid. It wasn't complicated.

The administration put its alternative on the table in June of '95, the per-capita cap, before I got there. And proposed a $115 billion Medicare cut. We argued that $115 billion was the right cut and would improve health care; $270 billion was the wrong cut and would destroy health care as we know it.

And so for about six months Medicare and Medicaid were linked. From the Medicaid perspective we tried to make them one word- don't cut Medicare-Medicaid. But, welfare reform was also going through at that point and the advocates for block-granting Medicaid were trying to make it part of welfare reform, since welfare was also being block granted.
So you had to fight to stay out of that. And it was a very interesting time. The governors were very involved.

Secretary Shalala, never, ever, lost confidence. She not only didn't blink, she never let us believe that the administration would cave in. Even though we lived in mortal fear about what the White House might do.

EBELER: And she never let people be discouraged.

SMITH: I remember Judy Feder saying during that period things like, "Well, it's not over till the fat lady sings. And I think he'll cut a deal in the long run." There's all sorts of people who really thought he was going to sell you out.

EBELER: You never knew. Chris Jennings and Nancy Ann De Parle did a terrific job in shaping opposition to the block grant, but a lot of the President's closest advisors were for the block grant. And he was very close to the governors.

MOORE: The "governor President".

EBELER: There is no question that we would not have succeeded in the block grant fight in '96 if a couple of the Democratic governors hadn't stepped up.

Lawton Chiles for a couple of weeks held the Democratic governors at bay just by saying we won't disagree with the president without looking at it. And then, Governor Roemer of Colorado got very involved and spent a lot of time and ultimately was able to bring the rest of them along.

EBELER: Discussions with governors are interesting. I might start the discussion with entitlement. The money has to follow the people and you need some set of standards. Governors will typically start with, "You need the money to follow the people?" Standards are okay and let's not talk about the entitlement.

A federal guarantee, a federally-backed entitlement is never going to be popular. But I think it is enormously helpful. Governor Roemer did a wonderful job understanding the program and options in a technical way.

SMITH: That's interesting.

EBELER: And Alan Weil is the person who made that happen, and Jeanne Lambrew was a big part of it as well.

Governor Roemer got to deep levels of detail on the per capita caps and block grants. He really understood it. And he realized that the block grant wasn't the best thing. And Alan really was the key.

This was probably not an instinctive thing for the President to fight. But Secretary Shalala kept saying, "We did not come into this government to reduce health benefits. We're not going to do that."...Fortunately, it worked out.

At the end, he threatened to veto welfare reform if it included Medicaid. So the Republicans took it out of Welfare reform and inserted section 1931.

MOORE: Thirty-one, 1931.

EBELER: Yes, section 1931, de-linking Medicaid from the categorical programs, continuing the trend that had started with all the Waxman expansions.

In that same time period, other things were looking good again.

Kassebaum-Kennedy, or Kennedy-Kassebaum, depending on who you are talking to, was legislated. We got it in 1996 in part because of insurance reform, and in part just to get health reform behind us, and to get back on the agenda of incremental change. You don't want the political process to be afraid to take up health care issues. A lot of the energy for Kassebaum-Kennedy legislation was because there were major fraud and abuse provisions. The legislation allowed various investigative arms of the government—Inspector General, FBI, Department of Justice—to tap into the Medicare Trust Fund for their work, which is just awful public policy.

But it was incredibly popular. And again, in the Secretary's view you had to make these programs credible. And the public at that time absolutely believed that the spending problem is fraud.

SMITH: You're talking about 20 percent being fraud and abuse and all that kind of stuff.

EBELER: Yes. That's never been my issue but I think the Secretary was right. It's had an unfortunate after-effect in that it led to an “illegalization” of lots of administrative transactions, and has been part of what's hurt Medicare's standing within the provider community. It just drives them

crazy. Basically, it presumes you're a crook when you file a bill unless you say you're not.

The other big question then was what's next after Kassebaum-Kennedy? We started working on getting money in the budget for things like child health. It wasn't SCHIP at that point, but I think we got two billion dollars put into the budget as a place-holder for that.

MOORE: It was four.

EBELER: Was it four?

MOORE: It was four billion dollars as a place-holder for what became SCHIP. And then they added lots more money.

EBELER: It was really fun because it was very wired. We did a lot of staff work. Chris Jennings at the White House wanted to do it. Nancy Ann at OMB had signed off. I was very involved in it. The Secretary was an advocate.

And we went over to these budget meetings at OMB where staff, who know what was going on, ask what we had in mind with this child health idea.

And, Chris, of course, is not supposed to say anything because he is the recipient of this. And Nancy-Ann asks how much is requested. And so my job is to say, "Oh, about two or four billion." It was very nice work by Chris and Nancy-Ann, getting it working like they did.

Finally, we created the president's commission on quality and consumer protection in the health care industry. That was basically the end of term.

Just to cap things here, Peter Edelman and Mary Jo Bain had resigned on principal when the President signed welfare reform, given all the work they had done for decades on welfare. That was about in September. The Secretary asked me to hold down the Assistant Secretary job on an acting basis, which was an honor to do. And then the first term was over and I left.

MOORE: As you look back on Medicaid, and you have been in and out of actual administration of the program, and you have been very much involved in at least keeping good track of it over the years, what do you think are the kind of key policy changes over time that have brought it to

the point where it is today, in terms of being bigger than Medicare, for example?

EBELER: On the eligibility side, I think there has been major change. If you go back to Medicaid in the early '70s when we started, income levels were based on cash assistance levels, which were state-determined. This is even pre-SSI, if you recall.

And eligibility had to fit into the categorical slot; such as child in a family with dependent children. We still had a lot of rules about old issues like whether or not Dad could be there. Starting with Ribicoff kids and then through all of the expansions through the '80s for kids and pregnant women, they slowly decoupled eligibility from the categorical requirements of what the family looked like—I mean, a kid was a kid was a kid.

A pregnant woman was a pregnant woman. And they changed income eligibility standards from cash assistance levels to something more based on poverty standards. So you're slowly creating an income-based health benefits program rather than a welfare-linked health benefits program. And then SCHIP continued it.

I don't think you've seen a lot of benefit changes. States have been able to cover anything they want under Medicaid, always have been able to and still are. The mandatory services aren't really that big a burden for them. I think if you look at the proportion of Medicaid that goes for mandatory services for mandatory people, it's less than half the program. At least it used to be—that's five-year-old data

MOORE: I think that's still true.

EBELER: In part because, some very important services aren't mandatory. One big benefit issue was EPSDT and whether or not states had to pay for treatment of services found in the diagnosis that were otherwise uncovered in the state plan.

That's a huge political issue, but it's not where the dollars are.

On the payment side, I think policy has waxed and waned. There was big effort to upgrade payment standards in the late '70s as part of the creation of HCFA, with the governors and then the Congress rejecting that.
You have more and more State flexibility on payment, not for institutional providers, but for physicians. There was a decision to allow states not to

supplement Medicare payment if 80-percent of Medicare is greater than what Medicaid would otherwise pay. That's an unfortunate change. Some of the increased Federal dollars are due to two types of refinancing. States were able to move with federal acquiescence services that were previously 100 percent or mostly state- financed into Medicaid with, in particular in the ICF/MR shift, institutions for mental diseases.

There's been a whole refinancing of that infrastructure, and that's a lot of federal money. And then there is the provider donation and DSH money, which started off as well-intentioned policy, to make sure states pay disproportionate share providers more than other providers.

The donations and tax stuff then comes in the 80's through a very awkward bureaucratic loophole that the agency actually tried to shut down, if I recall. The grant appeals board wouldn't allow them. Was it Tennessee or Kentucky?

MOORE: It was one of those...Southern states.

EBELER: So, you had in the late '80s this multi-billion dollar donation scam at the time. A state could almost generate a profit off of Medicaid. The provider would donate the money to the state. The state would pay it back to the provider and get Medicaid matching on it. I give you a dollar, you give me $1.50, and you're getting another $1.50 match from the federal government. It was just awful. That got slowed down, which Tom Scully and Gail Wilensky get a lot of credit for.

And then you get a little more of the disproportionate share scandals where states pay public hospitals a lot more. The refinancing of previously-established state responsibilities is a legitimate policy decision. The other stuff is just, I think is just awful, scandalous. The career people always wanted to stop it and it was just hard. It's hard to get off the train.

There's also a waiver trend. It starts off with well-defined, Section 1115 waivers for research and demonstrations and then the home and community-based services waivers. You start building those into statute, which was again a very explicit statutory policy decision that the agency administered.

But more and more waivers are granted that are not really demonstrations. You're really using the waiver process to dramatically change policy.

SMITH: A brief question on the waivers. Now, a lot of people writing on this period blame the Clinton administration strongly for this kind of almost disease of waivers that we've gotten into, post-health care reform.

A lot of the reform initiative, if it is going to come, has got to come from the states. And therefore, the state has got to have flexibility to experiment. Therefore, it's really a policy of being generous with waivers. Is that correct?

EBELER: Yes. I think that's fair. It was occurring on the welfare side as well as the Medicaid side. Maybe first on the welfare side. Some advocates said when welfare reform finally passed it just enacted the previously-granted waivers.

In Medicaid there's a couple of reasons. One is you are in an environment where there's lots of old statutory policy that is awfully hard to retain in the current environment.

The administration was trying to be more responsive to states. And we were also in a very difficult, political fight over the block grant and the flexibility that would come with that. In part I think waivers were an effort to defuse the governors' push to get a big statutory change. And I do think the ramp-up in waivers absolutely did occur on our watch.

I told Tim Westmoreland when he went into the Medicaid job at HCFA in 1997 that waivers are like a drug. Once you start you can't stop. I don't know that you can answer Judy's specific question about why spending is so high, because in theory every waiver is budget-neutral over a three- to five-year period...But it's very uncomfortable if you are a little bit of a purist about public policy to be waiving sections of a statute that Congress passed. I mean, what's that all about?

SMITH: They're theoretically budget-neutral but you always really wonder if they aren't somehow shifting functions, paying for some stuff...

EBELER: They absolutely are. There is no question about that. I think the best story, the sense of what a narcotic it is, is when SCHIP passed. There were very carefully negotiated final decisions in conference about what the limits were and how you connect SCHIP to employer-based plans and, how you connect it to Medicaid and all those options.

Everything was negotiated and settled, reaching difficult political compromise. And I think the waiver requests came in right away. Nancy-Ann, to her credit said, "Wait a minute. You know, the Congress just spoke. I can't waive something that they just decided".

Waivers give you a sense that a statute is sort of interesting policy guidance but not relevant to me—not this section. I think that's been a very unfortunate trend. But, again, for a year and a half, I too nodded agreement.

You know, you try to nudge them, you reshape them, and ultimately, I was part of every one of those decisions in 1995 and 1996. It's a very awkward process. I think that you particularly worry about younger staff in the agencies and in the states for whom waivers are truly a norm. A statute is something to waive. And, it's not a good thing because they're going to be the leaders now. There's a whole set of federalism trends that I assume were not unique to Medicaid. [END OF TAPE 1, SIDE 1]

SMITH: Jack, you've been incredibly generous with your time...

MOORE: We didn't say at the beginning that it was Judy Moore and David Smith doing the interview because we got into the subject of things without saying that, which we were supposed to say on the tape. Thank you Jack.

INTERVIEW WITH MICHAEL FOGARTY AND CHARLES BRODT JUDY MOORE AND DAVID SMITH – AUGUST 11, 2003

SMITH: This is an interview with Michael Fogarty and Charles Brodt at the Oklahoma State Health Care Authority with Judy Moore and David Smith conducting the interview. So you were just telling us about how Mr. Rader had the health authority set up originally.

FOGARTY: Well, when Mr. Rader became director in 1951 of what was then called the Oklahoma Department of Public Welfare, DPW—typical name—ultimately it became virtually an umbrella agency although it wasn't through an executive reorganization.

Originally there was an earmarked sales tax revenue that was dedicated to the agency and to the programs that the agency ran. It was a permanent appropriation so that as those taxes were collected they were deposited directly into the agency's fund and didn't require annual appropriation by the legislature.

MOORE: And did that start in '51 or did that go back earlier?

BRODT: 1936.

FOGARTY: It started when the Oklahoma Social Security Act was passed. I think this is fairly typical. Of course, Oklahoma—Oklahoma does important things with constitutional amendment. I don't know whether you have ever seen our constitution. It is a very, very large document because we do everything by constitution.

Including back in 1936 when Oklahoma passed its Social Security Act. That was done as a provision of the Oklahoma constitution. And at the same time there was created the sales tax. I think initially it was one percent. Later it grew to two percent. And it funded—initially it funded education as well as some of the new—then-new cash assistance programs.

SMITH: Uh-huh. What was the initiative behind it? I mean, things like that don't always just occur.

FOGARTY: Well, it was actually done as a result—and, Charles, if you remember who did that it was a—

BRODT: There was—actually, there was a study.

FOGARTY: Was it Brandeis?

BRODT: I want to say yeah. I think it was a Brandeis study.

FOGARTY: This was in the Depression.

BRODT: Marlon was the governor, right?

SMITH: Uh-huh. It's taking me back.

FOGARTY: Right. There was a Brandeis study and as a result of the study there was an initiative petition and the initiative petition created this Article 25 of the constitution, which created the Oklahoma Public Welfare Commission, a nine-member body that served nine-year terms.
And the State of Oklahoma has a tradition of using commissions and boards to—as the administrative function of the state, the executive function. The governor does not have quite the power that you might find in other states.

SMITH: Was that a Progressive or a Populist tradition?

FOGARTY: Populist.

SMITH: Yeah. That's what I thought.

BRODT: ...Bill Murray.

FOGARTY: Now, here is an interesting tidbit. Alfalfa Bill Murray, who everybody has heard of, I think, he is the guy who put the National Guard at the Red River because Texas wanted to charge a toll to cross the river. So he sent the Guard down there to protect our interests in getting across the river. Lloyd Rader served as Alfalfa Bill's driver back in his campaign days in Western Oklahoma. Lloyd Rader was from Western Oklahoma and his earliest experience politically was to serve as Bill Murray's driver.

SMITH: Literally drove his automobile.

FOGARTY: Right. Shortly after that, in 1932 during the Depression, he actually served as the Custer County relief director. This was one of the Roosevelt programs that provided some money to just get food to people. I

have heard Lloyd Rader talk about people that were living under the bridges and—

SMITH: Was this FERA?

FOGARTY: I know the dates were in '32-'33. It is mentioned—

BRODT: It had to be '33. Roosevelt wasn't in office until '33.

SMITH: So it precedes that.

FOGARTY: Right. And it may have been prior to—prior to Roosevelt. What I remember was Lloyd Rader telling stories about getting in trouble with the Feds because he was purchasing some articles for them to build little shacks to get cover and it was not one of the authorized expenses. And he used to always laugh about how in his earliest days he was pushing our federal partner.

SMITH: Yeah, yeah.

FOGARTY: Because he saw some things that these people needed and there was the money to do it and he did it as the relief director and—

SMITH: There was a huge shanty city right within the Oklahoma City limits.

BRODT: This was out at Clinton?

FOGARTY: Yeah, this was out in Western Oklahoma.

BRODT: I've heard that story a bunch of times.

FOGARTY: So—and it was a big deal. I mean, the Feds came down and they held all kinds of investigations and all that stuff. And he survived and so that was a longstanding tradition of Lloyd Rader. I think he tended to do what he thought was right and what was helpful to the folks he was intending to serve. And if it meant that he was going to get in a contest with somebody, so be it. It didn't seem to faze him.

But back to the organization. I think that Brandeis did these studies in a number of states.

I think Wisconsin was a state that had a similar structure. Lloyd Rader used to talk about some of the state organizations that initially started in a way very similar to Oklahoma. So that is, it was very insulated from the annual politics.

SMITH: But there was a 48-er progressive tradition that came into the state from the north that could be some background to that.

FOGARTY: Could be. Could be.

But this was very typical, as Charles mentioned, you had a nine-member commission created constitutionally. This isn't a statutory commission. This is a constitutional commission with each serving a nine-year term on a rotating basis. And at the time the governor was limited by a constitutional provision to one four-year term. So do the math, you know.

Unless there were deaths or other exits from the commission the governor could never actually gain control of a majority of the commission. And that was done intentionally, as was the dedication of the revenue I think. That was another expression of the same sort of desire that it not be controlled by the governor nor, in fact, altogether by the legislature. So it was fairly independent.

BRODT: And the commission was the one that appointed the director. And then the director had fairly broad powers with regard to hiring and firing of staff. It was intended to take out all the political problems that everybody was having. And I guess, you know, for us, Mike and I have been doing this stuff for 32 years.

FOGARTY: Didn't want to...

BRODT: He has the spottier work record. He did spend a few years in private life.

FOGARTY: And in Washington.

MOORE: And back in Washington, right.

SMITH: But it's clear, I think, it's about half Populist and about half Progressive. With some very Progressive features.

FOGARTY: I think that's right.

BRODT: Yeah.

SMITH: And certainly, among other things, this belief in having a strong director by taking the politics out of it.

FOGARTY: Right. What that really means is the political power was the director. What I have learned is, you are never going to take the politics out of it. There's going to be politics in it. Now, the fact is the way Lloyd Rader ran the agency, the Department of Public Welfare, we had a merit system. You had to take an exam and pass that to qualify for employment. But at some point there was discretion. You get within the top five by scoring on the exam, and somebody exercises discretion on which of the top five get hired. Well, the one of the top five that got hired was the one who got a letter from their state senator or from their representative.

And he used that, I think, in very legitimate ways. Number one, they were qualified to begin with. And number two, he used that to be accountable to the local legislators. He used that system, and obviously through that made a lot of friends in the legislature and was able to accumulate a huge political force.

The other sources of that were—two more. One is back again to this dedicated revenue. What occurred over years was that as this revenue outgrew the need for the traditional programs which were primarily the cash assistance programs. What else was in there?

BRODT: Eventually they got child welfare. But it was mostly just the basic cash assistance—

MOORE: AFDC and OAA?

BRODT: Old age assistance, yes.

FOGARTY: But what would occur is, there would be a program out here outside that agency that was dying, underfunded, couldn't make it. Well, they would just transfer that program under the DPW and relieve the general revenue of that obligation.

MOORE: Fine with everybody.

FOGARTY: And over the years, as you can imagine, that included the vocational rehabilitation program, it included—

BRODT: Title 5.

FOGARTY: Yeah, Title 5. The children's—it included all of the institutional services for juveniles, all of the services for the mentally retarded, including three large institutions.

Look at this picture of Lloyd Rader and Henry Bellmon, Henry Bellmon ran for office the first time back in the sixties on a no-tax platform, of course. And the state was broke. Shortly after he took office Lloyd Rader and he worked out an arrangement. And that was when the institutions for the mentally retarded came over.

BRODT: I think the juvenile institutions actually came over before. As I recall, the crippled children's came in '59 and then like '61 or '62 we started getting the juvenile institutions, orphanages. And then in '63 we got—which would have been the first year that Henry Bellmon was governor.
We got the MR institutions, including one that hadn't even opened yet. It was a brand new facility—

FOGARTY: They couldn't open. They ran out of money.

BRODT: But that was the institution that we got a deinstitutionalization lawsuit back in the mid '80s.

FOGARTY: Yeah. We'll get to that.

The end of his career came when that whole institutional emphasis went away. The fact that they transferred all these institutional-based services, both juveniles as well as MR, was in some respect his unraveling. Because what he did was, he made those the finest institutional-based services that were to be found and defended that far beyond what he should have. Everything was moving to deinstitutionalization and he never was able to actually make that shift.

SMITH: But this is what date now?

FOGARTY: That didn't come until the late '70s or early '80s.

SMITH: But preceding this, he had made these moves with respect to MR and that sort of stuff. So it explains a lot of his position when you get Medicaid.

FOGARTY: Absolutely. In fact, the MR program, that's why he, with the help of Henry Bellmon got the Medicaid federal statute amended to accommodate state institutions for the mentally retarded. And those began operating as ICF/MR and drew Medicaid federal matching.

So over the years that agency grew, as you can imagine. The last big obligation that was transferred to the agency under his administration were the teaching hospitals. First, the children's hospital, the OU Medical Center, children's hospital, and then later the adult hospital.

He oversaw the reconstruction of that campus, which is here in town. Borrowed no money. There were no bonds issued. Spent something in excess of $100 million refurbishing and constructing that campus which was—which was highly controversial at the time.

MOORE: Was this in the '70s and '80s?

FOGARTY: Yes, this was in the '70s and '80s, mid >70's.

BRODT: We took over children's in '73. And the adult hospital in '80.

MOORE: So there was a long tradition of DPW having more than just Medicaid. And the welfare medicine kind of things, but a larger emphasis on public health.

FOGARTY: That's right.

MOORE: And was there a health department?

FOGARTY: There is an Oklahoma Department of Health. It is the survey and certification agency. It indirectly oversees the community, typically county health department operations. It is more in the tradition of the public health model.

And they struggle, frankly, continue today to struggle with their identity whether they are a service deliverer or public health policy agency. And I suppose that is typical as well. But that agency was always freestanding as well as the Department of Mental Health. There is a freestanding department of mental health that operated direct delivery of services, again historically through an institutional base. They operated the state institutions and now continue to operate the community mental health centers and are the policy agency with regard to mental health.

SMITH: Well, a lot of questions arise. What about Lloyd Rader? You mentioned he obviously was politically adept. How was he as a manager, administrative manager? Did he worry about that or was he inspired? Did he get other good people to work for him?

FOGARTY: Well, I think he typically surrounded himself with competent people but he delegated very little. This is a man who worked seven days a week. This was a man that never to his knowledge were there any external communications that left that agency that were not under his signature.

There were a few people to whom he delegated signature authority. Very few: three or four. But it was very much Lloyd Rader's—he controlled it, every appointment letter of every employee. And at the time he left there were, what, 15,000 employees?

BRODT: About 15.

FOGARTY: Every appointment letter to a newly-hired employee of that department was signed by Lloyd Rader. And that is what he would do. He would spend his weekends in that office with stacks of mail. And he would sign those.

And also that was his favorite time to return phone calls. Politicians in Oklahoma that were in office back then talk about how they knew when the phone rang at 1 o'clock on Sunday afternoon it was Lloyd Rader calling because they had written him a letter or asked about something and he would be in his office calling them back to respond to whatever it was they were asking for.

So he was a genius administrator. I don't think there was a question about that. And I think it was possible for him to do that because he grew with those programs. I mean, for somebody to step in and take over that size of organization and have that level of managerial control would probably be impossible. But he just accumulated that over the years.

SMITH: Well, now, as far as his own motives, what motivated him? Was it power? Was it fascination with this? Or was he really a Populist at heart?

FOGARTY: I think he was very much a Populist at heart. I think he was in the tradition of the early thirties Oklahoma Populist. He enjoyed the power.

I think it's clear that was something that he liked.

He didn't do it for the money. He was never a wealthy man and would never have been a wealthy man doing that job.

SMITH: When did you start with him and what was it like working for him?

FOGARTY: Well, I'll give you my quick one and then Charlie can, too. I started in 1971. And I was hired as an eligibility case worker in Potawotamie County, Shawnee.

MOORE: And you got a letter from—

FOGARTY: And I got a letter from Senator Ralph Graves who endorsed my employment. And I got an appointment letter from Lloyd Rader appointing me to that position. And then I was able to take advantage of some scholarships that the agency offered and that sort of thing, worked in the juvenile institution. But part of this is being at the right place at the right time. I had been a student of David Boren's at Oklahoma Baptist University and I had gone to graduate school and come back to Oklahoma, gone to work for then the Department of Institutions, Social, and Rehabilitative Services.

SMITH: DISRS.

FOGARTY: DISRS. You know, all the agencies across the country were changing the names.

BRODT: The name they adopted whenever they took on all those institutions.

FOGARTY: Right. So as was his habit when a newly elected governor took office, which David Boren did in 1975, not only would the governor have a staff that was the liaison to the agency, but Rader would inquire of the newly-elected governor if there was somebody in the organization that they knew.

And of course I was the one. So I got transferred to the state office and worked as an administrative assistant to Rader. Also, the thing that was just incredible timing was I was the assistant supervisor of a newly-formed policy group called Planning and Evaluation which had the responsibility of maintaining the federal state plans and that included the Medicaid plan, the Title IV plans by social services, and cash assistance.

And then of course, as you remember, right about that time came the new child support enforcement, Title IV D, which was a brand new federal state plan to be developed.

As well as—what was the other one? There was another one that came along at the very same time.

SMITH: What's the date?

FOGARTY: '74-'75.

SMITH: The MMIS kind of stuff came—

FOGARTY: Well, that was—yeah, that was growing along about that time. But there was another major program besides chid support.

MOORE: EPSDT?

FOGARTY: It was Title XX. When they block-granted social services. So I worked closely with Rader's office in developing those new programs and overseeing the development of the federal state plans for those, but then also worked as liaison with the Feds. That was just a wonderful coincidence for me early on. I was by far the youngest person around that had that kind of access to Lloyd Rader.

You know, that was a bit intimidating. But he was fairly typical in that he appreciated independent thought and even disagreement with maybe the direction he was going. But it still made him angry.

SMITH: So, you're right, damn it.

FOGARTY: Yeah. So there were times when you wouldn't see him much because you had kind of offended his dignity; so you would be banished off to the corner. And you would wait. We used to laugh about it. You would be under the tub. And occasionally you would kind of lift the tub and peek out and see if it was safe.

But it almost always resulted in him getting you back in the mix. As you can imagine somebody of his power, he had lots of yes-people around.
Any time he wanted somebody just to say “yes” he knew who to call in. But he also had those of us—and I count myself among them who he knew

would shoot straight. And when it got tough, when he got down to something that was really an important issue I think he would tend to call on a few of us who he knew would step up.

SMITH: The natural tendency is, though the power corrupts kind of thing, you think that he would overstep somewhere along the way.

FOGARTY: So I think he kept that pretty much in check, was my observation.

Then, the gentleman who headed that policy division, planning and evaluation, retired in '75 or -6.

BRODT: '77.

FOGARTY: Seven. He's the encyclopedia. He knows all the dates. And then I became the director of that group. And so I began working even more closely with Rader. In the meantime, Boren was still governor and became very active in the NGA process and was on the NGA Human Resources Committee.

This was back when everybody was reforming welfare, everybody was reforming Medicaid. Sounds familiar, doesn't it?

MOORE: Yes, it does.

FOGARTY: And so I had this incredible opportunity to staff that committee for him at NGA. I got to serve on a number of work groups through both NGA and what was then APWA. Rader was very active in APWA.

SMITH: Uh-huh.

FOGARTY: He stayed very upset with them most of the time because they were not politically active enough.

MOORE: He must have been one of the stalwarts in APWA though in terms of the—you know, the structure and the functioning of the organization, oh, probably from the thirties on.

FOGARTY: Oh, he was.
BRODT: Yes.

FOGARTY: I have heard lots of stories about when APWA was in Chicago before they moved to Washington. They would go to Chicago by train. Of course, they would also go to Washington by train. But some of the old-timers that predated me would talk about the days spent in the railroad car, working away on their way up to Chicago to an APWA meeting or beyond to Washington.

Yeah, he was very active in that group. He had—and there were some of his counterparts. I'm trying to think of some of those because I thought you might be interested. People like...

BRODT: Dempsey.

FOGARTY: Jack Dempsey from Michigan was actually one of the later ones.

And then Wilbur Schmidt from Wisconsin—Schmidt. Norm Lourie from—where was he, Pennsylvania?

BRODT: Pennsylvania.

FOGARTY: Jack Affleck from Rhode Island was kind of one of the later ones but he and Rader seemed to get along. And then there were a couple from Texas: Johnson; I can't remember. But the best one was Garland Bonin. I don't know whether you ever ran across Senator Garland Bonin.

SMITH: How do you spell that last name?

FOGARTY: B-O-N-I-N. From where, you might guess: Louisiana.
Garland Bonin was a former state senator from Lafayette who had become the welfare commissioner in Louisiana and he and Rader became acquainted.

And when Bonin retired in Louisiana, Rader put him on the payroll as a consultant for the single purpose of his access to Russell Long.

MOORE: Interesting.

FOGARTY: And Garland Bonin—see, here I am, a kid at the time. But I traveled with Rader everywhere. He went to Washington, I'd go with him. And there have been a number of times when it was Garland Bonin and Lloyd Rader and me sitting in Russell Long's office.
And it was the only occasion in my recollection that I saw Lloyd Rader intimidated, that I saw him quiet. And it was so funny because he and

Garland Bonin would talk about all these issues they wanted to go talk to the chairman about, you know. They would line up all this stuff, and it was very controversial and they were really going to get this straightened out.

And sure enough, we get an appointment with Russell Long, we walk in his office, and Garland Bonin and Lloyd Rader would sit there quietly while Russell Long talked. And Russell Long would talk for an hour or an hour and a half about whatever subject he chose to talk about. And they would stand and say, "Thank you very much, Mr. Chairman," and they would leave. And then Lloyd Rader would come back and tell stories about how he met with Russell Long and how, “By God, they got that straight.”

SMITH: That is funny.

FOGARTY: I just remember it struck me at the time he probably didn't say four words. But that was not the usual Lloyd Rader. That was a rare incident.

SMITH: One story that is told about him had to do with the ICF/MRs.

FOGARTY: Uh-huh.

SMITH: And the story went as follows and I would be interested in whatever corrections you would want to make in that or whether you would just confirm it. Rader had started essentially using Medicaid funds to fund a number of these ICF/MRs. And it was beginning to get maybe a little bit risky to do this.

And he wanted to get taken off this hook. And he had access to Senate finance through Russell Long to some extent. And he also—Oklahoma and Arkansas were well-placed as far as, you know, Ways and Means.

MOORE: Wilbur Mills.
FOGARTY: Wilbur Mills.

SMITH: Was concerned. And so on the basis of his political connections he got that change made in the law. Is that substantially accurate?

BRODT: Yes.
FOGARTY: That was Henry Bellmon, who at the time was on the Senate Budget Committee, among others.

BRODT: He initiated the change in Medicaid for the public ICF/MRs. And when they created the regulation they allowed for private ICF/MRs, which is a longstanding battle in Oklahoma.

FOGARTY: Just another twist.

BRODT: —because we had no private ICF/MRs until 1986.

FOGARTY: Well, it was after Rader was gone. Because when you read that law today—

BRODT: It says public.

FOGARTY: —it says public facilities for the mentally retarded. And that was the amendment that we—he called the Bellmon amendment.

MOORE: Yes, we did used to call it the Bellmon amendment.

FOGARTY: The Bellmon amendment. That's right.

MOORE: Geez, I hadn't thought about that for years.

FOGARTY: And his position—Lloyd Rader's position was that that was not intended to fund private facilities for the mentally retarded and he never allowed facilities in Oklahoma to become certified licensed MR facilities. Except for the three state—what he called the three state schools for the mentally retarded. We had specialized nursing facilities in Oklahoma.

SMITH: So—but it was Henry Bellmon who was the political connection that got this done.

FOGARTY: That's correct.

BRODT: He was the author of that one particular amendment. There were multiple powerful congressmen and senators that Lloyd Rader used over the years. Robert S. Kerr was senator from Oklahoma. He is the author of the Kerr-Mills bill, the precursor to Medicaid.

Tom Steed was the head of appropriations for the federal government in the House, was a long-time U.S. Representative and—

FOGARTY: There was Carl Albert, Speaker of the House.

BRODT: And Rader was able to use influence through those sources also to get things done.

SMITH: But he didn't have any special connection with Wilbur Mills?

BRODT: Through Bob Kerr.

FOGARTY: It was through Kerr. It was Kerr who looked to Mills to carry that legislation in the House. Yeah, Bob Kerr was really the key I think to Lloyd Rader's influence in Washington.

That's where he met Wilbur Cohen, when they were actually drafting the Medicare/Medicaid statutes. And Wilbur Cohen was Assistant Secretary at HEW then. He and Lloyd Rader became very, very close friends.

And of course he was there under Kennedy's Administration. And then under Johnson, Cohen became Secretary of HEW. Lloyd Rader used to tell one of his great stories about the birth of the medically needy program under Medicaid.

And he could tell me what restaurant they were in. But he and Wilbur Cohen—I'm sorry, I can't remember. I ought to make one up because nobody else would know. But he and Wilbur Cohen sat in a restaurant in Washington, D.C. struggling with how you make this health care program available to people who weren't on welfare. I mean, even then, struggling with how you make—how you offer this program and its support for people who clearly can't afford health care but who aren't so poor that they are on cash assistance.

And they wrote the words on a napkin. Of course it's always the napkin. They wrote these—they crafted these words something like: “Those who are eligible but for income.”

And that was the formula—so, bingo! And he used to laugh about the napkin origin of the medically needy program which, of course, was part of the original Medicaid law when it was finally passed.

SMITH: Did he have a long-term vision for what he wanted from Medicaid. I mean, nowadays if you speak to many people they will say, "Well, what we expect of Medicaid is that it finances everything which is not covered that

should be covered." Or other people will say, "Well, but it's going to be the path to national health insurance or it should cover as many of the working poor as it possibly can." Or—

FOGARTY: If he had a bias, it was children. I frankly don't recall ever hearing him talk about the long term. No global kind of public policy issues. He was a much more, "Who needs help and how do we get it done?"

MOORE: Pragmatic, here and now.

FOGARTY: Right, now. I just—I don't recall ever hearing him talk about how we're going to make things better 10 years from now.

BRODT: I think that some of the things that he did was because when he first came in 1951 there were some things that were set in place. There was even at that time a real basic health care program for the elderly and their hospital program.

And then there were these programs that had child welfare. And so he had all these kids' things that he was trying to take care of. And he always stayed with those.

He always believed that he had to take care of the elderly because that was the original base for the income for that agency. The sales tax revenue that went into the state assistance fund, which was that dedicated budget. And they have these little things—do you remember the mills?

MOORE: I do.

SMITH: Oh, yes.

BRODT: Pocket full of mills. Make necklaces out of them. Remember what they said on it? For old age assistance.

SMITH: Yes. I had forgotten—

BRODT: So when—in '72, when they created SSI, he got a clause in that law that became Section 209B.

MOORE: The 209B law is Lloyd Rader's?

FOGARTY: Uh-huh.

BRODT: So that the state could maintain control of assistance to the aged, blind, disabled.

And we had a cash assistance program, a state supplemental payment. We still have it.

But he made sure that the state of Oklahoma continued to make a payment, a cash payment to the aged, blind, disabled.

FOGARTY: And administer it. He would have never turned that over to another entity.

BRODT: He retained control not only of the administration of that cash assistance, but of the eligibility for Medicaid.

He had certain visions as far as you had to take care of these needy kids, make sure that they have a roof over their head, meals, that they were healthy. And then also for the elderly that there was a place for them. And he pushed nursing home legislation.

SMITH: Now, another thing he was associated with—I may be wrong on this and if so I would like to get this corrected, but transfer of patients from mental institutions into nursing homes. Was he doing that or was that not so?

FOGARTY: Yeah, let me explain. That comes in two forms. Mentally retarded was one thing. Mentally ill was another thing. His approach to them was diametrically different. When he took over—and I said a while ago—what he called the schools for the mentally retarded, which is literally what they were to be.
MOORE: Uh-huh.

FOGARTY: Those institutions were full of adults. And children could not get access to those institutions because they were over capacity with adults. He believed literally that those institutions should be educational based.

SMITH: Miles ahead of the curve on that.
FOGARTY: Right, right. And so he went forward with a program that would create private nursing facilities that he called specialized facilities. They weren't ICF/MRs, they were specialized. And it was required that they do programs differently than the normal ICF. And it paid an enhanced rate. He actively partnered with the private industry to place those adults out of the

three MR schools—well, two operating at the time and another one under construction. That was—gosh, I don't know how many. Many.

BRODT: Are these specialized?

FOGARTY: Yeah. Well, how many people were in those institutions that needed to be moved out? Probably 2,000.

BRODT: By the mid to late '70s there was about 2,000, 2,500 in those specialized ICFs.

FOGARTY: So he partnered with people who had—traditionally been in the nursing home business that here was an opportunity.

He placed those adults in private facilities and opened those school facilities to children. You had to leave those institutions when you turned 18 because his theory was that that's when your education is over.

And so over the years the mission of those institutions became education and training—and he enforced it. The fact the average age of those institutions will grow one year every year if you're not doing something. The population is so steady and they live for a long time. And that is what had happened.

So as people aged out of the MR facilities, if they needed continued institutional kind of support they would typically be placed in a private, specialized nursing facility. So many thousands of mentally retarded were placed in private nursing homes. No question about that. And that was all to achieve the goal of having those institutions available for education.

SMITH: That gets totally blurred in the accounts you generally read.

FOGARTY: Yes, it does. Those schools had superintendents. The MR facilities had a school system. They had a superintendent. They had principals, they had teachers and—

BRODT: They even built school buildings.

FOGARTY: On the campus. And we didn't mention two other institutional-based services. The state was operating a large school for the blind and a school for the deaf. And those two also were transferred to the department

along about that same time, I think. I don't remember exactly when. But same theory applied there.

SMITH: Were you going to say something about mental health?

FOGARTY: Mental health, which of course was a separate state agency, was operated by another guy much like Lloyd Rader. His name was Hayden Donahue.

SMITH: I remember that name.

FOGARTY: An incredible physician, psychiatrist, whose mission was deinstitutionalization way before it was all that popular.

SMITH: What would be the date for this?

FOGARTY: This would be again in the—at least early '70s, if not late '60s, and then right through till his retirement in '82. And that policy never changed. Hayden Donahue worked on a consistent basis to place mentally ill from the large state institution into private nursing facilities. And back then—it's kind of interesting—those nursing facilities were viewed as community-based services.

We had little, 40-, 50-, 60-bed nursing facilities in every town with 3,000 or 4,000 people in this state. So they weren't viewed at the times as institutions, they were viewed as moving people home—moving them into a 30-bed nursing home in—you know, in Watonga. But Rader absolutely would not budge. He did not want the mentally ill in nursing homes. And frankly, I don't know that I can explain it other than it was just not his deal.

I suppose if they had transferred the department of mental health or the institutions to him, he would have viewed it differently. But it was just—it was kind of a bother.

He finally struck a deal that he would allow 100 patients from the state mental hospitals a year, 100 patients a year could be transferred from the institutions to private nursing homes. And they would count them. And every year Hayden Donahue would get 100 patients deinstitutionalized to private nursing homes.

BRODT: And they had to have at least one physical diagnostic problem.

FOGARTY: Physical.

BRODT: Physical. Primary diagnosis.

FOGARTY: Yeah. Let me tell you. You talk about somebody that didn't want to turn nursing homes into mental facilities. And so he would not allow—

SMITH: This is Donahue you are talking about?

FOGARTY: This is Rader. Rader would not allow an admission to a nursing home based on mental problems. They had to have an accompanying physical ailment that would otherwise get them in. I mean, it's really interesting thinking back about how forward-thinking that was.

BRODT: Yes, they always had a physical condition. And whatever Medicaid law was created, I mean, there were the two exceptions: the IMDs and the TB sanatoriums. And I think he always knew that the IMD was a problem.

FOGARTY: I think it was a problem for him. I think he thought it was inappropriate.

BRODT: So he always made sure that it was a physical condition.

FOGARTY: Of course, he was a cattleman. His analogies were almost always something to do with cattle. He would “open the gate.”

SMITH: Control the herd?

FOGARTY: How you control—how you control expenditures for nursing home services.

And he would talk about tightening the medical requirements. He always said, "Well, you would have to pull the gate down a little bit," and not let so many in or out. That was one of his favorites.

And then I left. Rader retired in '82 and I stayed in the agency when Henry Bellmon was there for a year as director. And then he left and Bob Fulton came. And actually it was Bob Fulton that asked me to head up the Medicaid division.

You may remember the name Bertha Levy. Dr. Bertha Levy, who was a pediatrician, was essentially the Medicaid director, headed up the medical program here from '65 or '66 when we implemented the program till 1983. And when she retired, Bob Fulton, then director, asked me to take over the medical division. So that was really my first—first time at actually operating the Medicaid program.

SMITH: —began that when?

FOGARTY: That was '83.
And I remained in that position till '86, when I left state government and went out to try my skill at practicing a little law and also owned and operated a couple of nursing homes. I stayed out of government till 1995 when this agency was created.

But the big change for me at DHS, I have skipped over. When David Boren left the governor's office in '78—he ran for the U.S. Senate. And I resigned—actually took leave—and worked on his campaign in 1978. And then, after his election he asked me to go to Washington and be part of the staff. So I resigned.

SMITH: You were part of his personal staff?

FOGARTY: Right. I was LA for the Senate Finance Committee. He got on [the] Finance Committee so I got to staff the Social Security Act, the social welfare programs on finance. I didn't do tax, thankfully.

MOORE: And what years were you in Washington?

FOGARTY: I was there in 1979 and 1980. And would have remained, except that—back to what was going on in Oklahoma—the legislature had transferred the adult hospitals to the Department of Human Services. And Lloyd Rader had literally relocated from the Sequoyah Building, where the state offices of the department were, down to the health sciences center.

And the commission created a position of deputy director for the first time in the history of the agency and invited me to come back to Oklahoma to serve as Rader's deputy. And my job essentially was to maintain the balance of the agency, administer the agency while Rader was focused on transforming the health sciences center.

And that was, again, one of those incredible strokes of timing and was a unique opportunity.

Again, in 1980, I was 32 years old, while the average age of those who reported directly to Lloyd Rader was probably closer to 74 at that time.

SMITH: Don't trust anybody under 65.

FOGARTY: So I was very much the young Turk.

SMITH: I would like to ask you a couple of questions. One was about David Boren. I'm very impressed with what he is doing at University of Oklahoma and I was aware that there is a certain amount of tradition in Oklahoma of people becoming Rhodes Scholars. And he was a Rhodes Scholar.

BRODT: He was.

SMITH: Was he a man that you would say was intellectually interesting?

FOGARTY: As I mentioned, my first acquaintance with David Boren was my senior year in undergraduate study when I was completing a minor in political science and he came as head of the political science department at Oklahoma Baptist University. So I took—I don't know, 15, 16 hours with him in that one year and they ranged from a course called state and local government which was just organizational theory of state and local government, to courses of social and political thought, which was very much a philosophy/policy course.

And this man—this man would stand up in front of that class for 50-55 minutes and lecture with no notes. I mean, I have never known anybody that had such a command of such a wide range of knowledge and material.

His intellectual capacity is incredible—and not just the capacity. There's others that have a huge capacity to learn and know, but his ability to actually communicate it in a way that people learn, and to apply it. People attribute to David Boren the ability somehow—and a lot of people think it's luck to somehow make the right decision that looks like the wrong decision but turns out a year or two or three later to be very much the right decision.

That's got nothing to do with luck. That's everything to do with understanding the real consequences and ramifications of today's decision even though it may not be obvious. And that's nothing but pure intellect.

SMITH: Well, I think it's an enormously exciting way of dealing with the University of Oklahoma. But now—

FOGARTY: As a staffer it was very frustrating to go in—This man—you would go into his office to brief him, as he was getting ready an hour later or 30 minutes later to go to a Finance Committee meeting and there is—what I considered—a very detailed, technical, complicated issue. And I would prepare for a week and go in there and this guy would be sitting at his desk signing mail, just doing all kinds of things.

And I would be talking as fast as I could to get all this great in-depth information to him. And at the time I would think this guy is not hearing a word. He would look up and start asking questions about everything I had said in the last 15 minutes. He didn't miss a lick.

SMITH: Amazing. Amazing. Well, now, were you close to his thinking about the famous Boren amendment?

FOGARTY: Oh, I wrote it.

SMITH: Could you tell us a little bit about what happened here? Because quite frankly I've read articles on it but they are not very informative. They don't tell you very much.

FOGARTY: Well, let me tell you about that. It initially was the Bellmon amendment, another Bellmon amendment. And this goes back to 1972. Public law 92-603. It was the big Medicaid Christmas tree bill that year. Had a lot of Medicaid amendments in it.

MOORE: The SSI bill.

FOGARTY: That's right.
It also had this little amendment to Section 1902(a) of SSA. Gosh, I should remember these numbers: Section 1902(a)(13)(E). That was it.

MOORE: That's very impressive.

FOGARTY: Well, you will understand it more after we—because I spent a lot of time working on this. 1902(a)(13)(E) for the first time introduced the notion of a cost-related reimbursement for nursing facilities. And prior to that time, in the absence of any specific language for nursing homes it came under the general requirements of Medicaid that you had to pay enough to make the service accessible and you could not pay more than a Medicare cost reimbursement methodology would produce.

So those were the boundaries, high and low. With 1902(a)(13)(E) came the requirement that somehow this reimbursement had to be related to cost. And you may remember there were no regulations published to implement that provision for several years. There were several attempts. You may also remember that there was this organization called HCFA created, which was dominated; I think it is fair to say, by Medicare people.

And so they kept producing these draft regulations that implemented a cost reimbursement requirement for nursing facilities. Oklahoma was one of the few—one of the states that had historically paid for nursing facility services on a statewide rate. It was a fixed rate.

We didn't have facility-specific rates because Lloyd Rader knew way before the federal government ever figured it out that cost reimbursement was a lousy way for the government to do business. He used to tell me when he was in the lumber business, "You find me a contract on cost-plus and I will make a lot of money."

And he applied that—I mean, cost reimbursement was anathema to him in terms of how to pay for public services or anything else. So he fought desperately and successfully to some degree and really caused for several years the delay of any implementing regulations. But when those regulations finally came out in—

BRODT: Well, October—I think October 1 of '78 was when we finally had to comply with the new regulations.

In '77 I think we had to have some kind of justification with the law.

FOGARTY: Right.

BRODT: But the regulations, as I recall, were initiated I think in '76 or '77. It's about '78 before we actually had to come up with a plan.

FOGARTY: Lloyd Rader went to Henry Bellmon and said, "We have got to get this law repealed. This law is going to bankrupt the Medicaid program. And if you don't believe that, look at what is happening to states who pay on a cost reimbursement." There were states back then that did, and of course we were all paying hospitals on cost reimbursement. And Lloyd Rader said, "You're going to bankrupt every state. There is no way to survive a cost reimbursement requirement." Henry Bellmon agreed and introduced what was then the Bellmon amendment. And the Bellmon amendment was very simple: Section 1902(a)(13)(E) of SSA is hereby repealed.

That amendment was defeated by the national trade association of nursing homes and it was done through the senator from North Carolina—Curtis?

BRODT: No, I don't think so. Curtis was Nebraska.

FOGARTY: That's who it was. It had made it all the way to a conference committee and it—and Senator Curtis got it pulled.

That would have been '76, '77. This is before Boren got to Washington. This was when Rader took the problem to Bellmon and Bellmon tried to fix it.

Okay. Now, Bellmon doesn't make it. Enter David Boren and Mike Fogarty in January of 1979. We brought the same amendment—or the Boren amendment, I can tell you that it was 1902(a)(13)(E) of the SSA is hereby repealed. Actually, it was Section 249 of PL 92-603 is hereby repealed. By that time the advocacy groups and the non-profit nursing homes had come to the table. And their theory was, of course, that better reimbursement would produce better quality. A lot to be said for that.

We kept saying, well, yes, that's true but it doesn't take cost reimbursement to do that. What that takes is enforceable quality requirements and a rate sufficient to meet them. That's what that takes.
What became the Boren Amendment was a compromise that was drafted by an individual employed by a group called the New Coalition for Nursing Home Reform.

I can tell you her name but I won't. She got fired after she wrote this. The staffer wrote it because it said exactly what they said they wanted. What they said they wanted was a law that said you have to have a rate sufficient to meet the cost of meeting these quality requirements, which as you probably know, is exactly what the Boren Amendment says.

The Boren Amendment says it's a state program. The state will determine the rate and the requirement is that the rate be sufficient for an economically operated facility to meet the costs of the requirements for quality.

SMITH: You know Elma Holder is in Oklahoma City right now.

FOGARTY: Yeah, she was very active in that group. I don't know whether her perspective on this issue would be the same as mine but I remember she was in the mix.

And of course we got that and that got passed. And as you know, the Boren Amendment only applied to nursing homes. It was later picked up by Henry Waxman and applied to hospitals. Henry Waxman essentially a couple of years later said, “If this works for the nursing homes it ought to work for the hospitals."

So this amendment was an attempt to preserve the state's prerogative in how it would pay nursing homes. It could pay them on a class rate or it could pay them on an individual facility rate. And it was directly intended to undo what we believe was the Medicare spin, the Medicare implementing regulations that were going to drive the states to a cost reimbursement system.

SMITH: Interesting. And Lloyd Rader, it seems to me, was also in a way kind of pioneering. It's a little bit like DRGs but it's also a little bit like—what do they call them in California? The HIOs [Health Insurance Organizations] with the state negotiating the rates.

MOORE: The managed care [rates]?

SMITH: Negotiating directly, the state negotiating directly with all these providers.

FOGARTY: Oh.

SMITH: Health insurance organizations.

MOORE: Oh, the HIOs, yeah.

SMITH: But that's—I guess it's not the same thing.

MOORE: Uh-huh.

BRODT: They negotiated the rate with the industry. And after the Boren Amendment became law I had Mike's old job of running the policy shop. I had responsibility for the state plans.

And so I wrote the state plan reimbursement page for Medicaid, Title 19 state plan, and it was one sentence, that we would meet the cost incurred of efficiently and economically operated facilities established through a negotiated rate with the industry. And that was it. And the Feds, they said, "Well, how you going to do it?" Fogarty and I today look at our state plan and that section of the plan, the 419D section that describes your reimbursement methodology for nursing facility, it's like 40 pages.

SMITH: Yeah. One sentence to 40 pages.

MOORE: It's probably short compared to some states, too.

FOGARTY: Oh, I expect so. But, you know, the sad thing—and frankly frustrating thing for me personally—is the hickey that David Boren took and continues to take. I mean, it's like the Boren Amendment is Satan incarnate...And of course I have always believed that the original Boren Amendment would have been much better. That is, repeal that thing and go back to, "You've got to have it accessible." And my position always was if you don't pay enough to meet the requirements and you are enforcing the requirements, you're not going to have a service. Ultimately it all is the same thing. It's just how much you want to write down.

SMITH: Boren gets tagged with creating a lawyer's full employment act.

FOGARTY: Well, and you know that's what happened.
Frankly, I think it happened because: one, states did a lousy job of just meeting the requirement. There were some things you had to document. You had to document that the rates you were paying was actually sufficient, given an efficiently and economically operated facility, to meet those costs. You had to—as I recall, the law required that you make certain findings around that issue.

Well, that's no big deal. You get accountants and actuaries to do that. But states did a lousy job of that. Most of the lawsuits that were lost by states were lost because the state had treated it as if the requirement had completely gone away. They didn't even pretend to go through the hoops

that needed to be done, which is a shame. And then of course the result was the federal courts found in favor of the industry more times than not.

And all of a sudden it became this huge problem for states, which was exactly the inverse of where that amendment was headed.
And David Boren has just taken a beating on that for all these years.

SMITH: But it's so perverse it has the ring of truth.

FOGARTY: That's right.

BRODT: A lot of states, you know, because of the earlier law requirement had gone to some kind of cost reimbursement methodology for the nursing facilities. And once they had set that in place it was—

MOORE: They couldn't get out of it.

BRODT: They tried to make an easy fix to it to say just disregard all that we were doing and this is the way we're going to do it now. And they couldn't do it. I mean, they had too much history there.

We did it differently. We never reimbursed facility by facility. We always did a class rate. I remember the first year that we had to have that cost-related reimbursement under the original 1902(a)(13)(E) and it was—it was four classes we were paying. We paid $18 a day for nursing facility care and $43 a day for ICF/MR.

SMITH: Of course that was a lot of money back then.

FOGARTY: Yeah, but it was still very low compared to other states. And our industry had become accustomed to making it work. I now have a perspective from the other side of that issue, having owned and operated nursing homes. And I can tell you that it's tough doing that. And if the state fails to actually meet the requirement of paying a sufficient rate to meet costs, then you're upside down. Some nursing homes that don't have any debt obviously do better. And so it's a very simplistic approach.

SMITH: We were both very interested that you had this experience in the private sector dealing with nursing homes and you got this background. Where do you think we should go in the nursing home business now? Is there something we should be aiming for?

You hear, for example, people saying, well, get rid of them. Other people say no, we can create nursing homes without walls, and that sort of thing. Do you have a place where you come out here on this?

FOGARTY: Well, yeah, I think so. First of all, I think what it's about is choice. I think it's about developing and having services available that allow people to make choices around whether they are going to stay at home with support or whether they are going to some form of congregate living. Now, if you are going to have—which I think we will—institutional or facility-based services, however you do it, those are going to be driven by competition, and I think we are going to continue to see improvement. Because if people have a choice they are going to choose to go to a nursing facility or their families are going to choose on their behalf, it better be a good one.

I think that's a good thing. And I think we are way past the old cinder block, gang bathroom stuff. I mean, if a nursing home is in business today in this state it has either been renovated within the last 10 or 15 years or it is newly constructed. And I think that's a good thing. I think this notion that everybody would prefer to stay home by themselves is absurd.

I wouldn't. I want to be with other people. That's just my nature. I'd go nuts, you know, if I was sitting at home by myself with my TV or whatever and somebody was going to come by once or twice a day to make sure I ate.

No, thank you.

I liked living in the dorm when I went to college. But what it's really about is allowing me to make that decision if that's the decision I want to make. But it's also allowing other people to make an alternative decision.

And the cruelest of all, in my opinion, is the Ronald Reagan approach to home- and community-based services. And that is it's okay if it costs less. Hogwash. That's goofy if we are going to give people a choice. And I can tell you right now, even as high as our nursing home rates are there are people who would choose to stay home but we can't do it. For $100 a day we can't support them at home.

And so we've got this waiver that supposedly has provided all this opportunity for people to stay home. But then it's got that little caveat down toward the end that says, "Oh, by the way, you can't spend any more than you would if they were in a facility."

SMITH: Could you do it for less if you assume that there is going to be a care giver there? See, I think what's hidden.

BRODT: That's the way our system works.

SMITH: Is that people figure that the wife is going to take care of him.

FOGARTY: Oh, oh, that's the first test. I mean, we've got a great home- and community-based waiver. We've got a super—we call it the Advantage program and it's got over 12,000 people.

But one of the first questions in the process of entering that system is what kind of home supports do you already have? And I can tell you right now, if there are none your chances of getting in that program are very slim because they know you just can't do it.

BRODT: Yeah, health and safety is a front-end issue for us and that has now become a big issue, you know, nationally with the audit and the blame on CMS for not over-sighting. And we'll probably get beat up over it because somebody will want to say that we're really not—and actually I think they refer to the Oklahoma review by CMS in that report. But our premise has always been with this particular waiver—because we didn't have a waiver until '93 and it started out very small—that you determine on an individual basis that there is a sufficient amount of support to allow that person to remain in the community and that their health and safety is assured. And it stays the course pretty well. There are other things that generate people being in those waivers and probably the biggest one is the drug issue because access to drugs through the waiver has brought a lot of folks into it.

SMITH: —access to drugs?

BRODT: Well, I mean, they are unlimited for the number of prescriptions. But a lot of it was income. I mean, if our income level was, you know, $550—it was back in those days around $500 a month.

And so anybody that had more than $500 a month was not Medicaid-eligible or they were medically needy and they had to spend down by virtue of the law; they had to spend down most of their income toward the cost of those drugs and they didn't have enough money to stay in the home.

When the waiver came into place we used 300 percent of the SSI standard as the income level and did not require a monthly assessment of income. So they were able to remain at home, keep their home up to date and...
Big deal. I mean, it really was. Prescription drugs and pretty much personal care services, which is a whole otherRader story, too. We'll get to that.

FOGARTY: We'll talk about that a little bit. But, for me it really is about people being able to choose where they want to spend those years. And, you know, we all probably know that there is a point in time or could be a point in time when it's just absolutely medically not possible to stay at home. That's why people die in hospitals. You just can't be home. You've got to be where somebody can take care of you at a level that you can't get at home. But in a way it's kind of the advocate's own fault. That is, they pushed so hard on the waiver based—or on services in home based on the notion that it was cheaper. They always made that part of their argument. They were waving the flag—you can do this cheaper, you can save money. And, you know, bless his heart, Ronald Reagan said, "Go for it."

SMITH: You look at those numbers and what makes the difference is an at-home caretaker.

FOGARTY: That's exactly right. So I think it's unfortunate that we have that kind of caveat that we believe in the choice as long as it doesn't cost more at home. And I can find no rational basis for the option being only available if it's less expensive.

SMITH: Well, maybe there—there is a remaining kernel of Lloyd Rader's wisdom. You've got to worry about just kind of how far you open that gate.

FOGARTY: That's true. And, you know, the cost to the states of a program like Oklahoma's Advantage waiver is largely in the famous woodwork effect. We've got a whole lot of people in the Advantage waiver that if the Advantage waiver did not exist they still would not be in a nursing home because their families would choose to keep them at home and do whatever it took to keep them at home.
And so, there's always that piece of the formula. And that, in a real way, is what Rader's was: how wide can you open the gate?

MOORE: Well, talk about personal care as long as we are on that subject.

FOGARTY: Yeah, let's talk about the granny program.

SMITH: Yeah.

FOGARTY: Lloyd Rader called it the granny program. And I don't know whether you remember this, Judy, but Oklahoma operated a program that was in the Medicaid plan under "other." And it was the non-technical medical care program, NTMC; it went by those initials.

In a very real sense it was Lloyd Rader's version of the home- and community-based waiver. This program provided payment to a caretaker who would—who would spend a minimum, what, four hours in the home of a qualified recipient. And interestingly his gate—here is the gate—you had to be medically eligible for nursing facility services. And this—how far back does that program go?

BRODT: Actually, he started the program as a state program, I think in '66.

FOGARTY: But not as a Medicaid program.

BRODT: It was 1970 I think before funding became available. I think that was another Bellmon amendment.

SMITH: Did you say it wasn't originally part of the Medicaid program?

BRODT: Right. It was called his granny program and the purpose of it, he tried to do two things. One was to help people be okay and safe in their home as well as to get socialization. The goal was not to bring in an agency that puts somebody in the home.

FOGARTY: No, these were individuals.

BRODT: This was an individualized program. Actually, it had to be before '68. What he wanted to do was provide a way for these individuals, typically widows who were not eligible for social security benefits yet, to have a source of income to take care of people in the community.

And so what you had was this kind of neighbor taking care of a neighbor. We paid the neighbor but we paid the neighbor on behalf of the recipient. So in 1965, I think is when it was, he got an agreement with the IRS for the State of Oklahoma to be—to be the representative of the recipient and to withhold the FICA on behalf of the—the recipient was the employer. And so the FICA was withheld on behalf of the employer recipient. But we did all the work.

FOGARTY: And these weren't agencies. They weren't home health care agencies. They were individuals.

BRODT: The state was the agency.

MOORE: But the people didn't work for you.

FOGARTY: Right.

MOORE: They were independent.
BRODT: So what you had was Grandma Smith, 80 years old, living at home. Can't fix her meals anymore. So this other lady down the street who is a neighbor, the social worker would hook up Grandma with this person.

FOGARTY: Part of our job as a caseworker in the county was to recruit those workers. If we had an old-age recipient on our caseload that was at that point where they needed help with their bathing and they needed help with the meals and making sure they took their medicine and that sort of thing, we would generally know enough about the neighborhood and know who was there and we would locate some lady down the street who would do that. And then we could pay her.

SMITH: And one of the elements concealed in all this, looking at this history, is that Lloyd Rader had this rich infrastructure that he built upon over these years. I mean, there were county caseworkers that knew what end was up and knew the neighbors and had...

BRODT: Well, another one of the power bases for Lloyd Rader was that every county—it's a state administered program, but every county had a county office with a county administrator that reported to Lloyd Rader. And they usually had to have the same kind of political correctness for their employment. I mean, the local politician had to agree and have an opportunity to express their opinion as to who ran the local office. And not just for the new worker coming on but who was running the office. So it was a very strong power base.

When you think about it you've got several thousand employees across the state that were voters.

FOGARTY: Well, just think about that. People can make that sound so evil.

It can be. But the fact is, my experience in that system was, one, you had a very loyal staff who knew who the boss was. And that's efficient. And, two, you had a sophisticated staff in that they were plugged into that community.

They were plugged into that local politician.

You know, these people wouldn't go off and do stupid things, typically. It just kind of elevates the sophistication, I think, of somebody that's involved.

They understand that if they had never met them before, they at least one time met their local senator or their representative because they went down there and visited with them long enough to get their endorsement.

SMITH: It also seems to me there is a curious way in which—I grew up in Oklahoma and both [my] parents worked a lot in the welfare system. And there is a curious way it fit Oklahoma because Oklahoma has its grungy side and it has nasty politics to it.

Yet at the same time, you did create a statewide system that survived and it was there when you needed it and when you had talent and ability and kind of enlightened thinking in a county it didn't really get much in the way of it.

FOGARTY: Right.

SMITH: You could work with that system. It also protected you from the down side of things.

FOGARTY: That's right.

SMITH: I think it fit Oklahoma extremely well.
Somebody who knows the history of this state should write all this up.

FOGARTY: I remember advising Henry Bellmon when he was agency director. Henry Bellmon was on the other end of the continuum. I mean, Henry Bellmon didn't want anybody talking to any senators. That was absolutely. And he didn't want to exercise any discretion himself.
One of the first things he did was disperse that discretion. So within weeks of his taking over, picking from that top five became the job of the county administrator.

Because in his view that eliminated the politics. And I remember sitting down with Henry Bellmon and saying, "Senator Bellmon, you didn't eliminate

the politics. You just made it 77 times." That's how many counties we've got.

You just put every county administrator in the position of building their own political base because as long as there is discretion to be exercised, whoever exercises it can use that if they choose to build a political base. But I couldn't get him to budge. I just said, "You know, I would rather you have it. I would rather you exercise the discretion than to disperse that to 77 county administrators."

Those people understood what the potential was. I mean, these county administrators understood how politics worked. And it didn't take long before they had their own little kingdoms established. We're still probably paying the price for that.

MOORE: I was going to say, did it ever change?

BRODT: Well, it would change a little bit back and forth but it never came back to where it was under Rader.

MOORE: What happened with the Department of Human Resources and when did that morph into the...

FOGARTY: —Department of Human Services, DHS.
That started in the late '70s, early—

BRODT: In 1980, when we took over the teaching hospital, the agency became the Department of Human Services.

FOGARTY: That almost was the overload. When the agency took over the adult hospital it had already taken the children's hospital, as Charlie mentioned a minute ago. In 1980 the adult hospital was transferred and—

SMITH: When you say the adult hospital, what was that?

FOGARTY: Well, there were two major units within the teaching hospital complex, the medical center complex. There was a children's hospital, which really had its roots in the old crippled children's hospital. And there was an adult, so-called adult hospital. So they really had two separate facilities.

MOORE: So this is the University—

FOGARTY: This is the University of Oklahoma Medical Center, right down on 13th Street. This is part of David Boren's kingdom now.

MOORE: But it's the University Medical Center.

FOGARTY: That's exactly right.

MOORE: And DHS took over the hospital—

FOGARTY: That's right. They owned it and administered it.

The administration of the hospital itself reported to Lloyd Rader. And there were two enormous jobs. One was to get the place physically fit. It was just in shambles. And then secondly, to get that operation administratively under control with all the difficulties that you would expect between the administrative responsibilities and trying to meet a budget and trying to educate doctors and satisfy faculty.

All of that was highly controversial. There were those, and frankly I count myself among them, who thought that it resulted in severe damage to the real mission of the agency. Lloyd Rader only knew one way to do things. He poured his own personal attention into that job, physically relocating down there. We used to call it the bunker. He had his own office in the complex. He also poured money into it.

Other programs—in this one man's opinion—suffered. We weren't able to keep up with AFDC standards. We weren't able to do other things because the resources were being poured into that hospital. And there were people who were critical of the move because of that.

SMITH: Why did he do it? I mean, you would think in one sense that he could well have said, "I have created this kingdom. I understand how it works and I've got sense enough to realize that people who mess with medical schools are asking for trouble."

FOGARTY: Well, part of it was he had gotten away with it at the children's hospital and had managed to pull it off I think fairly successfully without a lot of damage.

And he did it, the same reason he did every other one that came along. He did it because it was a way to save another state function. He had, he believed, the money to do it. And so he was willing to tackle it.

George Nigh was governor at the time and it was something that he pushed very hard.

BRODT: Well, they had a new building. I mean, they had built a new hospital building and it was empty. It sat empty.

FOGARTY: We couldn't open it. Couldn't afford to open it.

BRODT: It was a real tragedy.

FOGARTY: And it just looked terrible for the governor. So Rader was talked into it. I will tell you right now I know for a fact that when he was first approached he said “no.” No, no, do not do this. And he got talked into it.

SMITH: So it was really somebody else's political agenda.

FOGARTY: Absolutely.

I'm sure he became convinced he could pull it off. Because he had done that so many times over so many years. But this one was criticized. It was obvious, I think, to many people that the price paid was to the detriment of what many considered the real agenda, the real mission of the Department of Human Services.

And then there were so many things that converged. At the same time there was this; the people that were in the legislature didn't know that history. They didn't go back to '51. Heck, they didn't go back to '71, some of them. What they knew was that many hundreds of millions of dollars in state money going into this agency they had no control over. Now, this is what is interesting. I mentioned that the existence of the sales tax was constitutional. But this permanent appropriation arrangement was legislative.

So there was a big push starting right about that same time because people were demanding accountability. What's going on with this money? How is it that Lloyd Rader could come up with $100 million to put into that school? All of the questions you might expect. And the result was that they started making changes.

The first change was fairly subtle. The first change required the legislature to appropriate the sales tax fund to the agency although it kept it in a separate fund. But it required annual appropriation. That was, what, '80?

BRODT: It was 1980. It all happened in 1980. They created the human services fund at the same time that they created the Department of Human Services and they transferred the adult hospital.

FOGARTY: And it was about five years later that they finally just did away with the distinction altogether and the sales tax went into general revenue.

BRODT: That's after the state's economy went upside down, 1983-84.

FOGARTY: At that point in his career he was viewed as this huge, powerful, unaccountable state official. I had mentioned earlier that he came under tremendous criticism because of the “institutional bias.”

There was this big Gannett news investigative piece that came out about the juvenile institutions. You may remember. It was called “Oklahoma's Shame” and it was right about the same time that Gannett bought a newspaper in Muskogee, Oklahoma and a television station in Oklahoma City. And they went after him.

They sent a couple of their investigative reporters down here and they started doing these stories about this awful program that institutionalized all these kids. It was taken up very quickly by our friend Senator Arlen Specter's Judiciary Subcommittee. Specter held hearings in Washington, summoned Rader and others and put on this public show, which was sad. So, that obviously took its toll. There was also the de-institutionalization pressure that ultimately became a lawsuit filed targeting the Hisson MR institution.

BRODT: It came on the heels of another class action lawsuit in 1978 on the juvenile and children's institutions.

FOGARTY: So, all of those things kind of came together right around that 1980 to '82 time. He was '76 years old, I believe, when he retired in '82.

SMITH: That's quite a statement in itself.

FOGARTY: Yeah, 31 years. He was there from '51 to '82.

MOORE: How long did he live after he retired?

FOGARTY: Not very long.

MOORE: I wouldn't guess so, actually.

FOGARTY: Couple of years.

MOORE: And did he stay active in anything around the state?

FOGARTY: No.

MOORE: No? Did he have family?

FOGARTY: He had one son who is a physician who had relocated to Arkansas and he had several grandchildren who—three of them are now physicians, I think. His wife passed away. That was really another—frankly, I think that was another contributing factor. His wife of all of those years passed away.

BRODT: Mid '70s.

FOGARTY: Yeah, in the mid '70s. That kind of took the wind out of his sails.

MOORE: Has anybody ever written about him? Are there biographies of him?

FOGARTY: There have been some people who have written. I don't know that there is a published biography. Did they ever get—?

BRODT: They were working. I know George Miller was helping them work up something. I think it's at UCO where they—

SMITH: Yeah, there are some creditable things in Oklahoma's history of this sort and when you are talking with your old friend David Boren you ought to suggest to him that he could put a few people to work on some of this stuff. There is some really rich history here.

BRODT: There is indeed.

SMITH: I have been more heartened by what I have seen in Oklahoma in the last few years than what I have seen in the last 20 years.

BRODT: There have been a lot of good things happening here.

SMITH: One thing we wanted to ask you about because you've got all this NGA experience and you've got this enormous experience related to the state. What do you think about the relations between the Feds and the states and what could be done to improve this situation, not just for the states but for the Feds as well? You surely have thought about this.

FOGARTY: Yeah, I have, because now I am observing what I—my memory is being refreshed. And it sounds—it's so partisan that, you know, I hesitate to even say it. But when I went to work for the Department, Richard Nixon was president.

And so, I have literally seen the administration switch back and forth between Democrat and Republican now for all these 30 years. And what I have discovered is, I think, that it is predictable, absolutely predictable that when a Republican moves into the White House they make long and wonderful speeches about state flexibility and they hire lots and lots of auditors.

MOORE: Auditors?

FOGARTY: Auditors.

And they come—I mean, we have had more disallowances or threatened disallowances in the last year than we had in the previous 10 years. If you look right now on the DHHS IG web site, they list all of the IG audits, the HHS IG audit activity. In the last three years—less than three years since the current president moved in, that office has done 140 Medicaid-focused reviews nationally.

In the three years prior to that there were 19. Now, should there have been more audits previously? Probably. Who knows? But we started—are you old enough to remember the Twinum memorandum?

MOORE: Oh, yes. I was there, probably.

FOGARTY: We started with the Richard Nixon/Twinum affair. That was the old Title IV social services open-ended funding. But during his first term, the

Fed had lots of people out convincing states that they would pay for everything. And shortly after his reelection a man named John Twinum wrote a memorandum to the states saying, "Oh, by the way, here are the rules."

And I cannot remember the magnitude of that disallowance but it was huge.

It put Charles Miller in business at Covington and Burlington, literally put him in business.

BRODT: We had the money.

FOGARTY: Yeah. Lloyd Rader had a saying. He had a lot of sayings. One of them was, "The only thing worse than not getting federal match is having to pay back federal match." And he was very conservative and he was one of the last states that finally got pulled into the social services fiasco.

He put every dollar in the bank because he said, "This will not work. I promise you, this is not going to work. They are going to come back after this money." So he put it in the bank, drew interest, made a lot of money, and ultimately, three or four years later paid it back.

SMITH: Now, what was the social services fiasco?

FOGARTY: Well, this was the Nixon Administration using the old pre-Title XX block grant, the old open-ended Title IV social services expansion.

MOORE: Did you ever meet Tom Joe? Tom Joe sort of invented this in California. And then he went to work for the Nixon Administration and taught lots of other states to do it.

BRODT: You're exactly right. That's what that was.

MOORE: And then the Congress was not real happy about those expenditures and they put a cap on them.

BRODT: Well, that's when they passed out money.

MOORE: That was a short time that was like a five year period.

FOGARTY: This is something like what they talk about doing in Medicaid. I mean, the people are so frustrated, Congress and the Administration, that

Medicaid is open-ended and being abused by states so they want to do a block grant.

Right now the relationship is very, very difficult because it's all being run by Mr. Scully, I'm sure under the direction of the Secretary's office and the President. But the game today is how much money can we keep the states from getting or how much can we recoup? And it's ugly and it's unfortunate and it's going to be very hard on the relationship over the next months or years, sadly.

Now, having said that, let me tell you what these consultants and states have done to bring this on ourselves. Raiding the federal treasury is certainly a contributing factor. But the State of Oklahoma has never to this day—this agency has never to this day hired one of those enhanced federal match consultants.

It's not a game we play. It has been so damaging to the program. But, when states like Louisiana get $600 million in DSH money, who can blame the Feds for saying, "Enough." Oklahoma's cap on DSH is $18 million. And so, I hate that.

And I think that if there is any one single thing that has not only created this terrible tension between us and our federal partner, but also has been destructive to the Medicaid program, it's this game of finding these little creative ways of raiding the federal treasury.

SMITH: There is a school of thought amongst Medicaid directors that says you look at this the way you do the IRS, that if it's an allowance you take it and you use it for whatever Medicaid needs you have, once you have dealt with the legal requirements, that's all that is really required of you.
And if you talk to other people, they say “no,” there is an implicit relation of trust here and if you abuse that, over time, you are going to pay the price.

FOGARTY: Absolutely. Put me in the second group. And I think that is consistent with Lloyd Rader's approach. Lloyd Rader, people talk about his genius at capturing federal match.

But his genius was about how to make services eligible for match, including his clout to go to Washington and get federal participation in the cost of operating the state schools for the mentally retarded, getting federal participation in the cost of his little granny program. That's what Lloyd Rader did. He wanted the Feds' participation in a legitimate service for

which he paid a legitimate price. He wasn't looking for a way to game it. Look back to the social services deal. He absolutely said “no way.”

He came under such pressure because he was, “turning down this wonderful opportunity” to get all these federal funds. You probably get that from some Medicaid administrators and consultants today.

We get criticized because we have turned down these opportunities. But it just goes to the credibility of the Medicaid program in my opinion. We have a program that we can partner with the Feds and they put up the majority of the funds. We operate a legitimate program and try to get as many services funded through Medicaid as we can. But when it gets to doing hospital UPL programs where you get one public hospital being paid $10,000 a patient day just so you can draw the federal money through it, that's not legitimate.

SMITH: I am interested that you used several times this word “partnership” because some of my thinking as I began studying this program was that we have largely lost that sense, that it has been much more in the last five, six years Feds versus the states.

I am not quite sure what you could do, but whatever you could do to restore the sense that it is a partnership and that it depends upon at least a modicum of mutual trust I think would be important.

FOGARTY: Right. I describe what is going on today as the “Gotcha Game.” I mean, we are seeing audits performed on programs that were approved, encouraged six, five, four years ago. And now the Feds are reinterpreting what that program really was and are doing an audit that goes back four years. They are disallowing all the federal money.

I had a conversation within the last 10 days with federal officials and I said, "If you want to change the rules, change the rules. Just tell me what they are."

And, going forward, don't tell me the new rule today and then apply it to an expenditure that occurred four years ago. I mean, that's crazy.

BRODT: It's reliving the Twinum memorandum.

FOGARTY: It is so similar to that. And obviously it is more aggressive under some administrations than others. I think it is a particularly aggressive administration today.

We have always considered it a partnership. And we commonly refer to it as a partnership. It is a partnership that has tension, like most partnerships do.

SMITH: Do you mean like marriage?

FOGARTY: Yeah. We're not bashful about pointing out to our federal partner when we think they are way over the line in terms of what role we have, as opposed to what role they have. And we like to remind them that the law says state-administered program.

SMITH: Yeah.

FOGARTY: It is a state-administered program, operative term being "state." And of course they respond by saying, "Yes, but we're paying, you know, in Oklahoma 70 percent of the bill and we have to be accountable for that money." And so, you know, there you are.

But I have not seen it worse than it is right now. I have probably seen it as bad but I have not seen it worse with the agenda so clearly being to recoup money from states. Change the rules in the middle of the game.

BRODT: The late '80s. We're just back where we were then.

FOGARTY: Yeah, that's probably true. I was fortunate not to be in the agency in the late '80s but Charlie got to—

BRODT: Under Reagan's second term. It really got bad.

MOORE: Did the re-institution of the Medicaid Bureau with some more federal people who were committed to the Medicaid program make any difference? Did that make a change in the early '90s when Gail Wilensky put that group back together again?

BRODT: Well, in the early '90s or—yeah, she had a different twist anyway. And that did help. I think they were trying to get out of some of the bad press that they had had from the years of the '80s.

It was hard to say. There were still a lot of things that were just pending at that time. And then, of course, with the change that occurred in '92-'93 with a new administration things actually did loosen up quite a bit.

FOGARTY: I think the one single event that probably changed the relationship more than any other was the creation of HCFA. Prior to that time we had a federal organization that oversaw these so-called federal-state programs because the thing they had in common was that they were state-administered, federally-funded programs. And so their oversight was—was a very different kind of activity.

And when HCFA was created, and we have mentioned this before, it was heavily dominated by the Medicare personnel. And you would expect that. But there were an awful lot of folks that were in positions in HCFA that just didn't get it. They didn't get that it was a state-administered program. They ran it like Medicare. We were more like a carrier or an intermediary for the program than we were the administering authority of the program. And that probably should have been predictable but—just the sheer numbers of folks that were career Medicare folks, compared to those that were involved in Medicaid when that reorganization took place.

BRODT: Oh, sure. The transition from SRS to HCFA, and you had HCFA being the 800-pound gorilla in HHS. Before under SRS you kind of had this balance. There was Medicaid and there was AFDC and there was social services. And they all had to kind of talk with each other. Today they don't talk to each other.

That's why we get disallowances on services that we are claiming for Medicaid and they think it ought to be I=VE. And neither one really wants to take any accountability. Or it may be something that they think ought to be the responsibility of education.

The federal government has its own internal battle right now about who is going to be accountable and who is going to put up money.

FOGARTY: And when money gets tight, that's always what happens.

SMITH: Right. That's a fascinating perspective on the malign effects of HCFA, isn't it?

MOORE: Uh-huh.

FOGARTY: But it strikes me that you had a long, long history of organizing programs at the state level, which is quite different from medical services in the narrow sense of the word. And the notion of social workers has been a

bad word. People said, well, you look here at SRS, that's just full of social workers.

Now it begins to occur to us that a very difficult kind of problem is going to be how we organize these programs at the local level and handle all the issues of quality and fiscal accountability, et cetera, et cetera. We got a real job—there's going to be a real job of learning to be done in the next few years.

SMITH: You people are going to be pretty well positioned, as opposed to some others.

FOGARTY: Yeah. I'm going to be on the riverbank with my fishing rod.

SMITH: Well, maybe we ought to quit and let you get off to other things you have to do. But I hope that you set aside a few hours during the day to write up some of your memoirs.

FOGARTY: Well, I would like to do that.
SMITH: That would be a nice balance of talents. And thank you so much, both of you.

FOGARTY: Well, thank you.

SMITH: I mean, it's been absolutely great.

INTERVIEW WITH WILLIAM FULLERTON
JUDY MOORE AND DAVID SMITH – JANUARY 29, 2003

MOORE: We're talking to Bill Fullerton. And it's David Smith and Judy Moore and we're on the telephone. And I guess the best thing would be for us to have you go back and recount your career and how you got involved in health care and health care financing.

FULLERTON: Boy, I haven't thought about that in a long time. Well, all I can say is that when the issue of Medicare first came up, what happened was that Bob Ball—and you probably have a lot about him in your histories—

He picked me out of what I was working on, not Medicare but Social Security cash benefits, and moved me over to work on Medicare. This is, of course, about four years before it was enacted. So with that kind of a background, we worked on Medicare and everybody knows what happened to that up until the point when it was enacted.

SMITH: The initiative for this was coming from Bob Ball.

FULLERTON: Right.

SMITH: —it wasn't particularly Kennedy or it wasn't particularly the Department or anything—

MOORE: Did the White House or the office of the Secretary ask for this or did Bob Ball do that?

FULLERTON: Oh, Bob Ball did this.

SMITH: And was he simply looking at what we now know as King-Anderson or was he also considering the physician role in maybe Medicaid?

FULLERTON: Well, remember that we were not working on Medicaid; it was the idea of Wilbur Mills, just as was the proposal to include physician's services under Medicare, Part B (voluntary to appease the doctors).

SMITH: No, I understand.

FULLERTON: There were many other people in the Department, working on Medicare, of course. But my recollection of the actual legislative situation

is that the reaction to Kennedy's death increased the number of Democrats in the Congress and led to its enactment.

Mills had these two or three things, I guess that framed the whole legislative situation in '65. First he was worried that the people already thought that the physician services were going to be covered. At the same time he wanted to make sure that the programs for people who couldn't afford it—health care—were going to be treated a little better than they were before and that there would be more federal dollars sent out to the states, and so on. And I'd have to say Wilbur Mills himself did this.

Now, of course, the other Wilbur (Wilbur Cohen) and Bob Ball didn't hesitate one instant in going along with what Mills wanted to do. Of course, Mills didn't sit down and say this is the way a specific bill is and exactly what we're going to do. He just told them, "I want to do these things, so work it out."

And that's when things started coming down to us lowly people—back in Baltimore—from Bob Ball saying we're going to have to do this, we're going to have to do that.

I know at the beginning we were sort of skeptic, "Oh, yeah, you're going to do this and that." It didn't take long, like maybe an hour or so; everybody decided that he really was serious. And that's when we went to work actually working out what it was going to be. Now, the people who worked on Medicaid were of course another part of the Department and they were a different group that sat down and worked out the Medicaid part of it.

MOORE: Bill, do you remember who those people were?

FULLERTON: Well, I'm getting awful old for some of this but I guess—I'm trying to remember the name of the guy that we dealt with all the time on that stuff over on the welfare side.

MOORE: Right.

FULLERTON: Charlie—I don't remember.

MOORE: Saunders?

FULLERTON: No.

MOORE: No? I think I know who you mean. Did he work on the Ways and Means staff later?

FULLERTON: Yes.

MOORE: Yeah, I can see him. I can see his face but I don't—I'm not sure I can remember his name either. And I'm a lot younger than you are, so you can't put it off to age.

FULLERTON: Well, anyway, Charlie and I later we were both on the Ways and Means staff at the same time. But anyway, you'll be able to find that name. [Charles Hawkins, Staff Aide, Ways and Means Committee]

SMITH: I talked with Larry Filson over the telephone and he said when it came to Medicaid he scarcely even remembers. I know he worked on drafting the Social Security Act. And he said he doubted if the Congress spent as much as half a day considering Medicaid. He also said at the time that it was really—he viewed it as an annoyance. He liked the idea of Social Security, but this was welfare and he didn't very much care for that. More like it wasn't his kind of work than that it was an afterthought. It was kind of a bad aftertaste. And I don't know, did you have any of that sense about Medicaid?

FULLERTON: I guess I wouldn't have shared that with him. I'm sort of surprised that he would say that. But he was the guy who actually wrote the bills, of course. And I dealt with him with Medicare. And Charlie dealt with him also but we would actually have separate little sessions. I'd be doing the social insurance part and he would be doing the welfare part, if you wanted to look at it that way. Does that help any?

MOORE: Yeah, it does. So you would have your drafting sessions and they would have their drafting sessions. And you didn't necessarily work together on those kinds of things at all.

FULLERTON: That's correct, not at that point. **MOORE:** So after the bills—

FULLERTON: They've kind of divisioned a little bit a few years later when the committee had both of us. They added a lot of staff all of a sudden because Ways and Means Committee prided itself on not having any staff.

MOORE: Oh, yeah?

FULLERTON: Oh, yeah. But that got changed after some of these things. Newer members were coming and they couldn't believe that they didn't have hardly anybody on the staff and that they used the people over at the library most of the time. The staff help for taxation purposes came from the Joint Committee on Taxation, a committee composed of both Senators and Representatives. Does that help any?

MOORE: Yes.

SMITH: Yes, very much. I'm not quite sure what your title was—but essentially you were staffing HIBAC and you helped set it up. Did you have anything at all to do with the Medical Assistance Advisory Committee?

FULLERTON: Well, later on, yeah. That was established. I was the Chief of Staff for that.

MOORE: Oh, for the Health Insurance Benefits Advisory Committee, "HIBAC?"

FULLERTON: Yeah, HIBAC.

SMITH: I was asking about the MAAC.

MOORE: There was a Medicaid kind of committee, too.

SMITH: Medical Assistance Advisory Committee.

FULLERTON: I was not involved with that group, that's where the split between welfare and social insurance shows up.

SMITH: You weren't involved with that?

FULLERTON: Yeah. We felt there was a tension but people who were worried about poor people and then the social insurance people, they didn't—it's not they didn't like working together—they were both good guys. The social insurance guys sort of looked down at the welfare people a little bit. And they tried to find the solution to problems through the social insurance system, if possible. And Charlie would have to pick up whatever we didn't take, sort of.

MOORE: In those early years, Bill, do you remember people thinking and talking as if Medicare would eventually take over Medicaid? Or was it always just so separate?

FULLERTON: I was not there when there was any separation on the committee staff. If it's happened since then, it's not when I was there, which is quite a while now.

MOORE: Yeah. But, I mean, did people think that Medicare was going to take over the services to poor people eventually, like 10 years out or something like that?

FULLERTON: Well—yes. There was an expectation that sooner or later there would be national health insurance for the whole country.
But what happened, that's another entire story. But national health insurance was not to be. Let me put it that way.

SMITH: Then in '67, you went over to the CRS, right?

FULLERTON: Yes.

SMITH: And you stayed there about three years.

FULLERTON: Yes.

SMITH: And I read an earlier interview that you had with Mark Santangelo back in '95. And CRS was pretty much functioning the way a committee staff functions today? As far as working up the proposals for things and sitting with the staff—sitting with the committee people and being there for hearings and so forth?

FULLERTON: Yes, that was true for the Committee on Ways and Means.

SMITH: And while you were over there you worked some on welfare and you worked some on Medicaid. And did you begin to get involved at that point with Jay Constantine? I know you and Wolkstein—

FULLERTON: I was involved with Jay Constantine for a lot of time. Now you are talking about the division between the two bodies.

SMITH: Yeah.

FULLERTON: Well, Jay and I got along pretty well. When we disagreed with each other we—well, let's put it this way—we recognized it.

MOORE: We talked to Jay a couple of weeks ago, Bill. He's in fine, fine shape.

FULLERTON: Is he?

MOORE: Yes, he is.

FULLERTON: I haven't been in touch with him for a long, long time.

MOORE: He's very involved in working with a city in Russia and providing a lot of drugs and maternal and child health expertise. And he has adopted two young Russian orphans.

FULLERTON: Is that so?

MOORE: Yeah. Isn't that amazing.

FULLERTON: That's just like him.

SMITH: He's got a foundation if you want to give some money to it. It's called the Foundation for the Enhancement of Health of Russian Orphan Children. And he works with Jim Mongan. He takes drugs and medical supplies and physicians and people to train the local personnel. He's been going for some years now. And he brings some of the same focus and intensity to that that he did to his work in Congress.

FULLERTON: Well, that's great.

SMITH: Yeah, he's pretty happy with it. He is having a ball.

FULLERTON: Well, that's good because he could do good things when he wanted to.

SMITH: Well, now he gives a lot of credit to you and also to Irv Wolkstein in developing that famous blue book that became the foundation for the Social Security amendments of '72.

FULLERTON: Oh, yeah. I remember calling all the people together from the Department that would have to do all the real work on that. And they

could hardly believe it. But the reason I did it—I mean, it may be of interest to you.

I didn't give a diddlysquat what was in it. I wanted to make sure that the committee was seen as doing something from facts and that they were experts and all that sort of thing. In a word that they were responsible and knew what they were doing.

In short, to keep the way the public looked at the committee positive.

SMITH: Uh-huh.

FULLERTON: I didn't give a damn if any of them ever read it. But it got out and everybody went—everybody—went public. That's what we wanted.

And we had that name on it, so that makes them the experts, right?

MOORE: Uh-huh.

FULLERTON: That was part of my job at Ways and Means. First thing you think about—the committee, how people look at the committee. My first duty was to protect the committee.

SMITH: And is that coming straight from Wilbur Mills or is that your concern?

FULLERTON: I don't know. It goes a long way back. But you can't have a committee have any strength and the ability to say no to some people unless you have that kind of thing.

SMITH: Uh-huh.

FULLERTON: And Mills was very good at it. He could know nothing about it but he could get up there and take something, a few things, and he would make himself look like an expert, just boom, like that. He got that reputation...

SMITH: Well, you said you really didn't care about the substance of the Social Security amendments of—

FULLERTON: Well, I wouldn’t go quite that far.

SMITH: —or the blue book. But—

FULLERTON: I shouldn't say it quite like that. I would say my main objective was what I have already said. At the same time, you don't fool anybody if you come out with a piece of junk.

And you had to have something that people would say, "Hey, that's real good." And then that's associated with the committee. The committee did it, it was what it required from its staff.

And I wasn't out making speeches and taking credit for any of that stuff, I'll tell you. Because I knew people wouldn't know my name and that's exactly the way I wanted it.

SMITH: There's a couple of times in that earlier interview that you refer to the fact that Wilbur Mills was especially concerned to achieve unanimity or near-unanimity within the committee. And that seems to have been the case with the Medicaid legislation and later when he gets to the Kennedy-Mills bill.

And back then you had closed hearings and you had a kind of closed rule on the floor and you would think that he wouldn't need to be that concerned about it. Was that a personal quirk or was there a reason why he felt so strongly about this near-unanimity on the—

FULLERTON: He wanted—he had a very strong sense of the whole of the committee. And he always deferred to Johnny and to the other Republicans. John was a very smart guy and Mills wasn't able to con him at all. But they got along well. And I got along well with them. John would let me know if he thought I had gone too far—but he did it nicely and not often.

There were a couple of times when he went after me when he thought I was not being even-handed between the Republicans and the Democrats. But I learned.

SMITH: So that was also a very strong kind of—kind of article with him, of essentially it's a committee that tries to get it right rather than trying to take advantage of their parts and positions.

FULLERTON: Yes, you have to keep in mind that the main area that the committee worked in was income tax and other checks and all other taxes, such as duties on trade goods. And of course that means that they get

pressure from the real big guys, both in the administration and all these various industries and special interests that get affected.

So in some sense Social Security and Medicare were smaller—big as they are they were smaller than the tax legislation, it spent more time on taxes than the Social Security Act, which includes a lot of separate programs itself.

SMITH: Uh-huh. When you think back on the Social Security amendments of '72—

FULLERTON: I don't do that very much anymore.

SMITH: I could well believe that. But at the time was there anything that seemed particularly important or decisive in those amendments? What would you say were the big accomplishments of those amendments?

FULLERTON: Gee, I don't know at this point. I think it would be hard to figure that out.

MOORE: Did you work on the SSI, you know, that SSI was one of the biggest pieces to come out of '72 and then the changes in disability that made people eligible for Medicare? Did you work on both of those or on neither of those?

FULLERTON: Yes, I worked on both of those. There wasn't anybody else on the committee staff except Charlie. And I really don't remember whether he was on the committee or staff then after that period, but I think it was after that he came to the committee, which I was very happy about, actually. But essentially I remember working on all of those things. I mean, for a good part of the time I worked for the committee, I worked on all parts of the Social Security Act.

MOORE: Ah, okay.

FULLERTON: Everything except unemployment.
Medicare and Medicaid and the cash stuff, too.

SMITH: Did the federal poverty line as such—you know, there had been research on that and an index developed. But did you see the federal poverty line as having the kind of impact that it later had when Waxman got busy with it? Or was this just—

FULLERTON: I don't remember that it really had much effect at that time. At the periods of time we're talking about.

MOORE: Was the ESRD enacted in '72? You used to tell Grace amazing stories about the inclusion of the end-stage renal disease benefit in Medicare.

FULLERTON: You heard it all.

MOORE: So that went without too much to do. Now, in the years after the '72 amendments you were on the committee staff for another several years, right?

FULLERTON: Yes.

MOORE: And that was when they were working on a national health insurance proposal.

FULLERTON: It was a big thing after that.

MOORE: Right. And how long—were you on the committee? What year did you leave the committee staff, like '75–6?

FULLERTON: I don't remember exactly, to tell you the truth. It was in the mid '70s.

SMITH: According to the earlier interview you retired in '76 and then came back in 1979 to be Derzon's deputy.

MOORE: In HCFA, when they put HCFA together.

FULLERTON: Sounds right.

SMITH: What was your impression of the Nixon proposal that time? There were a couple of the big ones—I mean real big—along with the Nixon proposal. There was also Kennedy-Mills. But we talked to a number of people about the Nixon proposal and they said, "Hmm, that probably could have worked."

FULLERTON: Yeah, probably could have. It would have been a good step—we would have been further ahead than we are now.

Well, I think that a lot of the Republicans would have really fought for it. But, you know, other things were going on at that same time.
At least as I remember it, the whole Nixon problem was starting to take everybody's attention.

SMITH: When the second proposal came out it was the same period as a lot of the fight over Watergate.

FULLERTON: Yes.

SMITH: You did a lot of work on the Kennedy-Mills bill, right?

FULLERTON: Yes, I did.

SMITH: And that one came very close to passing.

FULLERTON: Yes, I thought it came pretty close.

SMITH: What finally do you think did it in, so to speak?

FULLERTON: Well, there just wasn't quite enough support. The Republicans were against it pretty solid. And I really think that a lot of the—well, not all the Democrats are liberals either.

SMITH: That's true.

FULLERTON: And I think it became pretty much a matter of did you have the votes?

SMITH: Well, it seems to me it might also have been true that labor itself—the Kennedy-Mills bill was a compromise bill—and labor felt that for what they were giving up they weren't getting enough.

FULLERTON: Well, I don't want to be knocking on Ed, but I told the labor guys, I said, "You're not going to get yours. If you can get this, if you get on the wagon, you've got the future to fix up things that don't work right."

I made this strong argument. And they said...they just backed up and said “no,” if they can't get this they're not going to get anything. And that's exactly what happened. Later some of the same people afterwards came to me and said—I'm not going to name any names—but, "Jesus, Bill, I wish

we'd have done what you said." I just shrugged my shoulders at that. All I can say is, "It's okay. You admit you were dumb."

SMITH: There's an ancient Greek maxim: A half a loaf is more than a whole.

MOORE: For sure.

SMITH: Well, then you came back in when Derzon became the administrator, I guess briefly. Had he known you or he just—

FULLERTON: No, we had not known each other before. I think he was—I got the impression that he went around asking people who is somebody that knows how things work in Washington health care, because I need to have somebody like that on the staff. That's my guess as to why he selected me.

MOORE: Bill, did you know Califano before that? Had you known Califano in the past when he was Secretary? Did he have something to do with your coming to HCFA?

FULLERTON: No. I can't go back and say why I really did that, but I did take that job.

MOORE: Well, we were glad to see you. You remember I was there then, too.

FULLERTON: Yep. Well, you know how all that went, probably. But for reasons I've never really understood Califano just didn't like Derzon—the guy that he chose for that job.

SMITH: Well, temperamentally they were pretty different people, weren't they?

MOORE: Who, Derzon and Califano?

SMITH: Yeah.

FULLERTON: The Secretary would be pounding his fist on the desk saying, "I want that program changed and I want it done today."

SMITH: Uh-huh. Or squish them together, I think was the phrase.

FULLERTON: You can put it that way. But on the basis of who was right, the Secretary was wrong in my judgment. It would have been—I mean, you can't make changes too fast or you're going to make a bigger problem than you started out with. In other words, what I really felt bad about—when I decided it was time for me to go do something else—I didn't realize until afterwards that it really would cause Califano to go so far as to let him go.

I didn't think he would do such a thing. In fact, I went into the Under Secretary's office charged up. I didn't wait for any invitation. I walked right into his office. I said, "What in the blankety-blank-blank-blank are you guys doing?"

And he kept saying, "Oh, Joe just wanted to do it. Joe, I couldn't talk him out of it," and all that stuff. But I really was mad and I never had anything to do with Califano after that. Not that he would have anything to do with me.

SMITH: Well, he hasn't seemed to have left a long trail of happy campers behind.

FULLERTON: Yeah. Anything else?

MOORE: I think that might be about it. Can you think of other people who were involved in the very early days of Medicaid that we might not be remembering? I do remember Charlie and I think his name will come back to me or I can—

Were there people in the library working on Medicaid in the late '60s the way you had worked on Medicare?

FULLERTON: No.

MOORE: Or did you—you were doing Medicaid, too, probably then.

FULLERTON: Medicaid came out of the blue, really.

That was—that was pretty much Wilbur Mills. And I've never been able to figure it out. I certainly didn't do anything—say anything to him that would lead him to... But he seemed to want to do that on his own because when he started saying what he wanted to do there were a lot of us old guys around who would look at each other and say, "Wow, he really wants to do it." So we went to work.

SMITH: And so there wasn't—I have wondered if there are some things that got into the Medicaid legislation that aren't necessarily a follow-on from Kerr-Mills. And I have wondered whether people were doing anything in the Department thinking along those lines. But it would seem not.

FULLERTON: As far as I know, it really came from Wilbur Mills. Now, there might have been somebody that tippy-toed into his office one day and—you know, got him going on this thing. But whoever did that has never been willing to come up and tell anybody.

SMITH: Well, I asked Jay Constantine whether people in the Senate, maybe from the Aging Committee or something like that were weighing in on some of these things.

FULLERTON: I don't think he'll know.

SMITH: And it doesn't seem so and he didn't say so.

One of the things in the '70s that I've wondered about a little bit was whether fraud and abuse was a visible thing to you or whether there was much worrying about it because you get the big fraud and abuse legislation right at the end of the Nixon administration.

And then of course implementation of it carries on into Carter, and so forth and so on. Was that something that was visible to you or was that something that was more like, oh, counsel within the Department of Justice worries about these things?

FULLERTON: I think it more meant that than anything else.

MOORE: It was high on Jay's agenda.

FULLERTON: Oh, if you want to know about who was big on that it was Jay—he loved to go after them. There's no doubt about that. And it was a good thing, you know. And if somebody looked like they were really into doing something bad for the program.

SMITH: Jay kind of reminds me of that old movie a good many years back called The Untouchables or something like that.
He just didn't believe you should cheat or take government money dishonestly or inappropriately.

FULLERTON: He was very strong about that. I backed him up on everything I could on the House side. And we used to work together on a lot of that. We weren't supposed to work together necessarily in public and we didn't.

MOORE: Not in public, anyway.

SMITH: Now, you were around just about the time that Wilbur Mills came to grief.

FULLERTON: Yes.

SMITH: And also when the Ways and Means lost some jurisdiction. Is there any story to be told there or—

FULLERTON: No, I don't think of any—that there was any connection between the two.

SMITH: Well, was Mills—

FULLERTON: There was a fairly strong and growing belief among the House as a whole that Ways and Means Committee had too much power. Too much jurisdiction. I mean, they raised all the money for the federal government under its jurisdiction for all Federal taxes and they spent almost half of the money from those taxes. Not half, but it was still a big chunk when you talk about Social Security, Medicare, Medicaid and public assistance and how much of that is federal money in one form or another.

SMITH: Well, and of course it wasn't just Ways and Means, it was about the time when subcommittees wanted to have a larger role and they wanted to take away some of the power from the chairmen and people wanted staff, and so forth and so on.

FULLERTON: You're absolutely right. Those things came together.

SMITH: And I guess that his unfortunate event in the Tidal Basin—well—my understanding is—and you might not want to comment on this, but my understanding is that Mills may have been a person who drank but if so he kept it very much under control and that this Tidal Basin thing was very uncharacteristic.

FULLERTON: Well, Mills started to have—I don't know whether it was just mental problems or whether he was aging faster than everybody thought. But he started to say some things in the committee that were very much unlike him.

One of the things he started doing was pick on a particular member. And he would say, "Oh, the member has never supported me," and...And I think he would do that, not in public but in a private session of the committee. So a lot of us were starting to raise our eyebrows—not too long, but before any public stuff. If that helps.

SMITH: Well, it helps. You sometimes kind of wonder, too. They say power corrupts and absolute power tends to corrupt absolutely. Maybe there was a lot of power there. There is a version of that I like, too: Power corrupts and the loss of power corrupts absolutely. But you may have heard that one.

MOORE: Easier to look back on it than to figure it out at the time sometimes.

FULLERTON: Yes.

SMITH: Mills had an absolutely astounding expertise in his heyday. A member—you probably remember this fellow, Randolph Paul.

FULLERTON: No.

SMITH: Well, he was a well-known tax attorney. He was one of the big tax attorneys of his time. And he just said on some very arcane point that Wilbur Mills knew but he didn't and there wasn't any way he could find out.

And I remember at one point Russell Long on Senate Finance was asked, "Why didn't you do better or know more about some such thing?" And he said, "Well, I ought to but Wilbur wouldn't tell me what was going on." So certainly the sense was that Wilbur Mills knew more about this subject than probably any person on the face of the earth.

FULLERTON: Well, he was very good at appearing to know everything. And the staff knew you wouldn't stay long if you didn't get the picture. Everything you did in that kind of a sense, you had to be sure in your mind that two things would happen: that he would like it and that he could take

credit for it. I never went around telling anybody about what I told Wilbur Mills.

That would have been a fast way to get out of there, no matter what you did. You know, there's really nothing wrong with that. That's what good staff is for.

One of the things that—one of the differences between Jay and me was that he was ready to take credit for all that kind of stuff...tell people what to do.

SMITH: Well, he made an interesting comment about his reputation for manipulating the Senators. And he said “no,”—he denied that that was true. He said what we would do—and he included you in this—he said, "We would simply work out the alternatives thoroughly and say, 'Well, Senator, this is what this would mean and this is what that would mean.'"

And it would be pretty clear which alternative you probably should choose, although you would never say that. But he didn't see that as manipulating, he saw that as just being a good staff person.

FULLERTON: Yeah, well, I guess that's correct. All I'm saying is that I did the same thing that he did but I didn't tell anybody. I would give ideas to the members and tell them things and that sort of business. One of the things I would do is, I would know the various organizations that were getting close to the committee and try to get them to do something.

I would know about them and I could tell them, well, you could do that but on the other hand that means so and so is going to be against you. You know, it was always tactical stuff. But I didn't go around telling anybody that because I thought that was the wrong way to do it.
But Jay and I got along okay. We understood each other.

SMITH: Well, I mean, you have to respect his integrity and the passion he brought to that job.

FULLERTON: Yes, that’s right.

SMITH: And I guess he's entitled to blow his horn a little bit. I liked him a lot. I've talked to him several times and I really enjoyed those occasions and I have a great deal of respect for him.

FULLERTON: I'm sort of surprised at what you told me about what he's doing these days. But I must say that I find that very pleasing because when he puts his mind to some things like that he's going to make a difference. And that's the way to go.

SMITH: Do you have any reflections about what's happened to these medical programs?

FULLERTON: These days?

SMITH: Yeah.

FULLERTON: Well, I think we got a mess in many ways. I think my personal problem I guess with the health care system is FMGs. I tried to stop that years and years ago but I couldn't have any luck with it. And it's getting worse and worse as far as I'm concerned. You know what I mean, I think.

MOORE: Foreign medical graduates?

FULLERTON: Yes. They are lousy, ill-trained, and they are all for money.

MOORE: Uh-huh.

FULLERTON: You may not believe that statement but I believe it. We have not done right by the medical system. And I think it is a shame.

SMITH: Would you make any distinctions amongst them? Some people say the FMGs that come from Britain or Canada are better trained but they may be more interested in money. And sometimes you get some of the ones from some of these Third World countries that—I mean, we have one who staffs the board of health where I live and the guy is just magnificent. And—

FULLERTON: Well, there's no reason—well, I guess in a way it's part of what the policy of the United States has been on the matter of immigration in general.

And the physicians were there first in many respects. And there are the people who hire or get physicians. Part of that is the hospital system. They wanted to get physicians and if the FMGs were the only ones they could get, they got them. And I think that we are getting more physicians that are

more like these, not dedicated to medicine but to American money. And that's why they are here and they make a lot of money. I did a study once, which showed that FMG's on average got lower scores on their specialty exams than domestic trained doctors. I wonder it that's still the case.

SMITH: Well, but the Americans certainly have a genius for screwing things up, don't they?

FULLERTON: It's based on what I see in my neighbors. But that's another whole story. Not in the jurisdiction of Ways and Means. Anything else?

MOORE: No.

SMITH: I don't think of anything.

MOORE: I think that's it. Thank you, Bill, very much—

SMITH: Sure, thanks very much.

FULLERTON: Just remember that everything I've been saying is from a guy in his 76th year and his memory may not be as great as it used to be.
MOORE: You sound pretty good to me and I hope you are feeling well and doing well.

FULLERTON: Oh, I'm healthy enough to exercise every day.

MOORE: That's great. We interviewed Stan Jones recently and he sends his best.

FULLERTON: Good.

MOORE: And he is doing fairly well. And let's see. We've talked to several of your old colleagues, and Jay, of course.

SMITH: He spoke very fondly of you. There's no question about that. I don't think he knew we were going to interview you, but certainly the feeling there is very warm.

MOORE: So everybody seems to be doing fairly. So you stay healthy and enjoy life there.

INTERVIEW WITH RAY HANLEY
JUDY MOORE AND DAVID SMITH – JULY 29, 2003

SMITH: Please tell us how you became involved with the Medicaid program and eventually become a director in Arkansas.

HANLEY: You know, in 1974 I was selling tires for Montgomery Ward. Got a little tired of that and started—I mean, I was a year out of college and went into the social services office here.

SMITH: Were you a state civil servant or were you a fed?

HANLEY: I was state. State: 28 years with the state department of human services here from which I retired...and I did that for the first year, eligibility case worker.

SMITH: A good many careers began there.

HANLEY: I will tell you. And I spent almost two years in Title 5 maternal and child health programs. From there I went over just into the Medicaid area, first to do utilization review work. And then one day the Medicaid director, the deputy, everybody around was either, had either quit or was let go. And it was pretty much nobody there in the supervisory ranks but me.

I was the acting Medicaid director for about six months. This is in 1986. And the Governor then was, of course, Bill Clinton. My boss, the director of social services, wanted to make me permanently the Medicaid director, but of course he had to get the Governor's approval.

And so that went to the Governor and the Governor said, "Oh, geez, I don't know." He said, "Well, my mother's got one candidate and Hillary's got another one." And I just—and so my boss made it an issue that as the CEO of the agency he ought to be able to hire for that. And the Governor said, "I agree. That will help me out at home. I don't have to choose between Hillary and my mother."

And that's how I became the Medicaid director...And I kept that job for 16 years.

SMITH: Right. One kind of background question. The point where you came in, what would be the salient features of the Arkansas Medicaid program?

HANLEY: In 1986, the entire budget was only about $200 million and the program primarily served only the poorest of the poor. This was before all of the eligibility expansions and everything were even thought about. It was a program choked in paper and frustration and it was simply something that tried to pay bills and that was about it.

MOORE: Ray, what were your priorities when you took over?

HANLEY: My priorities were first to try to live within the budget, which was not easy at the time. So managing that $200 million checkbook was the first priority. And then shortly after that we got into the expansion mode. We were the first state to exercise the OBRA options for pregnant women expansions, which was the first time I actually met

Mr. and Mrs. Clinton at the Governor's mansion.

My boss and I got called over there one very, very cold winter day and sat there with the future President and First Lady. And Mrs. Clinton told us what we were going to do and when we were going to get it done by in a schedule we didn't think could be done. But nobody was going to tell her that.

So myself, my boss, and the future President and I mostly sat there and nodded a lot while Mrs. Clinton gave us our instructions. And we went back and got the expansion approved and done and in place in what was probably a record time for something like that.

SMITH: So that's what she was pushing?

HANLEY: Yes, to extend coverage to pregnant women and children.

MOORE: We talked the other day to Sara Schuptrine and she discussed the Southern Governors' Task Force, which I think had several wives of Governors, including Mrs. Clinton on it. Were you aware of all of that activity? Did you take any part in any of that?

HANLEY: I was aware of it but don't know that I was in the meetings themselves. I think my boss, the department director, would have been.

But sure, I was aware of it.

So we did that, which was a success, and started covering obviously a lot more pregnant women. I think 133 percent of poverty in this state took us probably close to 40 percent of all births. And then, obviously later we had chances to do a lot of things which were part of an evolutionary process, taking something that was just tried to pay bills and actually changing it into a health insurance program that actually tried to intervene and manage both the providers and the patients.

The highlight, I guess, the first thing we did to really change things was to get rid of the paper. We were the runner-up, I think, in 1993, for what was the country's first automated eligibility and payment system. The first automated eligibility verification system, which equipped the recipients with plastic ID cards and started the process of processing claims electronically on line. Eligibility was verified by a third party.

The remarkable thing that this started to do for us was to increase access. The providers, particularly the physicians, noticed after a while they had little, if any, accounts payable on Medicaid. And that led us to our major foray into managed care, which was the Connect Care program, which is primary care case management.

We were able to lock all our recipients, except the dual eligibles, into a primary care doctor, because—for the first time—we had enough doctors.

That program was nominated for the Ford Foundation Innovations in American Government Kennedy School Award in 1997. It was one of 1,600 entries. In the end it was one of only 10 winners. We got MAJOR points from the judges because of access we opened up to physician care.

We had physician demand for three to four times as many patients as we needed placement for. We cut our E.R. use in half. We were able to do the things a good HMO does, report cards on the physicians, report each month to each physician showing what his practice patterns looked like compared with his peer group.

And then we added things like a decision support system, a data warehouse, I think the country's first for Medicaid, to do the analysis we needed to start doing disease management. And so, I was privileged to stay there long enough to be part of a real evolution in how the program changed.

SMITH: What did you call—what was the title of it? Well, you were telling us about the Connect Care and reciting some of the achievements involved in that. What were some of the roots of that. Was that just you kind of—

HANLEY: Well, the roots of the Connect Care was then–Governor Jim Guy Tucker, who was governor for a brief time between Bill Clinton and the current Governor until he resigned.

Governor Tucker came back from a meeting with the Kentucky Governor where they were doing a primary care physician program. He liked it and wanted us to do it. And so we got ready to do it. This was not long after we had implemented the other program, the point of sale system.

At first the providers said we wouldn't get enough physicians that it wouldn't work because we couldn't get enough providers. Lo and behold, we were able to get more than enough because of what we had done to automate all the claims and eligibility systems. So the evolution of it came about actually with Governor Tucker's visit to Kentucky.

SMITH: What kind of policy did you have on the level of payment for the hospitals and physicians under Medicaid?

HANLEY: Well, the hospital payment was an all-inclusive per diem. I don't remember how much it was when we started. Certainly probably in the neighborhood of $400 with the exception of the children's hospital and teaching hospital. Physicians—our physicians' fee schedule was roughly about 65 percent of the Blue Cross schedule, less than other payors. But because we paid very rapidly and very efficiently, the providers were willing to take our patients.

SMITH: So that was really a key move. That was the real prerequisite for future success?

HANLEY: Yes.

MOORE: That is interesting, Ray, because I had heard you talk about this before. And the efficiency and the speed factor are something that most people don't ever put into the equation in terms of reimbursement practices.

HANLEY: You know, the providers are willing to serve Medicaid and they are willing to do it for less than they take from others, but they are not

willing to do it if you saddle on a big hassle factor and make it too burdensome.

And we were able to pay a fair fee and to remove the hassle factor. More than once, I had physicians tell me they would rather take our Medicaid patients even at a discount than a lot of HMO patients because we were an easier program to work with and were more responsive to their concerns.

SMITH: How much of that do you think depended—what other factors made that kind of a success? Because I'm thinking here that Arkansas is not a rich state but it's a fairly small state.

HANLEY: As far as Medicaid goes—we have three-to-one federal match, which helped. But it's a rural state. Not a lot of penetration by HMOs. While we were doing this, TennCare was doing its experiment with total HMOs.

We were able to establish an excellent relationship with the medical society here that represents all the doctors and the pediatric academy. And physicians from big cities to little towns were receptive to this once we got them on these automated systems.

We went into physicians' offices in the early '90s that had never seen computers. And first we had them on a little eligibility box, like a credit card verification machine, to get them started. And then as more and more computers came along we just simply gave them the software and trained them how to use it.

SMITH:...little verification box, is that like some of these primitive things they used on credit cards?

HANLEY: Right, just a little stripe machine and a little display.

SMITH: Well, I'm still interested in where the inspiration came for this? Because it strikes me that it was a very smart move to make.

HANLEY: Well, the inspiration actually came from EDS.

Obviously, I work for EDS now, but I was their customer for 15 years and had a good relationship. And there were a lot of things they wanted to pilot.

And Arkansas was a good state, about the right size to pilot a lot of things.

And I was pretty good at getting them to do the development—somewhere between cheap and free—and get something established that they were able to later market successfully in other places. So Arkansas proved time and time and again to be a very good test ground for technological innovation.

The things you wouldn't, you know, test in California or Texas or New York you could do here. I mean, you know, a statewide system—all state administered, no counties involved—and one point of focus which was the Medicaid agency here.

MOORE: How did you work with the federal government on this? Did you run into a lot of roadblocks or just do it in spite of them? How would you characterize that relationship?

HANLEY: No, they were, I think, generally cooperative. We always had a good relationship with the Dallas regional office. And I'm sure that they were skeptical a time or two but it was never really a problem working with HCFA/CMS.

SMITH: And EDS was a big presence throughout that part of the country, was it not?

HANLEY: Yes.

SMITH: What about the Clinton Administration? Were they helpful in this?

HANLEY: Are you talking about as Governor or President?

SMITH: Well, actually I was talking about as Governor more than President.

HANLEY: Well, they were gone by the time we got a lot of this off the ground. I mean, they were gone on to their big house up there. But as far as getting approval on the technology, it was never really much of an issue with CMS. And it helped that for consistency purposes we were working with EDS throughout the whole thing.

MOORE: And through this time I assume you were also enlarging the program in terms of beneficiaries and new groups of people.

HANLEY: One thing led to the other. The automated eligibility payment system brought the physicians back into the program, gave us the access we needed to start Connect Care. That access and the successful Connect Care program led us then to Governor Huckaby's initiative to start the ARKIDS First program, which is our expansion to 200 percent of poverty, which we did before SCHIP in the spring of 1997.

Seven, yeah. SCHIP started in the fall of '97. We started our Kids First in the spring of '97. We were able to enroll, in about an 18-month period of time, 70,000 previously uninsured kids and we had the system there to accommodate them. It was no problem.

They could select a primary care physician of their choice for their medical home. Providers were there to take them and add them to their caseload. And they very easily slid into the Connect Care program that was already there.

SMITH: I notice you use the language "medical home." Now, is that a buzzword you have subsequently picked up or did you have pretty much that concept in mind?

HANLEY: Oh, I think it was in our mind early on. I mean, I go back to my child welfare background, where kids were just kind of shuffled from place to place and records are all over the place. And they might have three different shot records. And the concept of having a primary care medical home was fundamental from day one on this.

SMITH:...in some ways it's a kind of a thing that you can have a lot of flexibility with and may not involve as much capital investment as when you start thinking about doing one-stop shopping and all that sort of thing.

HANLEY: No, it doesn't. And politically it's more palatable. We ended up with a very successful, three-corner partnership here. We had EDS to do the technology that we needed to take care of the claims, create a data warehouse, a decision support system that let us profile our patients, do the report cards on our physicians.

And then the third part of the stool here was the peer review organization, the Arkansas Foundation for Medical Care. They set up a managed care support division for us and they would take the data—the report cards, for instance, and they would take the information out of the data warehouse that EDS could furnish, produce the report cards on the primary care

physicians, the Connect Care physicians, so that the physician would get his report card.

And he or she would see how they compared with their peer group for things like emergency room use, total cost hospital days. And then we were able to do what no state had done before, which was to link the physician up with the pharmacy claim so that even though those claims come in separately we could go back and tie them together and could profile even the physician's prescribing habits against their peer group.

So the PRO with their field reps, this managed care support, could take these report cards and then they would personally visit with the primary care physicians and Connect Care physicians that might have aberrant issues on their report card, which is immensely more effective than just mailing something in the mail when somebody from your peer review organization—virtually every practicing physician belongs to the PRO—comes to talk about those report cards.

SMITH: That's very interesting because in the original conception of PSROs and PROs, they hoped very much that they would get the physicians to sign on and participate. You sound like one of the few places in which that really happened.

HANLEY: Well, you know, this state in a lot of places, a lot of ways is like one big town. I mean, everybody knows everybody else and everything is within three or four miles or blocks even, here in Little Rock. And everybody works together. And it's worked and continues to work.

MOORE: What do you see as continuing challenges for the state?

HANLEY: Oh, money is huge because medical inflation obviously has outstripped the economy and revenue growth. Revenue, if it grows at all right now, is going to be in the single digits. And it's very hard to keep your Medicaid growth out of the double digits.

And when you're in a recession like this you have got a double whammy. The state's revenue is declining, but in many states, Medicaid enrollment is going up. And so it's a challenge to pay the bills. But what I think has to happen—and I talked with NCSL the first of the week about this in San Francisco—is states are going to have to be a whole lot smarter about how they spend their money.

Technology is the key to that. And a good example here is what we have been able—I keep saying we; I don't do this anymore—but what the state was able to do with this data warehouse and the technology that EDS developed.

If I had 500,000 or so recipients and at any given point 2,000 or so physicians taking care of them. And you look at 500,000 patients for which a $2.5 billion budget is going for and 2,000 physicians, it appears to be unmanageable. What we learned through applied technology, for instance, is if you look at chronic diseases that cost so much money—diabetes is a good example, which in this country consumes one health care dollar out of seven.

Eli Lily came to me. They wanted to do a disease management project on diabetes. They were willing to fund for a year the creation of certified diabetes education centers in rural hospitals. So we picked a dozen locations primarily in the delta, which has some of the highest diabetes incidence in the world.

With our system here we were able to go in and identify all our patients with diabetes. We could even profile the ones who had the highest morbidity and the worst disease. So we went out and we found, I think, somewhere between 200 and 300 of the patients that we wanted to enroll in these newly certified centers.

This process started last fall. And obviously the end of the year the state is going to try to determine whether or not intervention on the part of these educators for diet, bed management, foot care, whether or not that can improve the quality of their lives here and save money.

Asthma, we are doing the project with Schering Plough and the school nurses, on kids with asthma. We know where every one of our kids is with asthma. We know who their assigned primary care physician is. We can even overlay the standard of care for asthma on these patients and determine who is getting the standard of care and who isn't.

I got Schering Plough to furnish for the school nurses a web site on asthma and print materials they can use to work with the parents and the kids. And then we are able to link and help the school nurse know who the child's assigned primary care physician is there in the community so that the two of them can dialogue as they need to, which is something that had never occurred before.

These school nurses, they don't know in many cases who the doctor is and there is a certain intimidation factor there. That program again started last year. And asthma is probably the leading reason for E.R. admissions on children. So we're going to find out—because we know where all our asthma kids are. And so it's an opportunity to back up. And you're not looking at 500,000 recipients; you are looking at the subset of kids that have asthma.

The most interesting thing that we started last fall is—I was in a meeting where Bruce Bullen was, who is running the Harvard Pilgrim Health Plan up in Boston. And Bruce made the comment the 50 percent of his health plan's money goes for 5 percent of their patients.

So I came back wondering what percentage of the Medicaid patients it took to use 50 percent of the money here. I told the staff and EDS to run the report. Tell me. So they backed out the dual eligibles and the nursing home patients and that left spending approximately one billion dollars.

Lo and behold, it only took 3 percent of the patients, 17,000 patients, to use $500 million in services. So we profiled in detail the top 50 and had all the rest of them—obviously they are on the report. The most expensive patient was a $900,000 blood factor patient, and then on and on.

So this last fall we brought in the folks from the medical school, the dean, the various department chairs, family practice, pediatrics, and laid those reports out on the table. And what we want them to do is take those profiles, work on them, come back and tell us how we can better manage these very, very expensive patients.

And, see, all of a sudden you are not dealing with 500,000 patients. You are drilled down to 17,000 patients that are costing you $500 million. And I think that in the commercial health plan Bruce found 5 percent were using that. My guess is Medicaid in any state would find something similar, but nobody has ever thought to look before. And it wouldn't have occurred to me until I had this discussion with Bruce.

So—and I was on the phone with Mike Lewis in Alabama here about a month ago and talking to Mike about that. And he got pumped up on it. And so EDS in Alabama is going to do the same work for him. And he's got some ideas about who he could talk to about doing the analysis there.

And so I said all that to tell the legislators that you are going to have to apply some very intelligent technology here and think about this a lot

differently than you did in the past because you are going to continue to have more demand on the program than you can possibly meet.

SMITH: I am interested in looking at the history of this, that a lot of the movement into these areas of the dual eligibles and high-cost cases comes from a strong background of data capability, one, and secondly, a good bit of experience in primary case management.

HANLEY: Yes. And, you know, part of it is just if you stay around long enough you've got to learn something. I think that's part of it. As Judy knows, the life span on these jobs is probably not much more than two years. And I was fortunate enough to be here long enough to learn from a lot of my mistakes.

MOORE: Ray, have you got thoughts about how to replicate that learning or make sure that in the places where people have a shorter tenure they can get up to speed faster?

HANLEY: Let somebody like me and EDS come at them with some technological innovation. So if that sounds like a commercial, it probably is.

MOORE: There are plenty of places that don't have the kind of technology that you have there, at least as best I can determine, there should be plenty of markets to go into, I guess.

HANLEY: I would hope so.

SMITH: Well, this is also an interesting example of strong cooperation between public and private sector. You've got a for-profit EDS and yet the kind of stuff you are doing here is—it's really sort of leading the medical schools rather than relying on the medical school leadership.

HANLEY: Well, you know, EDS is a global conglomerate. I mean, 140,000 employees in 60 countries. But I think that they have hired some folks like myself and Trish McTaggart and hopefully some others because we can put a little different face and perspective on this than some of the people that just came up through the IT ranks, and bits and bytes, but don't know what it is like to have sat in the Medicaid chair. And so, hopefully, I can bridge some of both of those worlds.

SMITH: I think Judy may have to go out.

MOORE: I've got to go out and talk to one of our foundation funders. I can't stay but I'm going to let David finish.

HANLEY: I don't want to snub somebody that's got money.

MOORE: No, that's right. Thank you for your time, Ray. And I know David has got another question or two.

SMITH: Well, I heard you at this last Medicaid directors' conference and I have known that you felt that sometimes the Feds are a bit interfering and there were ways in which they could be more cooperative. What do you think should happen with this tension between the Feds and the states?

HANLEY: As an example, I think that they need to look into the dual eligible issue. According to Vern Smith, 35 percent of Medicaid spending is going to dual eligibles, people that also have Medicare, which is something that the founding fathers of Medicaid never intended. So Medicaid is now larger than Medicare, covers more people, spends more money. But there is a lot that could be done to better manage these dual eligibles.

The Feds need to give the states some incentives and some credits for doing that. For example, we can invest in technology and money and doing disease money for dual eligibles. But a good disease management program in a lot of cases is going to increase spending on pharmacy in order to decrease spending on hospital and physician care.

Well, guess what? I mean, if you do that with the dual eligibles the state's expenditures go up. The Feds, on the Medicare side go down. So where is the incentive?

So there is a lot of room to recognize what the states could do and to give them some incentive, financial incentive for helping the Feds save money on the Medicare side. That's just a no-brainer. But it's hard to get the Feds to buy into that.

SMITH: Well, I think we know some of the political reasons why it's hard for the Feds to buy in.

HANLEY: I know. And I go all the way back to Bruce Vladeck who—you know, it was like putting a cross in front of the vampire if you suggested locking a dual eligible into a primary care medical home or something. But if

anybody needs it, it's these folks, you know, who are prone to doctor-shop and end up with prescriptions from three different doctors.

SMITH: Well, I think that locking in—you are quite right—people seem to look at that with absolute horror. And yet, unless you've got some kind of lock-in for managed care you are not going to do it.

HANLEY: When we started Connect Care we had initially some push-back from the disability advocates over locking in the SSI patients and they said, "No, no, we have to be able to stay with our neurologist and our urologist," and all of this. And our point was, "No, you are going to have to choose a primary care physician and then they will be able to make referrals to this."

And, you know, six months into it, nobody complained. It worked. But, you need to have a central medical record, somewhere to get your flu shots and all this. I mean, everybody needs a primary care medical home. They don't need to be bouncing all over the system from three or four primary care doctors and multiple specialties.

It's coming. I mean, inevitably some type of electronic medical record, you know, once we overcome the confidentiality issues and make sure we are HIPAA compliant. So that's another thing coming down the road, I think.

SMITH: There are aspects of case management, especially as you get into dual eligibles that takes more than primary care physician. Now, where does that piece of it come from in your thinking?

HANLEY: Say what again?

SMITH: How do you get enough management if all you have got is a primary care physician in there?

HANLEY: Oh, the primary care physician has got to be able to make the referrals and has to have a relationship with a specialist. And the state has got to have done enough work with its specialists that there is going to be enough of them to take the referrals that the primary care physicians actually do need to make.

Which has not been a problem here. If we have had access issues anywhere in this state it's been with dentists.

SMITH: I see. Well, you don't have a problem with access. Do you have a problem with—what about cost containment?

HANLEY: Again, we rank the primary care physicians against their peer group and those that are making referrals at a higher level than their peer group whose per-patient cost is higher, they stand out and they get a visit. We developed beyond that a physician profiling system that let us profile physicians for aberrant patterns and that take into account patient morbidity so that those physicians that, say, took a lot of AIDS patients or cancer patients didn't unduly get profiled and singled out.

The first time I looked at that, I wanted to see the 25 worst physicians. And they developed a physician profiler, which was, I think, done first here. And I was not surprised at all at the 25 doctors that fell out.

So again, the applied use of technology here is all about trying to target your very limited intervention resources to where they will do the most good. I found that the physicians appreciate that. They much prefer that to having to force, you know, all 2,000 physicians to call an 800 number to do something every time they turn around.

The fact that we have the ability to profile our doctors and target for education and intervention the small subset that seem to have practice patterns and issues is what has been successful.

SMITH: You have spent quite a lot of time with the national association and I guess thought quite a lot about—

HANLEY: Chaired it three times.

SMITH: Federal/state relations.

HANLEY: Uh-huh.

SMITH: What is your thought about, say, some of these initiatives like HIPAA and so forth? Is this a good way to go? I mean, let's get the match up and let's—

HANLEY: I think to the extent that there is uniformity and standardization between payers, I think it's a good thing. I think the hard part is going to be what happens, say, with providers that aren't ready. And there's going to

be some subsets of providers, particularly in the non-profit areas, that aren't going to be ready.

I think CMS is going to have to be ready to show some flexibility come October 16th or some states are going to have to choose between continuing to have adequate access and complying with the letter of this. It's going to be a real challenge to CMS and state relations, how the HIPAA is handled over the next few months.

Payors like—and vendors like EDS are going to be ready. I mean, we are probably the most ready of anybody in this field but we have concerns about some of the billing agents and some of the provider groups being ready to submit HIPAA-compliant transactions.

SMITH: Well, I think that pretty well concludes the things I wanted to ask you. I wondered if you had any final thoughts here about the Medicaid program.

HANLEY: You know, if you look at it from a little distance here it is—it is enormous. It is 20 percent or more of every state's budget. But you have to respect, I think, what it has been able to do over the last decade. Remember that if it were not for Medicaid and the states stepping forward with a lot of innovative waivers and expansions when health reform collapsed in Washington in 1993 there would be millions and millions more people without coverage.

The health care infrastructure would be in much, much worse shape if it were not for what state Medicaid programs and SCHIP have done over the last five, six, seven years. Nobody should lose sight of that. You can talk about the economic impact of Medicaid in states like Arkansas. The fact that we have in this state the sixth largest pediatric hospital in the United States.

That brings patients from all over the world to do innovative procedures. It is available to the children of the state. It would not be here if it were not for Medicaid.

At the same time, recognize that programs cannot continue to grow at double-digit rates in an economy that provides the states single-digit revenue growth. So that all comes back full circle to what we talked about, the need to be ever smarter about how you manage the programs. And the key lies in some very intelligent application of technology.

SMITH: Just a final thought here. What is your feeling about the recent talk in the NGA about getting the Feds to take over a larger portion of the—first of all, to pass a Medicare pharmaceutical benefit?

HANLEY: I think that's reasonable. I think the states have taken up again a huge segment of the previously uninsured or would have been uninsured population below the age of 65—certainly children. In this state 40 percent of all children are covered by Medicaid and SCHIP. Other states have stepped up to cover uninsured adults, working adults, two–parent households. And I think that has been to the states' credit.

At the same time it becomes increasingly harder to pay and manage the dual eligibles that now consume 35 percent of the Medicaid budget, particularly without a lot of tools and flexibility to be able to do that.

So I think the governors are quite right to suggest that Medicare should assume more and more responsibility for Medicare patients and let the states concentrate on what they have done pretty well, which is rising to the occasion to meet the previously unmet needs of the under–65 population.

SMITH: Well, I must say, coming from Oklahoma and then having spent a fair amount of time in Arkansas, it is encouraging to talk to someone like yourself.

Thank you so much for your time. We will both look forward, I hope, to seeing you in some capacity in the Fall.

HANLEY: I'll be there in October, I'm sure.

SMITH: That's just great and I hope to see you there. Thank you a lot.

INTERVIEW WITH ROBERT HELMS
DAVID SMITH – JULY 31, 2003

SMITH: This is an interview with Robert Helms on July 31st, 2003 at the American Enterprise Institute. Judy was unable to join us but she will hear this tape.

HELMS: When Judy called, I reminded her that I didn't consider myself an expert on Medicaid. She said, well, she wanted to talk about that time, but I do not think I have a good memory of the early 1980's. Maybe you can bring back some things.

In my early days in ASPE, I was the health deputy under Bob Rubin. Bob Rubin is a person you should definitely talk to, I think, because he was quite involved with Schweiker and with those events.

SMITH: What dates were you deputy?

HELMS: I arrived in ASPE in March, 1981. Then when Rubin left in 1984, I became the acting ASPE and held that until Secretary Bowen came in.

Bowen nominated me and I was confirmed by the Senate in the summer of 1985. I was the ASPE for about the last three years of the Reagan Administration. All together, I was in ASPE the whole eight years of the Reagan Administration.

Now, the other thing I will preface with this story. When I first went to ASPE they were introducing the various staff. And Diane Rowland was my staff assistant in the health deputy's office. She had the various staff members come in groups so that I could get to know them. She introduced David Cooper as our Medicaid expert. David immediately threw up his hands and he said, "I know enough about Medicaid to know that I'm not an expert," he said, "because," he said, "the more you know about Medicaid the more you know you don't know." He said, "It's too complex a program to really be an expert in it. Maybe there are some people over in HCFA," he says, "who would be expert in little components of it." I always remember that statement when somebody asks you, "What do you know about Medicaid?" and, "Are you a Medicaid expert?"

So, I am certainly not a Medicaid expert.

SMITH: No, no. I think there are very few Medicaid experts and I am not one. And Judy would tell you that she is not one either. There are very few Medicaid experts.

HELMS: If you've seen one state Medicaid program you have seen one state Medicaid program.

SMITH: That's very true. Well, for the record then, you were appointed deputy ASPE in '81, so you were there for the OBRA of '81, which was a very big item.

HELMS: Yes.

SMITH: Were you given any particular marching orders as to what the role of ASPE should be under the Reagan Administration? Because they were very conscious about how centralized or decentralized policy should be and to what extent it should bubble up and to what extent it should come from the top and to what extent political people should talk about policy and experts or technicians should not.

So were you given any particular marching orders of that sort?

HELMS: I wouldn't call them explicit marching orders. We were a group of political appointees who had a different attitude and we had certain opinions about the historical role that ASPE and HHS had played in these programs.

They were viewed as the staff that had been hired over the years by strong Democrats who were trying to promote these programs. And we were trying to produce a kind of federalism. We had a set of policies that we believed in based on competition, deregulation, trying to simplify regulations, and federalism, trying to return control to the states.

SMITH: Devolution was a big item.

HELMS: Yes, as a general area of policy. You tried to do things within that context. I had been given lots of advice from people who had been in the government that you had to learn to use the staff. In other words, you couldn't go in and say you are going to do everything, and ignore the staff.

And I found, personally, that the ASPE staff people were a very knowledgeable group of people and quite willing to do all kinds of work. They sort of said, "We're here to serve you and it is not our job to determine

the broad policy direction, but we can provide a lot of analysis and good information about any issue."

And they did. I think I got very good cooperation from lots of people. I have seen lots of other political appointees, including some in this administration, who have not taken that tack, and tried to ignore the staff. I think that's a big mistake.

There is one thing I should make clear. AEI is a 501(c)(3) organization. As an institute it doesn't officially take positions on anything. The individual scholars here can speak out and express their own opinions about any issue.

But as an institute it does not come out and say the AEI position on Medicaid is such and such.

SMITH: And Brookings theoretically doesn't do that either.

HELMS: Some think tanks, also 501(c)(3)'s, push that limit a lot further than AEI does. AEI I think has tried to be more careful about it.
But getting back to your question, I was the health deputy and also responsible for health policy.

Medicaid was somewhat a minor issue for me when I went over there. We started out trying to promote competition and developed some proposals early on. As a matter of fact, OMB wrote a line into the budget that said we should come up with competition savings of $500 million. And we had a major battle with OMB about what that meant. You know, we were trying to promote competition as a policy but not saying we could identify budget savings from it. They just needed a number.

SMITH: I remember there was quite a lot of thought about competition, especially around then. It came to some extent from both sides of the aisle. Stockman was very big on competition. But so was Richard Gephardt.

HELMS: That's right. Gephardt and Stockman did a lot of things together.

SMITH: That's right. And some thought about it primarily as a way of saving money. I can remember even Gephardt saying one of the main reasons he wanted to get competition was so that you could delegate some of these decisions to other processes and get away from micro managing by Congress. And I take it that was a view that's fairly widely shared.

HELMS: It was the position that Scully had under Bush.

SMITH: Yeah.

HELMS: Matter of fact, Debbie Steelman had that position—

SMITH: You were saying that there was a view about devolution and about competition and about trying to readjust the federal balance but that you didn't have a strong sense that marching orders were given to you in ASPE.

HELMS: No, my impression was there were a group of people around Reagan in the White House who were trying to push this sort of federalism. In fact, I can't even remember the exact timing on this thing. But it was Martin Anderson. Those were the names that I associated with that policy.

They had this idea that they could talk the states into the federal government taking over certain functions and then the states would take over others. And of course it got nowhere.

But you're going to be talking to Bob Rubin. He was in more of those discussions with the White House and with Schweiker than I was. We did some analytical work on specific issues, but the broad policy issues were handled by others.

SMITH: Yes, I remember that Schweiker had about four priorities, not one of which had anything to do with Medicaid. It was not on his radar screen.

HELMS: I have no way of knowing what was on Secretary Schweiker's mind. But his various advisors and assistants were certainly concerned about Medicaid.

SMITH: But in OBRA of '81 Medicaid does come up in the sense that Stockman wanted to put a five percent cap on it and to give the states more flexibility. Did you in ASPE have any role in that? Were you asked to do work about impact studies or things of that sort?

HELMS: Well, I am really struggling to remember that because, like I say, Medicaid was not the highest priority thing that we were thinking about. And we must have been asked to do some things but the basic policy, I think, came out of the White House and OMB. I don't remember specifically the assignments about the impact of this.

SMITH: Most of this seems to have been pretty much what Stockman had in mind doing. And that's what they went in with. And then it gets modified largely on the basis of some proposals coming from the National Governors Association through Henry Waxman. And instead of having a cap—incidentally, at that point did a five-percent cap on Medicaid growth seem to you like an onerous figure?

HELMS: I don't really remember that being discussed.

SMITH: So it seems that a lot of these things that we later make a lot of noise about were scarcely even on the radar screen at that stage.

HELMS: Yes, because a lot of these things are discussed in terms of budget trends.

But there was this political notion of federalism that was developed in a stronger form under Chuck Hobbs on the welfare side later on. I don't remember it in the early '80s but I did a lot of work in the late 1980's on welfare reform with Chuck Hobbs who ran the welfare reform effort out of the White House.

There was also later in the Reagan Administration a federalism work group that I participated in that was run out of the Justice Department. And it was pushed by a bunch of people who had an agenda to promote federalism wherever they could in any department or program.

And that fit very well within what Chuck Hobbs was doing because he was trying to use the demonstration authority under the welfare and Medicaid rules to let states have this demonstration authority to come up with some new AFDC and Medicaid programs.

Most of the battles were technical ones having to do with being able to measure the effects of the demonstration project against what would have been because there was strong distrust of the states in OMB that they were gaming the system.

SMITH: So, a great deal of the policy with respect to Medicaid really doesn't go through ASPE.

HELMS: I think that's right because if it went anywhere, it would have been in HCFA.

SMITH: And policy proposals coming up in HCFA, would they be vetted by you?

HELMS: Yes. We had a policy process to review regulations and legislative proposals. ASPE was known throughout the Department for its non-concurrences in regulatory matters but also in legislative proposals. We ran the legislative process of coming up with the legislative side of the budget proposal. So yes, we were involved in those...

SMITH: But as far as initiatives in Medicaid were concerned, most of those would be coming typically from Congress and HCFA.

HELMS: Yes. We would be asked to analyze legislative and budget proposals. But that first budget was pretty much put together in a hurry before I got there in 1981.

SMITH: One of the next big flaps that comes along is the AIDS controversy.

What are people going to do about AIDS?

I know that Ed Brandt was very much involved with it, as Assistant Secretary for Health. And so was CDC and so was NIH.

HELMS: And C. Everett Koop, the Surgeon General, was the name that was mostly associated with AIDS, in terms of efforts which were quite controversial within the Department and certainly with the people over at the White House.

SMITH: And that may be the last time that the Surgeon General took a really strong, substantive leadership position.

HELMS: Well, you remember that was very early on and Koop and the Public Health Service were really doing a lot of very fundamental research about AIDS and how it was transmitted and so on. There was just lots of misunderstanding about it. And we were doing our best to try to understand what it was and I think, given what I know about AIDS now—and I'm not a physician—but they did quite a bit of good work on the disease. They were resisted by a bunch of conservatives over in the White House who were very upset about Dr. Koop saying anything about the use of condoms.

I remember in terms of timing that there was some discussion of AIDS in the Department in the early '80s. But I remember most of that being when I

was acting ASPE. I mean, it was more the mid '80s that it was really widely discussed, when we had more meetings.

Quite frankly, my policy was to keep ASPE out of that as much as possible. I had to go to a lot of meetings. But we resisted the attempts to get into doing studies and that sort of thing. We wanted to leave that to the Public Health Service the best we could. And it was my personal policy to keep ASPE out of it. We were mostly a bunch of economists and policy analysts, not scientists.

SMITH: Well, your sense was—and this is, of course, understanding, you weren't that involved. But your sense for it was that there were a lot of people—Public Health Service, Ed Brandt, and the CDC—who were concerned about trying to get an answer to this.

HELMS: Oh, yes. And also public education.

There was a big fight about a brochure that Dr. Koop and Dr. Brandt helped prepare to educate the public on very basic information about HIV and AIDS.

SMITH: But the brakes were being put on over in the White House and this was the kind of the religious right and people of that sort.

HELMS: I didn't know them. All I knew was that they didn't like the brochure.

SMITH: Well, the next major development is when you begin to get the Waxman–sponsored reforms extending coverage to pregnant women and children. My sense is that a lot of the initiative for that was coming from the Southern Governors Conference and people of this sort, also from Congressman Waxman. But again, was much happening at the level of ASPE or HCFA?

HELMS: Well, I would have to say there was some—there was some activity. There were always concerns about the cost of these things. Waxman was viewed as a very clever guy who was always able to get in a little expansion of a program here and there over the years.

They were always under the radar screen, but added up to program expansions. Nobody had the political courage to take them on one item at a time because it was like, when did you stop beating your wife? We are talking about pregnant women and children here.

SMITH: Yes.

HELMS: Within the Department there was probably some actual support for some of these things. I mean, it wasn't like whatever Waxman did we were going to try to kill it.

But there was always this notion that if you could do it in a way to give the states some options and do the things that people wanted to do, the view was to cap the budget and tell the states to reallocate it as they wanted to. But I think I'm right that there wasn't a lot of specific studies or analyses of things, though there probably were some. I can't remember them exactly.

SMITH: Well, again, this checks with my sense for it that a lot of the action is not there. Much of this is happening between Congress and the advocacy groups and the National Governors Association and relations of that sort.

HELMS: Apparently.

SMITH: And other people are reluctantly going along, probably not sensing at this stage quite what all this incrementalism adds up to.

HELMS: That's right in terms of the budget. But I think there were some analysts or actuaries that were concerned about it. Certainly the budget people at OMB—David Kleinberg and his staff were concerned about it.

SMITH: One other big episode that you probably had some involvement with would have been the Medicare Catastrophic Act and then the repeal of that act.

HELMS: Yes. And that's where you've really got to talk to Joe Antos about that. Tom Burke brought him over from the Council of Economic Advisors. And he ran a task force that was putting together the catastrophic proposal.

But that was under Bowen later on after Margaret Heckler left.

SMITH: Was there a sense with the Department that this was largely to make Bowen happy?

HELMS: It was really being pushed by Tom Burke, who was Bowen's Chief of Staff.

Joe did a lot of the analytical work on it. ASPE was quite involved also. I personally didn't like some features that Tom Burke was pushing, primarily, the way it was financed.

By the way, you have to remember that early on, under Schweiker, we had developed a catastrophic proposal for Medicare. It would have added a catastrophic benefit and financed it by more deductibles and cost-sharing up front.

We had gone through an early '80s exercise in trying to get catastrophic coverage in Medicare. Those of us who were involved in the earlier effort saw it as a better approach than the way Tom Burke wanted it and the way the Catastrophic bill finally got written.

SMITH: What was it in particular about the Tom Burke version that—

HELMS: Well, I'm trying to remember. It was mainly the financing. You have to remember that when Bowen came in and said—and Bowen's history had to do with his first wife who died when he was governor. So, he had a personal concern about Medicare not covering catastrophic expenses and wanted to change it. I think the White House told Bowen, "Okay, you can do it." But the deal from the start was that OMB and the White House basically said, "We are not into creating new entitlements here. Whatever you do you have to come up with a way to finance it. In other words, it has to be self-financing."

That little provision really was its downfall in the final analysis. Because my version of what happened was that Tom Burke came up with this tax, which he wouldn't call a tax. It turned out to be a tax on people who pretty much already had coverage. As a Democratic staffer later said, "Once the President let that train leave the station, it was just a matter of how many boxcars we could hang on it." Basically, what the Administration proposed was relatively low cost compared to what the Congress finally passed. The two big boxcars were a drug benefit and a long-term care benefit.

Now, you go back to this original agreement. You had this tax system set up, this surtax, under this agreement that whatever you passed had to be self-financing. You couldn't add more to the financial burden of Medicare than already existed, the payroll taxes for Part A and the general budget financing that was paying for Part B. You had this mechanism set up and then you add these two big cost items, so what you had to collect from this tax went way up.

There was a separate battle going on about the difficulties to even estimate what this thing would cost because nobody had any good evidence about the effects of cost sharing or what a drug benefit would cost. And there was a major analytical battle going on between CBO and the actuaries and others. That's my historical account of how the self-financing principle killed the bill. Once it got to the Hill they added some major cost items on, which had to be borne by this tax.

The actuaries kept upping the estimate of how much money this thing would cost, which meant that the tax had to be raised. Then you had all these political groups who were complaining about the burden of the tax on the seniors. So, after it was passed, the tax burden led to its demise.

SMITH: And the sort of after-sting of this act was that the states got stuck with no pharmaceutical benefit and taking care of the dual eligibles. So you create a long-term, major problem for the states.

HELMS: You sure did. But Joe can give you his own interpretation of the history of the Catastrophic bill. What I remember was at our initial deal with OMB was that we had to come up with a way to pay for it. We couldn't add to the existing Medicare burden. And that principle turned out to be crucial.

It affected the size of that tax and the incidence of that tax by hitting some elderly who mostly already had this coverage. So their view was they were paying a lot of money and not getting anything for it.

SMITH: So then you left at the end of the Reagan Administration. That takes us down pretty much to 1989.

HELMS: I actually was there a couple of months but I didn't try to stay.

SMITH: Did you have any particular involvement in the nursing home legislation? That came in '87 with a follow-on in '89. That was very important, of course, for Medicaid.

HELMS: Yeah, but tell me—I know we were involved in it but tell me what it did.

SMITH: Well, basically what it did was to set up a lot of standards about care. And it was extremely specific about staffing standards and conditions for certification and inspection and et cetera, et cetera.

HELMS: Yeah, I think ASPE tried to play a role in terms of objecting to that kind of approach to it. You know, it was not a federalism approach. It was not deregulation, and so on. By the way, I should just mention this history.

One of the first things I did under Rubin when I got there was to head a Departmental task force on Medicare deregulation. And basically we tried to reform what was called the hospital conditions of participation regulations.

We took an approach that they were a set of very complicated, detailed specifications of what should be done in the hospitals. This was mostly Medicare. It wasn't Medicaid.

And we tried to use an approach to simplify the way these things were written and say here is the outcome we want. You decide how you get there. In other words, we were not telling them how big the refrigerator had to be.

We were trying to say you had to provide safe food or something like that. And of course we got every special interest group in medicine mad at us, especially the dieticians. I remember the medical librarians because we took out the requirement that small hospitals had to have a medical library. And the medical librarians got all upset with us. The dieticians were upset and a lot of others because we were trying to take out detailed rules that some of these people believed in very strongly. It also protected their jobs.

That's not strictly Medicaid policy but I was involved in that early effort. And we did revamp the way they were written and we certainly reduced the number of pages of regulations.

SMITH: And so it seems that there are whole areas, particularly areas involving Medicaid, in which what was frequently significant was an initiative on the part of Congress with strong objections from OMB. And initiatives maybe got through and maybe they didn't, but a great deal of what we would think of as policy, the normal and proper kind of policy process through the executive departments, didn't take place.

HELMS: In the Medicaid, the nursing home thing, I think you are right. You didn't have a Secretary or politicians who were willing to take it on to that extent that you would really have an all-out fight against these things.

And Secretaries like Bowen are fighting a lot of battles and you have to pick and choose which ones you can fight. He was pushing for the Medicare Catastrophic Bill.

SMITH: What was your sense in that respect? Because I had an interview with Schweiker and I was impressed, I must say. What was your sense of Schweiker as a leader of HHS?

HELMS: Well, I wish he had stayed. He was, in my view, a very good Secretary. He was knowledgeable and willing to try to learn things about the Department.

But I think he was frustrated dealing with the White House and OMB. I was disappointed he didn't stay longer. But he had this opportunity I think to go off and head the life insurance institute.

SMITH: Well, one big shift, it seems to me, taking place is that policy is increasingly politicized and is increasingly made by agencies like OMB and the White House. And that's got to be frustrating. I mean, Schweiker came in and he thought he was supposed to run a Department.

HELMS: Yes. Well, I think Tommy Thompson has some of the same frustrations.

But in a sense he has put his own stamp on policy. He was picked because I think the Bush people wanted somebody who would push his kind of federalism, that is, give the states more latitude.

SMITH: Well, maybe we could shift a little bit to what your own perspectives would be about what to do about Medicaid.

HELMS: Well, you made a statement I wanted to comment early on that AEI hadn't been very involved in Medicaid and I wanted to just make the point that when I was in the administration Jack Meyer was running health policy in the early '80s here. And they actually did at that time a number of publications. I was not involved in them. Jack Meyer is somebody, you

know, you might also want to talk to about these things. He calls it Economic and Social Research Institute now, ESRI.

AEI has relied on outside academics and we look under the lamppost, that is, where the research is.

I am the first to admit that there aren't many academics that do a lot of research on Medicaid

This gets back to Dave Cooper's observation that it is hard to be an expert on Medicaid because these programs are so complicated and different.
The other big problem with doing research on Medicaid is that the available data on this is not very good. Joe knows a lot more about this data problem than I do. But it's an explanation I think as to why it's so difficult for people to do good research in this field.

My view is Medicaid is a real mess both in terms of state and federal policy. It needs some good studies with some careful attention about what to do about it.

Philosophically I like the federalism approach—give the money to the states and let them come up with the program. I mean, the rules and regulations of Medicaid, in my view, are a perfect example of what happens when you politicize a program.

It's gotten into lots of micro management by the Congress, requirements to do this and that politically popular thing. But is also the set of benefits that nobody could afford to buy, in other words, the mandated benefits that really get written into this thing make it very difficult for a state to make logical tradeoffs.

Getting back to the notion of efficiency, if you could really set up a system that would let the states do this in a more efficient way without having to worry about all the details of covering all these benefits and also the reporting requirements, they could devise a much more efficient system, maybe copying some ideas from private plans—but not in every state, because a lot of states that are rural just don't have these kinds of delivery systems.

SMITH: Are there any major steps that might make what you are talking about happen? For example, I think one change that could make a lot of people in the states happier—and maybe even get things set up a little

better with the feds, would be if there was some way that some of this burden of the dual eligibles could be taken off of the backs of the states.

Then you could say to them, okay, you are managing for a lot of your own citizens here and you've got enough money to do this, especially if you are a little more efficient about it. And it's not going to be the case that grannies are going to be put on the street or that people with total disabilities are going to be liquidated because that is going to be taken care of. But it does seem to me that would be one major stroke that would make a big difference.

HELMS: We have published a number of studies about the use of tax credits. Tax credits are a way to transfer money without creating a new welfare bureaucracy. To administer a new voucher system with income standards would be bureaucratically very difficult to do for the federal government. The appeal of tax credits would be if you could separate out different populations. The hard-core disabled, the mentally ill—you are just going to have to take care of those people. But if you could use a tax credit for lots of the working uninsured you could take care of a lot of the Medicaid problem and give these people purchasing power and let them go out and purchase different kinds of plans. And that would take away a lot of the burden for the Medicaid program and let them concentrate on the disabled, the really poor people, the kinds of people who aren't in the work force or that you would not expect to go out with a voucher and purchase their own insurance.

When you look at the numbers, about half of the non-insured, something like 25 million, are either working or dependents of working people. If you could let this tax credit be used to buy into an employer's plan or a state plan, you could simplify Medicaid's problem.

SMITH: Well, it seems to me a lot of our hang-ups at the present time—at least from the partisan point of view—do come from the fact that the Democrats in particular are terribly concerned about this hard core that has to be taken care of. And on the other hand Republicans in many cases are saying, "Yeah, but that's not efficient. And what about the working poor, and so forth?

HELMS: Well, you've always got the definitional problem of how to define the truly needy. I try to say in talks that if you go back in the history of the church and the early role that it played before governments became [], there was always a concern about taking care of truly helpless people.

What happens when you get into politics is the most votes are in the middle class so politicians basically want to use these programs as a way to buy votes from the higher income and the middle class.

There is a legitimate concern about taking care of truly poor people, for example, the severely mentally ill. Somebody has got to really take care of them. But where do you draw the line?

I think Chuck Hobbs is a person who is under-appreciated in terms of what he did to start the movement toward welfare reform. He went to all these efforts in the Reagan years to set up this system of state experimentation. Later on it created a desire on the part of the states to get more latitude and freedom. And I think it led to a lot of the political support for welfare reform. If Tommy Thompson is successful in creating more of this kind of state flexibility under Medicaid, is that going to create a situation that may lead to Medicaid reform?

I will leave it to you political scientists to answer that. Is it going to lead to more support for breaking down the federal rules and going to more state flexibility under a different system?

SMITH: Yeah. And of course you, being an economist, could see that a big part of the hang-up, at least right now, is this just kind of triple whammy that has hit a lot of people in the states. And when they put forward this most recent proposal and say how we'll give you a certain amount of money with increased flexibility and some immediate help. People in the states said, yeah, but we've got—we really get it in Medicaid because we've got the rising medical care costs and we've got the pharmaceutical benefits and we've got the big drag on Medicaid with unemployment and we've got reduced incomes within the states. And that leads to a feeling that they are coming unraveled.

HELMS: Yes, sure.

If they pass the Medicare drug benefit I do think that will help the states, especially if the Feds pick up more of the cost of the dual eligibles.

SMITH: That might be a very big help.

HELMS: On the other hand that's one of the big cost drivers on the federal side because you've got the financing problem of how are you going to pay for that.

I'm not at all convinced that they are going to come up with a compromise and this thing is going to drag out—

SMITH: Some of it seems to be difficult maybe technical problem, looking at this donut [hole] that they have in it. Why is that there? I was told the first time around that's there because that's what you had to do to get it within the $400 billion mark. Other people seem to think that a major reason for that donut [hole] is they may be worried about the unraveling of the employer.

HELMS: Well, that's part of it but I do think it was mostly a cost-driven thing. I am glad that they kept with the concept of catastrophic. But, of course, they wanted something up front to appeal to politicians. If I were designing it I would have more cost sharing up front and just have the catastrophic start lower. If the Congress is willing to put more money into it, you can then lower the catastrophic threshold.

That's not appealing to large numbers of people. When you look at utilization data, the catastrophic expenses only occur for the small number of very sick people. If you want a benefit that covers a lot of people, you had better start down low. So, I think they have two political objectives and the only way to keep the cost down is leave the gap in the middle.

SMITH: Maybe that's a good way to think about it.

HELMS: Well, I'm sure there are things that I could add. I don't disagree with your characterization that Congress just kept adding little things to Medicaid that people didn't pay a lot of attention to. But in my view it's clear Medicaid is, in terms of the federal budget, a major problem in its growth and its projected growth.

At some point they have got to face up to it. If you take Medicaid and Medicare and Social Security together and look at what has happened in the entitlement side of the budget relative to the discretionary side, it makes me wonder about the future of politics. I understand why politicians who have to get reelected every two years or six years do not want to worry about the long-term financial viability of Medicare.

They know it's a problem out there but why should they take the political heat to doing anything about it right now? If the actuaries are even approximately right about this thing, tell me what happens when entitlements keep eating up more of that budget and it begins to take away

not just the pork barrel things but defense, education, and highways—all the things that politicians like to tell their constituencies that they're doing.

There's always a long list of pork barrel projects. Every district has members of Congress trying to get people a few hundred thousand dollars for this and that project. All those things add up. I see entitlement expenditures as a threat to what politicians like to do. It seems to me somewhere along the line they have got to pay attention to this.

They have got to eventually recalculate the political cost of doing nothing about entitlements. But I can't get anybody to tell me how they think the politics of that is going to play out.

SMITH: Well, it's interesting. It seems to me that that goes right back to the beginning of the republic, with a very big concern about how do we get some people in here who will think about the long term, i.e., the Senate, that sort of thing.

As well as representatives who will be responsive to what is happening to people right now, i.e., the House.

HELMS: Yes.

SMITH: And of course they succeeded to some extent in finding a solution.

But not enough.

It does seem to me that one of the things that we have lost with the kind of declining role of the Department in making policy has been a certain amount of rationality, concern about institutional history, what has happened in the past, what may come up.

HELMS: I am sure Barbara would tell you this, too. But the Department has lost a lot of that institutional memory in terms of the career staff that used to be around and knew a lot of the history.

SMITH: “Yes, minister.” All of these mistakes have been made many years before.

HELMS: Right.

SMITH: Well, thank you very much. I really appreciated this and I look forward to seeing you.

HELMS: I have enjoyed it.

INTERVIEW WITH DON HERMAN
JUDY MOORE AND DAVID SMITH – JULY 17, 2003

SMITH: This is an interview with Don Herman, with Judy Moore and David Smith doing this taping. This interview is by telephone and this is July 17, 2003.

We wanted to talk with you about some of the earlier days of Medicaid. I understand from Judy that the states weren't geared up for policy development or for oversight of these programs.

MOORE: I told David, Don, that you and I had talked earlier about the fact that the states really had contracted out a lot, if not all, of the program in the first decade or at least the first five years. I thought if we could go back over that experience. I know you weren't there for the whole thing but you were there early on, I think in the '70s. So that's the first thing to talk about. And actually you might want to start out with mentioning your association with the Medicaid program and when it started and how long it lasted just to put it all in context.

HERMAN: Okay. I'd be happy to do that and at any point that I'm getting into too much detail just let me know and we can move on from there. I began my career in Medicaid here in Iowa right out of college.

It was my first job and I started with the Iowa Department of Human Services in 1971 working in the Medicaid Agency, initially as an auditor traveling around the State of Iowa conducting audits on providers participating in Medicaid.

During that time Medicaid in Iowa was almost—you could say being administered by the local Blue Cross and Blue Shield Plan. What occurred in Iowa is that when our enabling legislation was passed in 1966 those individuals—and there were only a handful of them—who were working on Medicaid in Iowa looked around and said, "Who can help us with this?"

The logical answer to that was Blue Cross and Blue Shield of Iowa because they had in place a relationship with the provider community, of course, through Blue Cross and Blue Shield. They also had been selected as the carrier for the Part B Medicare program as well as the intermediary for the Part A Medicare program in Iowa. So an agreement was entered into between the State of Iowa and Blue Cross and Blue Shield of Iowa for

administration of Medicaid. And it truly became administration of Medicaid in that they were not only processing the claims but they actually were interpreting federal law and applying policy and utilizing of course what they were learning in Medicare and applying much of that policy to Medicaid.

I don't think that there is anything particularly unique about that in Iowa. I think that there were a lot of other states doing the same thing because states were not staffed up and not ready for implementation of Medicaid and so they needed a system.

SMITH: You would think that it would really be the norm rather than the exception. There would be some states like Michigan that we know got on top of this very quickly and New York did and so forth. But probably where they had strong departments of public health or there was some history of these things.

HERMAN: I think that's right, David, and there were a handful of them that made that decision early on to put the resources into it and to act as their own fiscal agents. So they did get their arms around the program much sooner. In Iowa the turning point for us was when we implemented our first MMIS, which we did in 1978.

We put it out for bids because that was the first time we had a system. Up to that point the claims processing system was a proprietary system owned and understood only by the Blue Cross and Blue Shield plan. So when we developed our own system and put it out for bids we then selected another contractor whose bid was substantially less than the Blue Cross and Blue Shield bid.

And it was that step that became the impetus for the Department of Human Services in Iowa to staff up our Medicaid Program. And frankly, we were forced into that situation because we were turning it over to a contractor whose business was electronic transaction processing.

They were looking for us to provide the policy and the interpretation of policy to them. So that was the point at which we really began to take over and understand the program in Iowa.

SMITH: Now, how much and how effective was the federal prodding at this point? There were some people at the federal level who were very concerned about getting MMIS systems up and running. Was this pretty

much the impetus coming from within Iowa or were you being prodded along by the feds?

HERMAN: Oh, we had certainly been prodded by the feds. We had had that visit from the regional office at the time they released the General Systems Design—if you know the term “blue books” which I’m sure you do.

SMITH: Yes.

HERMAN: That was the original MMIS design that the federal government had contracted for. And so from the federal level there were teams that went out to each state and introduced the states to that MMIS design and encouraged those states to implement.

Of course, the real incentive there became the legislation that provided the enhanced administrative match for implementation of an MMIS, both the 90 percent implementation monies and the 75 percent operational monies.

And then we also are very fortunate here in Iowa to be in Region 7 and I cannot say enough positive things about the Kansas City regional office. Over the years I think we have had an excellent working relationship and they were not just there prodding us to implement an MMIS but they were there to help us.

I was instrumental in that process because that was my second move within the Medicaid agency in Iowa. After auditing providers for a number of years, I was given the opportunity to become project manager on implementation of that MMIS and we received a lot of support from the regional office. I remember very well the personalities who were involved at that time and they were very supportive of us.

SMITH: Really without your own machinery and data gathering and cross checks and things like that in your computer program you had no way of knowing what was going on?

HERMAN: Oh, gosh, and the feds didn’t either, David. I can’t imagine how they could. At that time, my recollection is, we were submitting data to the feds on the old NCSS 2082 format. We sent them an annual statistical report in hard copy. But who knows how close states were to following the definitions that were to be used to produce that data.

And we at the state certainly didn't know. That was sort of that black box over at Blue Cross and Blue Shield. And this is not to be critical of the Blues because they were there when we needed them but the reality is we did not have control over or understanding of the program or the data that was being produced.

SMITH: You wouldn't know whether services were actually being performed would you?

HERMAN: Well—

SMITH: You'd have a bill.

HERMAN: —sure, we had a bill and we paid those bills. We had a relatively high degree of comfort that services were being provided because of the fact that within their own line of business at Blue Cross and Blue Shield and within the Medicare line of business there was some auditing going on.

And that was the reason that I had been hired at the state, although the number of providers that I as a single auditor was able to get to was rather miniscule. But we did focus on high dollar volume providers. That was back in the days where the only rationale you had to audit a provider often times was the amount of business that they performed under Medicaid.

But it's true there was no surveillance and utilization review system, which of course became part of the certified MMIS. There was no such system in place to assess and to rank providers against one another.

SMITH: How long did it take from when you really started going on this to get a system in place and functioning without too many hitches?

HERMAN: We started that effort in 1977. We released an RFP for development of the system and hired a contractor. And we actually implemented—I think I said 1978 earlier but I believe we actually implemented the system in January of 1979. So we were close to three years from the time we had started the effort to implementing the system. And it may be relevant to note that we implemented that new MMIS into Blue Cross/Blue Shield's shop. We implemented it on their computer system using our contractor's assistance

But it was throughout that process of designing the system when we at the State of Iowa began to fully understand our program because we rewrote

our provider manuals. In order for us to provide direction to our contractor we had to understand the programs.

So I and my staff on the implementation team spent an awful lot of time at Blue Cross and Blue Shield. I remember those meetings well where we were over there picking the brains of the staff at Blue Cross, learning the program and then transporting that information to our contractor as well as turning that information into new provider manuals.

By that time Iowa had an administrative procedure act so of course we were writing administrative rules. And it really helped us develop our initial set of administrative rules.

MOORE: So as things settled down with the MMIS, presumably you knew more about the program and where your funds were going and so forth. What kind of priorities grew out of that and what were your concerns then in the '80s?

HERMAN: A couple of things, I think, occurred at that point in time. One was understanding our program and having greater control over the program gave us the incentive to look for a more cost-effective way of processing claims. So we put the fiscal agent contract out for bids since we then owned the software, owned the MMIS.

It was at that point, which was in 1980, that we selected a new contractor, which was of course very, very dramatic. The state agonized over making that decision to switch from the local Blue Cross/Blue Shield plan to an out-of-state organization, which at that time was SDC or System Development Corporation.

We made that decision in large measure because the bid was so much more cost-effective. And we had done a lot of research on the organization and we were comfortable. And it turned out to be a very good decision.

So I guess that was the first priority after implementation of the MMIS. I think our second emphasis was to determine what the data coming out of the MMIS was telling us.

The financial and statistical data helped us identify where our dollars were going and where we ought to begin concentrating in terms of cost containment because at that point in time—like every state's Medicaid

program—ours was growing faster than health care in the private sector, which in the early '80s was growing significantly.

SMITH: Now, around '74 and fairly far into the implementation of MMIS, there's a lot of noise about fraud and abuse and you get almost the impression from looking at some of that—if you just read the congressional hearings—that people are thinking that the program is crumbling and so forth. One reaction would be that maybe this is hyping it a bit to get people mobilized. How did that seem to you? Did you feel mostly that there were some inefficiencies and missed opportunities or, more dramatically, that actually you were sitting on top of a lot of fraud and abuse?

HERMAN: I don't think that I would characterize it as a feeling that there was a lot fraud and abuse going on. There were some areas that came to our attention. But I think as I reflect back on that it was probably a natural part of implementation of a new program where the scope and the intent are yet to be known. What the health care community at the time believed was the norm in medicine sometimes conflicted with government's intent.

Now, does that sound like we were blasé about it and let it go on? No, because I think that any time you implement a program of that magnitude which involves health care you will have providers who are still feeling their way along because they weren't getting a whole lot of direction from us about amount, scope and duration of service.

So I think it was to be expected that there were some situations that would occur that we wished hadn't occurred, some abuse situations. But it was part of developing the program.

Frankly I don't think that we were seeing a lot of excess utilization on the part of the client population. But I guess two examples of providers who took advantage of a situation where the loopholes had not yet been identified and closed come to mind.

One is in the area of nursing homes because at that point in time we didn't yet have a long-term care program. So what we were providing in Medicaid was skilled care. And the issue for us in Iowa had to do with the reimbursement methodology.

Here again this was part of the fact that the Blues administered the program for us. For those services covered under both Medicare and Medicaid we simply allowed them to apply the Medicare reimbursement methodology.

And we had several corporations that built facilities where depreciation became a major issue. They were able to take large amounts of depreciation and then sell the facilities. The reimbursement methodology then allowed the new owner to set up a new depreciation schedule which contributed to a lot of “churning” of facilities resulting in Medicaid (and Medicare) paying for depreciation over and over again at ever increasing rates.

That became a major issue in Iowa and our attorney general's office ultimately got involved. We did lots of audits of skilled facilities and sought recovery of funds from those facilities. So that was something that in my recollection made the newspapers at that time.

I think the second area of abuse that came to our attention was pharmacy. There were a handful of pharmacies that were taking advantage of the program. We had wholesale ignoring of the usual and customary requirement with pharmacies billing Medicaid’s maximum allowance on every item. We also had a number of high profile cases where pharmacies billed for prescriptions not filled.

That was some of what we were discovering as I was going out and doing those field audits on providers.

So that's my take on abuse or excess utilization during that period of time. At that point the client community was too new into it. I really don’t attribute significant abuse to the client population.

SMITH: Certainly, it's not the sense you get from some other places. California, for example, where the Mafia was encroaching in some areas. And in New York in some cases Medicaid was almost being overwhelmed in New York City. But nothing like that in Iowa?

HERMAN: Not good old clean Iowa.

SMITH: What about a state like Minnesota? Would it have been pretty much the same kind of situation in Minnesota or were they more ahead of the curve?

HERMAN: You know, you would want to talk to Mary. But Minnesota served as their own fiscal agent. And therefore I suspect they probably were ahead of the curve. They developed their own claims payment system in conjunction with whoever their Medicaid staff was at that time. And so I

suspect that they had an opportunity to put some better controls into place than we in Iowa, for example, who were not acting as our own fiscal agent.

SMITH: Do you have any kind of estimate of what number of states would have been more or less in your situation and what number would have been like New York and Michigan, Minnesota?

HERMAN: Oh, I can only venture a guess on that. Let's see. After I left the State of Iowa at the end of 1999 I went to work in an organization that is in the Medicaid fiscal agent business so I became a little bit more acutely aware at that point of who was using a fiscal agent and who was not.

And I think there were approximately 15 states that were acting as their own fiscal agent and the balance of them had contracted it out. I think that's the best that I can provide.

SMITH: Now that's in 1999?

MOORE: Yeah.

SMITH: My goodness.

MOORE: And it's hard to know how that changed over time because there might even have been more states acting as their own fiscal agents in the '70s, or actually more in the '80s and '90s because states began to try to contract that out so they didn't have to have as many state employees.

So that would be something don't you think that might have changed up and down over the years?

HERMAN: That would be an interesting piece of information to know or to dig out. You may be right, Judy, in that, early on, there were more states acting as fiscal agents. And then as the private sector got into that business and it became more competitive there were states who then decided to let that business out because the private sector had become very efficient and could do it less expensively than the state could. And, yes, there's that issue of state governments who were also attempting to downsize.

SMITH: Over the years you would think that inevitably the state governments would have learned more about their priorities and be prepared to say we want this and that, and we want some data from you and so forth with respect to their fiscal agents.

HERMAN: I think that's correct. I think it made all the sense in the world for us in Iowa, once we had developed that MMIS, to put it out for bids. And the State of Iowa has actually changed contractors a couple of times since then because the business became more competitive and contractors were more responsive.

There is no reason, now, for a state not to write an RFP and be very explicit about what they want in the way of the system, and what kind of add-on services they may want. In Iowa we had taken it far beyond the mere processing of claims. We were practicing business process outsourcing before the phrase was created.

We had asked our fiscal agent to do many other things beyond supporting the MMIS software such as provider enrollment, providing a complete medical staff including RNs and full-time physicians, conduct prior authorization, and auditing and cost settlement services.

SMITH: From the examples you've cited, in one case you don't know enough not to outsource but then you'd better learn as you go along so you know enough to outsource.

HERMAN: Yes.

SMITH: Yeah. That's a very instructive piece of history. I must say I don't think that most folks are aware of that part of the history of Medicaid.

HERMAN: You really do raise an interesting question there about what the pattern has been over the years. For those who use a fiscal agent I would venture to say that they have virtually all expanded the role of their contractor. Because rather than hiring state staff it's much easier to contract a piece of work out.

MOORE: It really would be interesting and I don't know—it would be hard to find that information. There probably are some people in HCFA/CMS who have been around long enough to remember some of it but I'm not even sure their files would be clear enough on that, you know, going back 20 years, 10 years, to track it.

HERMAN: I agree. I think that the best opportunity would probably be to find an individual who has a good memory and interview them.

MOORE: Well, there would be people in regional offices.

HERMAN: Yes, I recommend Vince Cain who is out at Region 7. I think that Vince would be one of those people who could do the best job of reconstructing the issue.

MOORE: Right. Interesting. Okay. Were there other priorities or concerns over the years that you wanted to highlight?

HERMAN: I want to talk briefly about the home and community based waivers. After you and I visited earlier, I did go back and refresh my memory on that. It was an exciting time for Iowa because Katie Beckett was from Iowa and it was her case that provided the impetus for the HCBS program. However, Katie was never on the HCBS waiver program because Katie was one of those granted an exception to SSI eligibility criteria as there was no HCBS legislation at that point in time.

MOORE: Yeah.

HERMAN: And so working with then-Congressman Tom Tauke at the federal level, I believe there was a review board set up. They reviewed cases for exceptions to policy and Katie was granted an exception. So she was given a one- dollar SSI grant and therefore was never on our HCBS program. But when President Reagan signed that legislation in '81 or '82 then we in Iowa did apply for a waiver.

In fact, we applied for two or three different waivers at the time. We were turned down on all but our ill and handicapped waiver. We did a model waiver with 50 slots. That program was slow to build because families out there knew virtually nothing about the program.

In Iowa we have 99 counties and all of our intake occurs out at the county level. It was difficult for those of us in central office to prepare all of those caseworkers for the small number of cases that might come in that would be eligible for the waivers. But what really made the difference in Iowa is Julie Beckett and the excellent advocacy she has done over the years. She worked with the University of Iowa and they developed a home care monitoring program or case management program.

And so there were staff at the University of Iowa, including Julie, who were working with families and helping families to understand the waiver and what might be available. It took some time. It took literally years—probably two or three years after we had received approval of that model

waiver—for us to ever fill those 50 slots and then begin to expand the waivers.

MOORE: And say again, Don, what that first waiver that was approved was called? I misunderstood.

HERMAN: The ill and handicapped waiver.

MOORE: Oh, ill and handicapped. Okay. Then after that one was filled did you slowly move into some other kinds of waivers? And was it a slow progression towards home and community based care that is still ongoing?

HERMAN: It was that. We did submit amendments and expanded the number of slots in the ill and handicapped. And at that time they could be either elderly or they could be children. Initially far more of the slots were being filled by elderly, than they were by children. And again, part of that was families with handicapped children who were accustomed to taking care of those children themselves and there wasn't a lot of awareness out there.

It was a number of years later before we made another attempt at submitting an MR waiver.

I believe it was approximately 1986 before we resubmitted and received approval of an MR waiver. I think there was a much stronger advocacy community already out there for the MR population. And once we had designed that program and put it in place it grew fairly rapidly.

Of course, waivers are very difficult to administer. I know my colleagues back there at the Iowa Medicaid agency are still struggling with the administration of HCBS waiver programs. But over the years, then HCFA, now CMS, has understood that and have worked with states in attempting to simplify those programs.

SMITH: I don't know whether you saw this most recent GAO report saying that a not very good job was done of oversight of these home and community based waivers.

HERMAN: I have not seen that report, no.

MOORE: They were questioning oversight for quality purposes as much as anything else.

HERMAN: Oh, gosh. I can relate to that because it was the difference in night and day between the waivers versus institutional care. In the institution we were pretty darn good at monitoring quality because you had a captive environment there. And so we were light years ahead, although that's not to say that our quality monitoring programs in institutions cannot be improved.

You know, we've gone through, between the states and the Feds we've gone through numerous cycles and lots and lots of meetings and debates about the ICF/MR program. But the fact of the matter was we did have some pretty decent monitoring programs. On the waiver programs where do you go? What do you do?

How do you go about assuring that these children who are living out there in many cases with their family, how do you assure that quality is being met?

SMITH: Yes, yes. You would almost have to plant a TV in every room, wouldn't you?

HERMAN: Almost, yeah. And what we ultimately ended up doing in Iowa—well, it varied according to the waiver and in the MR Program we developed our own MR quality review teams, state employees who did literally visit homes or in the case of the small ICF/MR or other group homes, visited them.

In the case of the ill and handicapped waiver we used a two-pronged approach. One was we had entered into an agreement with the University of Iowa who had developed a case management program. And then we also entered into an agreement with the Iowa Foundation for Medical Care, which was serving as our PRO.

We entered into an agreement with them to provide medical teams to go out and periodically literally do a review of these individuals who were living at home.

MOORE: Uh-huh.

HERMAN: But I can remember many conversations about the ICF/MR program. I can recall many discussions with HCFA and then CMS about that program and that always led us into discussions of quality for the waiver program.

MOORE: I think for the record you need to tell us the years you were Medicaid director because I don't think we got that—we got you to the MMIS project directorship but we need to have in our notes here the years. And I know you left in '99 but I don't know when you actually started. It was in the '80s there, wasn't it?

HERMAN: I had the good fortune of being appointed as the Medicaid director in February of 1984 and served in that capacity up through December of 1999.

MOORE: A good long tenure.

HERMAN: Well, there are several that have more. Barbara, of course—

MOORE: But you were—

HERMAN: And I think Ray then ended up—Ray Hanley ended up with more than 16. I think the other one is
Phil—

MOORE: Phil Soule.

HERMAN: Phil Soule, yes. I think Phil must have well over 16.

SMITH: We hear a lot of people lamenting the fact that it's not becoming a long-term occupation.

HERMAN: It is not. Of course, that has something to do with how the positions were placed. In many cases those were appointed positions. I was not—I was an exempt position here in Iowa,—not appointed by the governor—but rather, worked at the pleasure of the Secretary of the Agency. And I was just fortunate that those I worked for were always very supportive.

MOORE: Well, thank you so very much for your time. I'm sorry, did you have another question?

SMITH: No, I just wanted to express my thanks, too. It's been extremely useful.

HERMAN: Well, you're welcome. I hope it's been useful and I enjoyed doing it.

INTERVIEW WITH THOMAS E. HOYER, CMS, AT THE NATIONAL HEALTH POLICY FORUM, BY JUDITH MOORE AND DAVID SMITH – JANUARY 14, 2003

SMITH: We thought maybe it would be helpful for us if you would just briefly review your career, particularly your career—

MOORE: After the Army was behind you.

HOYER: All right. Well, I started in the Bureau of Health Insurance (BHI) at Social Security, which ran Medicare, on January 3rd, 1972. And my first assignment was with the Health Insurance Inquiries Branch. I spent my first five months proofreading the answers to inquiries, looking up all the statutory citations, all the words I wasn't sure how to spell, and counting all the copies to make sure that everybody's copy was in place.

One of the things I learned was that a whole lot of those letters were actually read by Commissioner Robert M. Ball because they had revisions written by him in his own personal handwriting, following which, of course, no one revised them further. And after I did that for a while, I pushed the production quotas up to an uncomfortable level and was transferred to the letter-writing part of the activity where for five or six months I tried to learn the program so I could answer the letters and then tried to push the production quota up so that I would be expelled into something—more interesting.

And I was. I was sent by the end of the year to the HMO task force. Implementing the—by now it was '73 but we were implementing the '72 amendments. And it was an interesting job because it was a typical bureaucratic power play. A fellow named Jim Williamson, who ran operations, who ran a piece of the operation, had put together this task force to implement the HMO provision.

But of course before we did that somebody had to write the regulations and that was the policy component. So I spent six months reading the law, reading up on HMOs, which were all staff-based at that time. I remember there was a great Harvard Business Review issue on managed care—about 100 pages long—that I thought was exceptionally good on the subject, and which I have never subsequently been able to find.

And so we worked on it, thought about it, and about that time Nixon started getting impeached and we also listened to that on the radio and did crossword puzzles. And it turned out the policy folks were in no big hurry to write the regulations, so we realized that we would not soon be implementing anything.

And I found a job with Erwin Hytner on the PSRO, the Professional Standards Review Organizations task force. And that, too, proved a bit of boredom. I spent a lot of time studying the law and Medicare. But meanwhile there was this struggle within the Department about who would actually establish the PSROs and run them.

The struggle turned out to be won by the Assistant Secretary for Health, Henry E. Simmons. And so when that occurred, the task force in BHI was broken up and I found a job in the policy component in the Office of Program Policy working for Irv Wolkstein who really, as near as I could tell, actually invented Medicare out of his own head.

And I was in the Health and Utilization Review Organizations Branch, which was where we were supposed to be doing the Medicare piece of PSRO policy. But BHI had taken an organizational position, apparently, that this was a stupid piece of legislation, that our contractors could just as easily deny claims without the help of PSROs.

And if you will remember, BHI had attempted to do rule-making requiring hospital utilization review committees to perform pre-admission review in some cases and had had some trouble with—with the courts. The AMA sued us about the chilling effect and the judge who did the Chicago 7, Julius Hoffman was the judge.

The thing I remember about it was reading a transcript of the hearing or trial or whatever it was. And there was a great colloquy between Irv Wolkstein and the judge. The judge had said, "Well, Mr. Wolkstein, are these determinations made before admission or after admission?"

Irv said, "Well, utilization review is a process."

And so the judge said, "Well, all right. So before or after?" Irv said, "Utilization review is a process."

And after he had said it three or four times the judge said, "Well, let the record show that it occurs before.

Mr. Wolkstein, if you would like to make a speech you may use this room after we adjourn for the day."

And, you know, I worked for Irv and I thought it was pretty impressive that he never gave in.

MOORE: That he never, ever answered the question.

HOYER: But we did lose. We did lose on that. So I was at the time a GS-9 and I was in charge—actually in charge, if you can believe it in those days, of PSRO policy because the agency's thought was those morons in PHS will never be able to implement it without the strong right arm of BHI. And so they didn't put anybody important or smart on it. Putting me on it was, you know, their way of making a—derogatory gesture.

The bright spot was that, at a very early spot in my career, I really was the only contact between the early Directors of the PSRO program, Mike Goran and Helen Smits. And was expected to “comment” on all their efforts to make policy. So it was really a reasonably high-pressure situation for me because I didn't have any management. And I didn't realize how lucky I was. And I was just doing it myself—going back and forth with—if you will remember Dennis Siebert and Rhoda Greenberg and Joyce Somsack.

Joyce was their head of operations initially and then Denny was, both of them working on what the policy would be. I spent a lot of time working on a Medicare regulation, which was supposed to describe the correlation of authorities and functions between the two programs.

And also non-concurring on all their regulations about the authority of the PSRO's work, what they would do. That's what I did for three or four years. I just kept on “commenting” on all their rules till Helen offered me a job.

SMITH: Helen Smits?

HOYER: Yes. But even as a junior analyst I thought, let's see here. I’m her biggest obstacle, so she offers me a job, following which I'm at a higher grade but in a broom closet somewhere. So I said “no” and stayed in BHI with the PSRO thing. I did that for two or three years and then Califano reorganized us to become HCFA.

When the reorganization came, I became the special assistant to the guy who was running policy, Alvin Diamond, and stuck with Al through the

reorganization and learned all kinds of valuable things about how to write organization plans and job descriptions and also how to manage moving furniture and telephones to new places on new floor plans.

And I learned about Al something interesting. You know, Al was a quintessential accountant. And I would run up a floor plan and over the doorways on the plan I had written the room numbers that were actually pasted outside the rooms. Al renumbered it to reflect the logic of the building's original construction.

I said, "You know, Al, the movers are probably going to use the numbers on the door." But he was a detail person. Anyway, I did that. And Al didn't stay around long because he and Ed Steinhouse, our General Counsel, were kind of blamed by the new crowd for all the sins of BHI.

And the BHI sins were basically two sins. One was taking an unconscionable length of time to do anything. And the other one was arrogance. You know, Social Security saw itself as the only agency in the government that really worked.

And I was a new guy. I wasn't from the field so I didn't—you know, I mean I knew that that's what we believed.

SMITH: You hadn't been through the apprenticeship.

HOYER: Hadn't been seeing it. And what I had been seeing was that we had said the PSRO program would never happen and we had ignored it. And so it had happened in a way we didn't like. That was a really valuable early lesson: to never ignore anybody. And so I was a special assistant to Al and then he was replaced by a guy named Morris B. Levy.

MOORE: Oh, yeah, Morrie Levy.

HOYER: And Morrie was an interesting man. You know, they say in public policy there's kind of two ways you make it. You figure out the right thing to do and then you do it or else you accommodate.

Well, Morrie was that second guy. And working for him was kind of interesting, but he was definitely playing a defensive game. He was toward the end of his career and part of the old guard that was out of favor. The bright spot of being a special assistant was everything that came in came to me. So I was able to take off the top the stuff that interested me.

So I did all the legislation and current events. And that was a lot of fun. And I did that for maybe a year or so. Time flies when you're having fun. I'll send you a resume if you want dates. And then Robert D. O'Connor was our bureau director. You remember old Bob.

MOORE: Yeah.

HOYER: One of the three horsemen, one of Irv Wolkstein's three horsemen—and he made me a special assistant at the Bureau level. And at the time that Reagan was elected, so just before he got—I worked for him for five or six months before he got exiled to San Francisco for his role in implementing wage and price controls under Nixon. George Bush, the Vice President, was running the president's Task Force on Regulatory Relief.

MOORE: Oh, I forgot about that.

HOYER: My assignment was to be the bureau's representative to the task force. And it was an extraordinarily interesting process. Carolyne Davis was the Administrator. Paul Willging was her Deputy.

MOORE: Yeah, that's when I met you, when you were working with Paul on that reg reform stuff.

HOYER: Yeah. You were in The Office of Legislation with Larry Oday and Carol Kelly.

MOORE: Carol Kelly, yes. Patrice. Don't forget Patrice.

HOYER: Oh, gosh, yes. Idiot savant. You know, the thing they used to say about Patrice was that she had perfect nails. She had a lot of chutzpah. I'll say that for her.

In any event, the structure of the task force was interesting. What they did was, they would appoint a grade 14 analyst from every major component. I was the one for our bureau, the policy bureau.

And then all of the regulations were supposed to be examined and the analyst from the bureau responsible for the regulation would do the work. Well, the policy bureau had all the regulations.

And what you had to do was to take the rule and then do a briefing paper that traced it from its original enactment through any of its amendments and

all of the rule-making and whatever experience we had had with it, and then lay out a set of pros and cons for, you know, can it be changed, and if you change it, what would you do?

MOORE: How many were there?

HOYER: I did it for a couple of years. I did—you wouldn't believe how much work—

MOORE: Yeah, well, every single reg in the Medicare program.

HOYER: I wore out two platens on my Underwood typewriter because I did all the typing myself...

And it was kind of nice because I learned how to do the research. With The Commerce Clearing House Guide you can check all the previous amendments. You can find all the rule-making, read all the committee reports and preambles.

And my instruction from the boss, of course, was to make sure nothing changed. And we did both Medicare and Medicaid. And that was interesting because Medicare was pretty much solid as a rock in terms of rule-making.

You know, there were statutory provisions and regulatory provisions. Medicare was interesting in many respects because of the provisions that had been built into the law to stimulate the activities of the states and municipalities in getting more sophisticated. So, for example, there was the Medicare share of medical education, which had been intended to stimulate state investment and then wither away like the proverbial communist state.

You know, it never did. There was the provision for return on equity capital but only for SNF and home health. And then there was, of course, the way we funded survey and certification and where the feds bore the full freight in the hope the states would ultimately pick up a share. So those things were particularly interesting, at least the things that stick in my mind.

And we went through those. But Medicaid, which was new to me, relatively, was extraordinarily interesting because we had paid the American Public Welfare Association a chunk of money to do a study of the states on which regulations they found the most burdensome.

And they produced a book with tables and comments and I studied it carefully. And in fact, we used the book to decide which regs to do, what order. And there were all kinds of provisions like, for example, each state is required to have a Medical Assistance Advisory Committee. And it had to be appointed and it had to meet and it had to have reports and hearings.

It was pretty clear from the history that nothing much had ever come of that that was useful. Equally true, the states didn't care at all about that but they would meet forever if we wanted them to. Burdensome provision after burdensome provision had virtually no protest.

What the states didn't like was statewideness, the requirement that you have to offer the benefit everywhere in the state or else send people out of state, and amount, duration and scope. Those are the two I can think of. They mainly cared about the requirements that you pay enough to obtain the service, that the service be of adequate quality. They focused right in on the requirements that led them to spend money. And of course none of them were particularly burdensome in a regulatory or paperwork sense. And states were unhappy with the conditions of participation.

And they were also unhappy a little bit with eligibility. They were particularly unhappy with, for example, on the medically needy side, the rules that related to post-eligibility treatment of income for the medically needy because the rules that we had said that once you were eligible as a medically needy person every month you would get your ten-buck allowance.

And then you could spend whatever amount of money you had to buy services not covered by Medicaid. And then whatever was left over, Medicaid took. So it was a provision that increased the states' financial exposure for the middle class, which is what irritated them.

A more basic injustice was that the provision also made sure that in a welfare program the middle class were always better off than the poor because they could get more services. That really infuriated me. It seemed to me, you know, if you want the taxpayers to pay your freight then you ought to be on the same footing with the other people in the Medicaid program.

So that was one that interested me especially. And I remember when I presented—the way this thing worked, I'd do this brief I talked to you about. And then it would be circulated among the other analysts, who weren't doing

anything but reading my briefs, by and large. And then they would comment and I would have to redo it to reflect their comments and suggestions.

And then two or three times a week I would spend—we analysts all, but it was mainly me—would spend three or four hours with the senior staff in the conference room with me presenting the regulation in all of its glory to the senior staff and answering all their questions and assisting them during their debate.

And then they would vote, you know. It was a wonderful experience because I discovered that the difference between them and me was that they had those jobs and I didn't. And they weren't smarter, they weren't more acute.

They weren't visionaries, most of them. Some of them were pretty bright, but there were some amazing boneheads. And—

MOORE: ...senior staff, right?

HOYER: Yeah, sure.

MOORE: There were some real boneheads then, yes.

HOYER: Oh, yeah, there were. And I remember when we did post-eligibility treatment of income I argued strongly for changing the rule. And Dennis Fisher, whom you may remember, called me a communist. Steve Pelovitz started talking about the number of elderly relatives he had who would be badly affected.

By that time, O'Connor had been sent to Elba and Larry Oday was my boss. And he, of course, took my side because he is a Libertarian. But as he said to me, "You could predict those assholes would vote to leave it alone." So we went through all these things week after week and I was really working like a dog. I was working day and night on that stuff.

And we finally got through several years of my stuff and we decided to take up the conditions of participation. And one of the first things that we were going to do was to look at the deeming rules to see whether we could stop surveying nursing homes and recognize nursing home accreditation by The Joint Commission on Accreditation of Hospitals, which was pretty shabby at that point. The idea was to recognize private sector efforts where possible.

Congress was all in an uproar and actually passed an amendment prohibiting HCFA from making any change in the nursing home regulations.

The other thing we were doing at the same time was going through the conditions of participation. And our working rule was that we would simply eliminate from the regulation all the language, all the rhetoric that couldn't be enforced.

So that if, you know, if you had something that said, well, you have to employ a registered nurse, well, fine, we could leave that. You could check.

But if we had something that said a patient must be treated with respect and dignity, well—that would have to go because what does that mean?

MOORE: How do you measure that? Right.

HOYER: And if you'll think back, we had put residents' rights in the SNF conditions under Jimmy Carter, I think. And here we were proposing to take them out because they were unenforceable. I still remember Rozann Abato, who was the staff director for the activity, and I went to see Paul Willging kind of separately and said, "You know, Paul, this is not a good idea. This is probably going to be controversial and when it is the political folks are going to have to step away from it. And then the people who are going to be there are you and me."

"So let's not do that, Paul. Let's just like round up some usual suspects.

And convict them and execute them and call it a day." He said, "No, no." He said, "Carolyne assures me that they will defend me." So off we went doing that, and fortunately I wasn't in charge of that thing because the conditions were the responsibility of the Health Standards Quality Bureau.

But there was a fellow there who [told] somebody in the press like that New York Times guy, all about what we were doing day by day. And it wasn't long before Paul Willging left to take a job with Blue Cross of New York. And we dropped consideration of the conditions of participation.

And Congress then enacted a law which lifted the ban on changing the rules, on condition that we commission the Institute of Medicine to do a study on quality of care in nursing homes, which they did. Bruce Vladeck and Helen Smits were two principal members of the IOM Committee.

SMITH: —his book.

HOYER: It was three or four years after. Now, I had read the book (Unloving Care) and I actually got him to autograph it later when he was the Administrator. But anyway, the end of regulatory reform—

MOORE: So let me go back to reg reform. The conditions of participation really were dropped because of the press?

HOYER: Right.

MOORE: Speculation and the advocacy—constraints around it.

HOYER: Still, reg reform continued for a while till we got through the rest of the rules. And at the end of the process there were a couple of fairly bulky regulations reform packages that contained what would have been the results of reform were put together and massaged endlessly for years till they were dropped.

MOORE: Were there any regs that were reformed?

HOYER: Yeah, there were. I think we got rid of the state medical assistance.

MOORE: Advisory committees.

HOYER: But we did very little.

MOORE: They're still optional though and lots of states still have them. I would just like to point that out.

HOYER: Well, they would need to be optional because you wouldn't want, under federalism, to abridge—

MOORE: To require.

HOYER: —the [states]...

MOORE: I know. I know.
SMITH: But little else changed with all this regulatory review.

HOYER: Right, little else changed.

SMITH: Except it did become a pretext or at least it became a basis for Congress to raise all sorts of hell.

HOYER: It did. But, you know, it proved something to me. And the thing that it proved to me was that our regulations weren't off the reservation, they weren't exceptionally burdensome. They weren't unsupported by the statute and they weren't unnecessary. And in fact, the only ones the states really didn't like were the ones that required them to pay for the services. I mean, I went through the Medicaid and the Medicare regulations to look for things that went beyond the statute, like the medical education thing.

There was actually an HMO provision that went beyond the statute. There was an option, and it predated the 1972 HMO option provisions, for group practice prepayment plans. It was based on three or four fairly incoherent words in the statute.

And early on when we were implementing Medicare there were a number of unions that were operating basically Part B plans, you know, like the one I remember. The one I remember was the Hebrew Kosher Butchers' Union or some outfit like that. An early decision made by Ball and Hess was to prepay them and they had done that since 1966. We thought about eliminating that, but we didn't.
In fact, they never disappeared until M+C came in.

But we finished regulatory reform and then for me a couple of other things came up. Most immediately, in '81, the Baucus Amendment on regulating Medicare supplemental health insurance came in. And Peter Bouxsein, who was by then my bureau director, assigned me to write the regulations on that. And it was how I met Larry Oday. He represented Bankers Life, I think, a major insurance company.

SMITH: This was which reg you were working on?

HOYER: Medigap policies. This was the deal where Medigap policies (private policies that supplement Medicare) or, actually, where state regulatory programs for Medigap policies had to meet certain basic requirements or else the federal government would step in regulate Medigap policies—I forget which Schultz it was. It was the—
MOORE: Charlie.

HOYER: It was the economist Schultz, Charlie. You know, he always said that the best kind of regulation is the sword of Damocles regulation where the [federal] government will come in if states don't do the right thing. This was a test of that principle.

And so we wrote the requirements. And again I was in charge of it because it was important enough to do but apparently not important enough to care about. And so that was fun. You know, the insurance industry was very interesting. You know, you see these AFLAC commercials on TV.

MOORE: Yeah.

SMITH: Uh-huh.

HOYER: Well, AFLAC was either the first or the second biggest company involved at that point in offering Medigap indemnity policies. These were the kind of policies which unscrupulous insurance agents sold to the elderly, often selling one person a number of policies. They had duplication of benefit exclusions, so you could buy 100 of them and each one would exclude the other. Whichever one was left standing at the end of the day would pay you like 70 bucks if you lost a hand or 50 dollars a day while you were in the hospital.

Congress really hated that non-duplication business. And then there was in the law a requirement for loss ratios which of 95 percent for non-profits and 75 percent for for-profits. I met Linda Jencks and Larry Oday there. And I remember it because I gave Larry an exceptionally hard time and he was very shortly thereafter appointed my bureau director.

SMITH: But Larry wouldn't always listen to reason, would he?

HOYER: Well, as in the case of Tom Scully, I think he concluded that having me in the tent was better than not, so he treated me very well. I think I did Medigap regulation simultaneously with reg reform, actually. And then after that came hospice in the '82 amendments, section 121 of TEFRA. I had the good break of being assigned to write the hospice regulations.

And so I did that in '82 and '83. And that actually has been a continuous thread in my career because I have actually been in charge of hospice policy continuously from that minute until I retired. It's really kind of nice to have your own federal benefit. And I used to go meet with the hospices a couple or three times a year at their meetings. In fact, it was fascinating because I

got called into this conference room with—with—it was just about the end of Peter Bouxsein's tenure, and Duke Collier had already left. He was at Hogan & Hartson. I got called into a meeting with Peter and Duke Collier, who had come over from the firm, because he was representing an organization called the National Hospice Education Project, which was a lobbying spinoff of the National Hospice Organization, which was a non-profit—and theoretically couldn't lobby.

And he came over with a woman named Ann Vickery who was—at the time had just gotten her law degree and was a young lawyer in their wills and codicils department or something, and had gotten her big break. And so I met those two. And Peter told me that I would be doing the hospice thing.

And all of the years I've been doing hospice, once or twice a year at NHO meetings, Ann and I have had a two- or three-hour presentation where basically all comers come and ask questions and make arguments and we answered them. So—and I think actually those sessions were their major policy guidance from '83 on.

To me it was extraordinary because Ann had—I mean, I understood early in the game that this is a business of rules. And if somebody figures a way to do it to you under the rules, well, then—then it's done whether it's good or bad. Ann, lawyer though she is and God knows, she is effective enough representing people, had a much stronger moral view of hospice than simply the letter of the law. I mean, both of us were personally interested and personally committed. But she—we would be at these meetings and somebody would ask a question about whether they could do something.

And it would be a questionable something that they could do. And I would be forced to say, "Well, you know, the rules do allow you to do that. On the other hand."

And by the time I got out the words "other hand," Ann would be saying, "On the other hand, it's immoral and you can't do it. You don't want to be in this business if you're going to be doing those kind of things." Of course, we did also spend a fair amount of time fighting with one another in public and got to be fairly well known for it, actually. Anyway, I did that, and that was quite a challenge because the Administration had opposed the hospice provision.

Apparently it was enacted because Secretary Califano knew Ella T. Grasso and she had apparently offered him lodging one night when his plane was

snowed in and lobbied him all night for a hospice demonstration. As a result he had Medicare do one in '80-'81-'82. And we were about a year into doing it when the statute passed.

MOORE: This was when Califano was secretary.

HOYER: He was before Reagan.

MOORE: He started this demo.

SMITH: Yeah, he was before Reagan but in '83 you got Reagan.

MOORE: But the demo had started with Califano.

HOYER: And it was, I think, 57 hospices.

MOORE: It was a lot.

HOYER: And then Reagan came in and the hospice folks lobbied strenuously for it and they argued that it would be a saver. They said it would be a saver because they would accept a statutory provision that placed an aggregate cap on reimbursements to a hospice which would be basically, after all the legislative folderol was set aside, the cost—Medicare's cost of caring for a beneficiary in the last six months of life times the number of unduplicated beneficiaries they had in a year.

So basically their annual revenue couldn't exceed Medicare's exposure for the last six months of life. The statute made the benefit—made the eligibility criterion medical prognosis of six or fewer months to live. The benefit itself initially only lasted seven months, a 30 day margin for error. There was a requirement that bereavement counseling, which was basically counseling the family about the death and counseling the family after the death for some period of time, be provided for free and that volunteers—volunteer services—be an integral part of hospice.

You had to have volunteers to get certified and you had to maintain the effort to stay certified. And then there were a bunch of other very restrictive requirements. You know, by and large providers rent lots of their nurses from registries. It was a hospice requirement that certain core services—they were physician services, nursing services and several others I can't remember right now—but nursing and physician were key. These core services had to be substantially provided directly by the hospice. The

thought behind the core services requirement was that a home health agency or a SNF or a hospital, absent that requirement, could have simply added a hospice program as a sub-provider. But the statute was chock full of provisions that made it very hard for a hospice to be anything but independent. And so there was an enormous backlash. Val Halamandaris had hoped that hospice would be like a doubling of the home health benefit. And—

SMITH: It wasn't.

HOYER: No, it wasn't. And he never—you know, he's a visionary; and a lawyer, it turns out. But apparently, not a fact-oriented man. And he was just sure that those core services were an invention out of my own forehead and he had clouds of Congressionals raining in on us from everywhere. And the responses all had to be typed individually.

But anyway, that was very controversial. And then it got to paying hospices. The law authorized cost reimbursement or some other form of reimbursement. We were in the midst of implementing the DRG system for hospitals, and the decision was made we would also pay hospices prospectively. This was key because under cost reimbursement, since we recognized capital expenditures, we would have shared the cost of building a hospice industry from the ground up.

Whereas, if we had a prospective payment system that did not include significant capital we would only be buying the services. It would be somebody else's problem to establish the hospice.

So we developed a prospective payment system that had four rates: a routine home care rate, which would be the bread and butter staple rate, the amount of money you would get paid every day you had a patient. And then three other rates. They would be available on special days. There was basically an inpatient hospice rate for when you were an inpatient, a continuous home care rate, because the statute authorized brief periods of basically 24-hour-a-day nursing; and an inpatient respite rate.

We established the inpatient rate at roughly the cost of a day of hospital care as reflected in the hospital cost limits. For continuous home care, at the time the average R.N. wage was 13 bucks an hour, so it was basically 13 bucks an hour. And there was a threshold. You had to have at least eight hours to get that rate, so you would get 8 times 13 as the basic rate and then you could get another up to 24 hours if you put it in. And then there

was an inpatient respite rate, which was roughly a SNF per diem. Actually, it was roughly an ICF per diem. And that also was enormously controversial.

MOORE: Well, it was the first prospective rate—was it not?

HOYER: Hospital prospective payment was being—was being put together—at the same time. I mean, it was enacted before—it was enacted after hospice but hospice was—implemented before it.

So there was that issue. So I wrote the conditions of participation and the eligibility thing and Bernie Truffer worked out the payment system. And as I said, that was very controversial and I had to go around speaking to a lot of groups and meeting with a lot of people. And the Administration had opposed the law and was hoping it could pay little enough so it wouldn't happen on a wide scale.

And I remember, in fact, there was a big brouhaha over the rates because the initial routine home care rate which was based on the operating experience of the demonstration hospices was, I think, $46.85 or some amount like that. And the hospice movement really was unable to focus on the fact that you got the money no matter what. So that if you—even if you have a patient seven days you get $48 and change every day.

And you would only visit the patient twice. And you got the money no matter what.

MOORE: They didn't get the prospective part of it.

HOYER: They didn't get that and they were really mad about the cost reimbursement thing. And I wasn't getting any help with this from the management because they were opposed to it. And at some point it all went bad. And I remember Jim Scott, who was our Associate Administrator for Operations at the time, telling me that it was the first regulation that had been screwed up so badly by me that it took three Cabinet officers to fix it.

And it was basically, the Secretary of HHS, the Secretary of the Treasury and the head of OMB. They had tried to reduce the rate even lower and they got caught at it in rule-making and there was an embarrassing round of publicity, hence the involvement of other Cabinet Officers. They ended up having to backtrack a bit.

And we had adjusted it by wage index and we ended up unwisely putting a .8 floor in the wage index so that nobody would get—a rate too much lower than the rate itself.

And so that was also very interesting. And then just about the time the workload had returned to manageable levels, the Institute of Medicine came out with its report on assuring quality of nursing home care.

MOORE: At this point were you the director of a unit that had both Medicare and Medicaid—long-term care kinds of stuff in it, right?

HOYER: Right. In fact, that's interesting. We should go back to that. When HCFA was formed and nursing home reform—we'll definitely get you back there—it was Califano's notion that Medicare and Medicaid would be combined in their administration. And although he shied away from saying it publicly, the notion was that we would standardize Medicaid.

Maybe not the options the states could elect or what they might—you know, what they might do, but standardize the rules so that if there came a time when Medicaid was nationalized there would be pieces that could intermesh.

And the Office of Coverage Policy, which I was in, had three divisions: a division of provider services coverage policy, a division of medical services coverage policy, and what was called the division of technical policy, which was sort of all the other stuff—eligibility, waiver of liability, etc.

When I was doing hospice, I started off doing hospice as a special assistant to the bureau director. But shortly after I got into it I became the director of the Institutional Services Branch, which was in the Division of Provider Services Coverage Policy. And at the same time in this reorganization the conditions of participation became my responsibility. And in this Division of Provider Services Coverage Policy there were both the Medicare and Medicaid programs.

MOORE: After about '80, right?

HOYER: Well, whenever HCFA started, '80, '81.

MOORE: Well, that was '77 but they didn't mush the programs together until either '79 or '80.

HOYER: Whenever. We had them there and we had the people from SRS who had been involved, or at least the two or three who hadn't quit.

MOORE: Uh-huh, who didn't want to go to Baltimore every day.

HOYER: And it was really an extraordinary challenge because the Medicaid policy staff had all jumped ship pretty much, except for Henry Spiegelblatt, the head of it, and Milton Dezube.

MOORE: Oh, I forgot about Milt Dezube.

HOYER: And Milton Dezube had been the head of the payment side of it, the state payment plans for hospitals and nursing homes. Spiegelblatt decided he would stay in Washington as—

MOORE: Intergovernmental affairs.

HOYER: Yeah. I mean, I think he took the position that if he couldn't run it, to hell with it. He wasn't going to do it. Dezube went to the Office of Payment Policy and he was working for initially Robert Streimer. Robert moved around a lot. And he made the mistake, I think, of asserting that he was the Medicaid guy and he would continue to run it. The reigning Medicare powers asserted themselves and they never again allowed him to make any decisions. He took an early out and went to work for the AHA. But the net effect of the creation of HCFA was all of the Medicaid state plan amendments that came in and were not about payment went to the Office of Coverage Policy.

All of the ones that weren't nursing home rate setting or hospital rate setting or physician rate setting came to Bob Wren and me and we reviewed them. So at the same time I was doing hospice and nursing home reform I was doing both Medicare and Medicaid in terms of all the benefits. And there was a lot of activity in areas like personal care and, you know, and particularly interesting things.

The Reagan Administration was particularly interested in abortions and sterilizations and the thought that states might be inappropriately claiming payment for some of them. And if you'll remember, at some point the Hyde amendment allowed abortions if the life of the mother would be endangered if the fetus were brought to term.

And there was quite a business in some of the states and some of the states encouraged it. I believe Michigan might have been one of them, but my memory might be fading, with psychiatrists producing certificates that the mental condition of the mother was such that she might commit suicide.

So some states had very high numbers of abortions. And I remember I was asked to write in secret a regulation that would have greatly curtailed that. And I did write it in secret. But it stayed secret. Nobody ever had the guts to publish it. Senator Gordon Humphreys was torturing me and Henry Desmarais, a former staffer of his, who was appointed our bureau chief by the Administration. The Senator was torturing us over getting disallowances back. He thought that the Agency wasn't actually taking the money back. And at one point his staff asked us for the cancelled checks that arose from the disallowances. And we were forced to tell him it's not checks. We did send him copies of accounting records.

So I did a lot of that stuff. And Medicaid was new to me and it was fascinating. And I had, because I had done regulatory reform, I had really learned the Medicaid regs, learned about amount, duration and scope, and statewideness and the like.

And so I was in a really unique position to do it because Wren and I pretty much had to replicate Medicaid policy from what we inherited, which was a set of about 100 three-inch black binders that had been the Medicaid precedent file—where people had filed letters and papers and stuff.

MOORE: What ever happened to all that? I remember those files, binders.

HOYER: Well, I remember the binders. The binders were going to be thrown out and I discovered them in a hallway and had them put in my office and I used them for years. But what happened in the end was, you know, once I wasn't there to protect them, they vanished.

SMITH: These were the files of—

HOYER: The social rehabilitation services.

MOORE: The '60s and '70s.

HOYER: Well, not the actual files, the precedent file, you know, the sort of common working file.

MOORE: Sort of like the letters to the states that said yeah, you can do this—or no you can't do this.

HOYER: But it had fascinating stuff in it. Like, you know, Medicaid had—has two transportation benefits. One of them is a state plan option, which you can add. And it has some limits attached to it. The other one is a mandatory transportation requirement that is built into the state plan and is part of the state's overhead.

And that always puzzled me and I found a paper in the precedent file that explained to me that on the historic March on Washington, Ralph Abernathy—I can't say that this is true. But this is what the paper said. Ralph Abernathy was there talking to the Secretary of Health and Human Services while holding a mule, the reins to a mule, and basically saying to him, "You know, a doctor visit isn't much good to a guy who can't get to the doctor."

And it was very shortly after that that we discovered Title 19 to require transportation. But because there was no statutory authority for it, it was initially an administrative requirement. And some of the initial guidance that we published—that was published before I took it over, because it would have been in the '60s, encouraged states to use, you know, pickup trucks and dump trucks and school buses and other state vehicles—

MOORE: And put people in the back.

HOYER: —you know, in their off hours.

MOORE: So the mandatory benefit came out of the March on Washington, possibly? The optional benefit was always there?

HOYER: Yeah. Well, the optional benefit came later. Because states—remember, the administration's matched at 50%. The benefits are matched in poorer states at [a] higher [percentage]. So the states started to want to get the higher matching rate for transportation. So they added the benefit. So I began to learn that kind of stuff. And I began to discover that the level of oversight for Medicaid was pretty low.

The hot-button issues that I remember were Institutions For Mental Diseases (IMDs) which, you know, later came back under nursing home reform. And in the ICF/MR setting, educational and vocational services, where states

were in effect using Medicaid to operate voc rehab. So they would have, you know, an ICF/MR attached to a broom factory.

SMITH: Well, I have often wondered whether on the IMDs there wasn't just a lot of benevolent overlooking of things.

HOYER: Well, there might have been at the beginning but the problem with it came when there was—with the institutionalization and when the states figured out that you don't get any match for a state hospital but if you can dump them in a nursing home, you can. The IMD exclusion itself is statutory and it's from section 1905. The IMD exclusion was a maintenance of effort issue. And in fact, a little-known truth is that there is also an IMD exclusion in Medicare for both SNFs and home health.

And so one of the problems with nursing home quality is that in order to beat the IMD exclusion states were not 'fessing up to the diagnosis and they weren't providing any treatment.

So there's a heroic quality problem. And the Survey and Certification folks had been trying to take it on their own for several years before nursing home reform. And the Medicaid folks had been trying to take disallowances. I mean, typically, the IMD criteria, there were seven or eight of them. And some of them—have a big sign that says IMD and staff—a predominance of staff trained and certified to care for persons with mental disorders—and holds itself out to be IMD. But the real criterion was more than 50 percent of the people are nuts. That's a diagnosis of mental illness. And we are trying to take disallowances there and also on the ICF from our side to get out of the—to get out of the—to keep from funding voc rehab.

And I remember I did a lot of work on the IMD exclusion, writing new instructions, doing the typical thing, which is to say taking a few steps backward from where we were and trying to draw a much brighter line so that we would actually be able to take disallowances, even if fewer of them. I think it took me two or three years. I think I succeeded at it.

I think Judy Boggs twitted me about it for years. The same thing was true with education and vocational services. I mean, there was initially this issue with ICFs/MR that, you know, an essential part of treatment would be habilitation services and we tried to distinguish between habilitation and rehabilitation, which is kind of tough. And the courts have never really liked that very much. And at some point somebody came up with the idea, well,

if the ICF/MR is having people make something that doesn't have a function and it's sort of thrown away after they make it, that would be okay.
But if they make something that is later sold like a broom, that wouldn't be okay. That would just be making inmates work. And I discovered—and Wayne Smith was very helpful here—Wayne Smith came to CMS from New Orleans where he had been running an ICF/MR. And he had been brought in to help write new ICF/MR requirements and taught me what little I know about quality.

And he said, "You know, even retarded people can figure out when it's fake work." And they don't do it. You know, it has to be real. And so—I can't remember what this was, but I remember over a period of time I managed to develop some distinctions that were implementable and so that we would be able to take disallowances there as well. So that's what I was doing after hospice, sort of getting used to Medicaid and working on those issues.

And later on down the road there was an IMD report to Congress required. And I recruited a guy who is now in SAMHSA to do it.

MOORE: Who, Jeff?

HOYER: Jeff.

MOORE: Buck?

HOYER: Yeah. He was in ORD at the time and I kind of helped him do it. Because I wanted an IMD report to the Congress that recommended that we keep the exclusion. This is my job, my job to keep the exclusion. So that's where we were. Took a while to persuade Jeff that that was the right answer.

SMITH: Since I don't know who is necessarily on the side of the angels here, you say you wanted to keep the exclusion. Now—

HOYER: Yes, I did because I thought that the fundamental principle that Medicaid ought to not be refinancing other state efforts was a sound one. And it didn't seem to me that I ought to be helping set up a situation where the states were able to refinance this stuff out of Medicaid. I mean, as a practical matter, the IMD exclusion is problematic.

It's like those psych exclusions in Medicare where you only get 190 days in your lifetime. And subtracted from that are—if you're in a mental hospital

for up to 150 days before you become eligible for Medicare, they are all a direct subtraction. So with Medicare, if you had been in a state hospital for 150 days you start Medicare without any hospital eligibility. You start at zero.

It's the same kind of thing. Institutionally I felt committed to keeping it going. So that's what I did with the IMD exclusion. And then there were as well in 1981 home and community-based services waivers. And we implemented them as well. Actually, Bob Wren did them himself, ran them himself until—

SMITH: How do you spell his name?

HOYER: W-R-E-N. He's really one of those—completely unsung—

MOORE: —around Baltimore?

HOYER: Sure.

MOORE: I figured he was. I haven't seen [him] for a long, long time.

HOYER: He's been working for Don Muse a day a week for years.

MOORE: I knew he was working for Don at some point, but I didn't know how much.

HOYER: Yeah, he got the waiver thing off the ground. And that in itself was very interesting. It was one of the most interesting Medicaid provisions. I actually wrote an article for Bruce, Bruce Vladeck, on that exclusion, among other things because it—because the statutory test for getting in a waiver was that you had to be eligible for nursing home care.

SMITH: Uh-huh.

HOYER: But the requirement for coverage of nursing home care is that you have to require services which, as a practical matter, can't be provided anywhere else but in a nursing home.

SMITH: Right. Catch-22.

HOYER: And it seemed to me that it was the Congress's kind of invidious way of dealing with institutional bias. But the only people who were eligible

for waivers were people who in fact couldn't possibly get into them. And initially the notion was that people who got into waivers would actually empty a nursing home bed. And then the bed might be closed or remain “cold” as they say, cold bed. Or in some cases they had to prove that a bed had been vacated.

And I think—and the legislative history strongly supported that, but it was difficult to enforce and the states took to issuing certificates of need to people so that they could later cancel them.

So we were doing the waiver thing. And that was very exciting because, I mean, we were really kind of babes in the woods with respect to Medicaid. We were pretty innocent and we took the waiver provision for what it said it was in the statute.

And so when states sent us requests for community-based services waivers we sent them letters saying, "Well, we would like to see the job descriptions for these waivers and we would like to see what you're going to pay the staff and providers. And we would like to see how you're doing the care planning.”

"And we want to see all of the details about everything you're going to do. And we want cost estimates as to the expenditures you're going to make and we want to know what you're spending per capita."

MOORE: That would be the old federalism. As opposed to the new federalism.

HOYER: And we said, "And we want to see—we want to know what you're spending or would be spending on nursing homes." Well, states had pretty rotten data reporting requirements and we soon discovered that the document they sent us every year, which was the equivalent of a cost report, didn't actually balance with the documents that we retained about how much money we were paying them, or with the statistics they kept on their utilization.

And so initially we would send back a waiver estimate and say, "Well, you know, these numbers don't balance."

And somebody would call us up and say, "Well, which one do you like?"

SMITH: That's wonderful.

HOYER: But we kept at it. I mean, you know, we pushed them as absolutely hard as we could and I think initially forced them to fully develop waiver programs before we gave them the waivers. And we did that for, you know, three, four, five, six, seven years. And we were enormously pressed, for example, by Oregon, which wanted to basically use the savings from the waivers to add patients to the waivers.

SMITH: I thought that's what everybody is supposed to be doing.

HOYER: Well, it's what we're doing now. At the time Dick Ladd was a pioneer. And he knew Senator Packwood. You know, they called him the Jackie Presser of Medicaid because he looked like Jackie Presser and he had been a truck driver in his youth.

MOORE: I didn't know that.

HOYER: There you go. So Dick Ladd was torturing us endlessly because he had more people in his waivers. And that wouldn't have mattered, except they were for three years and they had to be renewed.

So at some point you'd get caught. Well, the states by and large figured, you know, Medicaid has never actually audited us, so—

MOORE: Uh-huh.

HOYER: And I still remember I went to—the year before the first set of waivers was going to come up for renewal I went to a state Medicaid directors' meeting. I forget what they were calling themselves.

I said, "Look, you know, all those tests that we require for you to get the waivers, well, you're going to have to meet those tests at the end of the day to get a renewal. You can't just show up."

I didn't remember saying this but I have heard the quote often enough. "You can't just show up with a shoebox full of receipts and a smile." Darn, that really made them all mad.

You know, it's the Robin Hood thing. If you're stealing for God it's—I wonder what goes with—never mind—what priests are doing these days.

So we had the enormous battle over the waivers. And when we were approving waivers there were these endless negotiations over prices because the states would be inflating the cost of their current experience and deflating the costs of their expected experience. But what happened over time is we got statutory waiver amendments that got rid of the cold bed test and allowed states to meet what had been real tests with assurances. And so, by the time the Medicaid Bureau was started, which was—I don't know if you remember when that was.

MOORE: '89 or '90.

HOYER: Yeah.

MOORE: Something like that.

HOYER: Well, what happened basically is, Wren and I ran Medicaid.

MOORE: Probably '90.

HOYER: Ran Medicaid with, I would say, pretty much an iron fist right up until then. And at that point, I think, the administration—and it was George Bush, Sr. at the time—decided it was time to take a different federalism direction. So they started a Medicaid bureau. They hired, I believe, Tina Nye.

MOORE: Tina Nye.

HOYER: —to run it. And their kind of byword was, "No more are we going to torture you with these endless negotiations and requests for additional information, you know. You want a waiver, pal? Come see us."

And Tina was a virtual genius at that. She came into that job to undo Medicaid. She was working for Gail Wilensky. And whether on purpose or just by accident, she sort of chose the ditzy redhead approach. She did about everything you could do to make the management think she was virtually incompetent and to cause them to ignore her, and sort of deregulated everything about as quickly as she could.

And it's really kind of neat because, you know, I knew her from my own Medicaid experience. I had been arguing with her over disallowances and we had a personal relationship and I used to go down in her first months on the job and tell her, "You know, Tina, somebody is going to catch on to this

dumb, dumb broad thing and stop you from doing this. You know that, don't you?"

And she smiled at me. She said, "No, they won't." But basically, when the Medicaid bureau started, they basically took Medicaid out of—

The only place it really had been fully integrated was in our shop. And that was the place they took it out of. I think the fiscal administration was separate in BPO. The eligibility stuff.

MOORE: All the fraud and abuse stuff—was separate.

HOYER: Fraud and abuse stuff was mainly funding state fraud and abuse units. So the only place that was integrated was our shop and it was taken out. And we lost it, which made me very sad because I really enjoyed it. And I was just so frustrated watching Tina undo it all and having Gail have not a clue about that. And that was at the same time, again under Bush, that we decided that the authorities that authorize demonstration projects, didn't necessarily need to be used to gain knowledge. They could be used to—you know, just to go...

SMITH: Back-door agenda building and whatever.

HOYER: And we had a lot—there was a lot of internal hand-wringing about that, a lot of meetings and a lot of arguments and—but at the end then there was TennCare and then—

MOORE: That goes over into the Clinton administration. Then we had the Governor President.

HOYER: Right. But, I mean, Clinton didn't change that. He just continued what Bush did. I mean, he brought Ray Hanley in, who was, you know, about the sneakiest guy who ever worked in a Medicaid program and the whole notion was, you know, if the state wants to do something you should be thinking why it's okay. And for a brief period of time—

SMITH: Is that ironic or—

HOYER: It is ironic because we also have at the same time taxes and donations, incredible abuses in school-based services, and disproportionate share. All of those were by and large, little infant state schemes that we caught onto and then which speedily got the protection of Henry Waxman.

Because his theory was every dollar that goes to a Medicaid program, that's a good thing. He didn't actually anticipate the states would spend it on roads and public buildings and stuff.

SMITH: He thought they would spend it on health.

HOYER: And I actually blame Henry Waxman for what has happened in Medicaid because I think his theory, given the way the federal deficit was going and the way the economy was going, that the smart—you know, the smart thing to do from his perspective was to grow Medicaid as big as you can with QMBs and SLMBs and mandatory this—and optional that, so that whenever the day of reckoning came, you know, it would be as big as it could possibly be.

MOORE: Uh-huh.

HOYER: But I realized when Newt Gingrich started talking about unfunded mandates that when you've got somebody who is already sort of stuck in a categorical grant program that they can't back out of and then you begin to add requirements, they really are unfunded mandates—if you do it on the federal side without state buy-in. And initially when Gingrich was going on about it, I thought he was nuts.

SMITH: Technically, they are not unfunded mandates.

HOYER: Because technically they are not unfunded mandates. But when I began to think about it from the political standpoint—

SMITH: Uh-huh, from whether you're going broke or not.

HOYER: Well, yeah, and when I began to realize, you know, that the Constitution is a political document. All of the statutes are political documents. And when I started in Medicare the whole notion was, we are apolitical. We have the Social Security Act. You know, it's just like any other book in the Bible.

It came down to us along with its legislative history, which would be its own Talmud. And, you know, we will implement it the way the law says. And that's that. But Social Security is a whole kind of different thing. I mean, you're only making one kind of determination, you know. Are you old or what?

And in Medicare, I gradually began to realize that the statute was, you know, kind of a political treaty, that the political appointees who kept coming in were in fact a part of the process that was a legitimate part of the government. Actually, I think that's why I've been as successful at what I've done, because I figured that out and stopped wringing my hands about it and started working with it.

And I think in Medicaid what was happening was exactly that kind of political thing. And the same thing has been happening in Medicare as well. But I think I might be off. Does somebody want to ask me a directive question?

MOORE: No, no. That was actually very interesting. That's a very interesting comparison.

HOYER: And, you know, the thing of it is, you can—Ed Steinhouse has always interested me because in many respects Ed was a fine scholar. And that works, by the way, for Don Muse, if you want to—

MOORE: Oh, yeah, he was in the general counsel's office, David, for a number of years.

HOYER: Yeah, to interview him. He came—he started out as—in a Social Security claims center and went to law school at Temple and became a lawyer and was in the Social Security general counsel's office. And he lived, you know, in the golden days of the Social Security Act being written on stone tablets and the general counsel being kind of the high priest of what it meant.

And if you talked to him, he had a virtual romantic attachment to Medicare. I mean, he loved it and he respected it and he honored and treasured—cherished it, and under Reagan and Bush and later as—you know, as Medicare stopped being a sacred text and started being something you had your lawyer look at to see if you could—do something or other, Ed became, you know, increasingly angry and disgruntled and disillusioned and unhappy. And it was his unhappiness, in part, that helped me learn what the deal was. And it also made me realize that the more you do that, the more you operate the program by a broader political process than enacting laws, the more you reduce the respect for the law that the Congress itself has, that the Administration has, and that the courts have.

So that, you know, you suddenly find yourself in some sort of...I mean, once you have interpreted—once you've got the general counsel to clear a zillion things that are in the penumbra of some provision—

SMITH: It's stopped being a procedure. It's become a process.

HOYER: It becomes a process and the law stops—the law stops being like the Constitution, something that you read for a vision of what the program is about. And it starts becoming a place where people file amendments to do stuff.

And I think that's where we are with Medicare and Medicaid. Neither statute any more reflects a statutory vision. They all just reflect a series of amendments made by people, people who run the program.

And I think there is another issue here. And that is, when Reagan took over the whole generation, both in the Administration and in the Congress, Congressional staffs who had used the statute as the source document for what we did, were swept away.

And the new people were by and large people who knew about Medicare from its operations, not from its statute. You know, people who didn't know that oxygen is durable medical equipment, for example, and who had no idea what statewide-ness meant.

And so it's become a whole new thing. And I actually had thought that it would be useful, if demanding, to get somebody to write a fundamentally legal history of Medicaid that deals with the issue of how—how you make public policy for a statutory program as you drift away from the statute. Because you figure there is public morality, you know. There's wrong things you can do and right things you can do. But when you don't have the law as a real benchmark anymore, how do you determine what those things are?

I mean, it's an interesting thought.

SMITH: It is an interesting thought.

HOYER: Because Medicare is sort of beginning to go down that same road. To a smaller extent, and it's just beginning.

But, of course, the current Administrator, when he wants to do something, calls an attorney to see if he can do it. He doesn't ask me if it's in the law.

Well, he does, I tell him no, and then he calls the attorney. But the whole nature of these programs has become much more fluid and less bound by statute.

And I have fallen to thinking that this is actually the exact kind of behavior you would expect if you had read Future Shock where you find yourself as an organization faced with myriad immediate challenges for which the structure and procedures of the organization are not adequate, you develop ad hoc structures and procedures.

I guess in the loosest sense you could count the legislative process as a bureaucratic process because it is highly structured. Typically, historically, if you think about how a bill becomes a law, well, somebody—somebody writes it. It gets referred to a committee. They have some hearings on it. Maybe something happens in the Senate. There's plenty of back and forth and this and that. Maybe after a year or two it gets into a bill.

If it were the old days there would be a Ways and Means bill, there would be an Energy and Commerce bill, there would be a House Budget Committee bill; on the Senate side there would be a Finance bill and a Kennedy bill and a Senate Budget Committee bill. And then there would be a reconciliation bill. So you have five—four committee reports and a conference committee report.

And hearings. I mean, I have the hearings from the original Medicare statute. But you don't have that anymore. What you mainly have is a reconciliation bill. For which there is very likely only a conference report. Because there hasn't really been a House or a Senate bill that got to the point where there was a committee report.

SMITH: Or if they had a committee report, they didn't pay any attention to it. I mean, in BBA-1 there were committee reports but they had very little to do with what happened in the rest of the process with the conference. It wasn't as though you built on those. Those were to make you bulletproof.

HOYER: Well, and I think—I mean, the Supreme Court said a few times recently that legislative history is not the same as law, is it? You can't follow it. But it's—I mean, increasingly Administrations have to move maybe even faster than the Congress. And people know that.

Look at what happened this year with the physician fee schedule. Rather than take a reduction, the Administrator caused this to not—I'm sorry, the

Administrator discovered a woeful mistake which prevented CMS from publishing the rule timely, delayed its publication as long as it could, hoping that a lame duck session would change the law. Couldn't get that, finally had to publish it, and is very much hoping that Congress will change it before it goes into effect, something we would never have thought of doing two or three years ago. Because it's basically having the Administration do things that are arguably legal.

And not doing it—not doing it necessarily out of opposition to the Congress. But doing it because there is a need to do something faster than the Congress can act.

That's where I get to the Future Shock thing. You suddenly realize that we have a legislative process that arguably can't respond quickly enough to economic needs and business problems and a rule-making process that certainly can't.

And you find people looking for all these shortcuts—not to cheat, necessarily, not to avoid—not to avoid...the rules but just to deal with real and pressing problems—for which you can't look to the Congress for help. Makes it much riskier to be a federal Administrator. I know even in my own case I have had a few moments that have been uncomfortable.

SMITH: Well, when you got all involved with this business of whether you were going to use this FIM-FRGs or—

HOYER: Yeah.

SMITH: There you were. I mean, I guess you would say that was a dilemma. And you have to choose the one you can actually do under the circumstances. It doesn't matter too much what Congress says.

HOYER: You know, that was an interesting dilemma because I had succeeded. I really wanted to use the MDS and I believed it was appropriate. And I succeeded in getting Scully to back off and let me publish a proposed rule that required the MDS.

But I also undertook some research during the comment period to compare the accuracy of completing one versus the other. And what I discovered was that the FIM instrument was not very good but mine was worse. And I really had no alternative but to step back. And I've got to tell you, I was just consumed with fury at my MDS cohorts because, you know—

MOORE: They must have known that.

HOYER: —we had the opportunity to have the same assessment instrument for nursing homes and rehab hospitals and it would have been a golden opportunity to analyze the services.

MOORE: Uh-huh.

HOYER: The MDS for post-acute care could have been that instrument. And at the end of the day, for whatever reason, they just didn't do it, you know. I mean, I kind of had them in and I said, "Look this has got to be fireproof."

Oh, no problem. And then I get Joan Buchanan at Harvard to look at it, and it wasn't. And honesty on my part required that I go with FIM at that point, you know. I had said my argument for using MDS was that it was more accurate because it had a wider range of data, which it did. It just didn't have good interrater reliability. So anyway, that—

SMITH: But that was the one where you said you had time to do only one rule.

HOYER: Yeah.

SMITH: But you didn't use the FIM-FRGs.

HOYER: I used them—I didn't use them in the proposed rule, I used them in the final rule.

In the final rule I came out and said, "Well, you know, we've looked at—in the comment period we have done an analysis and we're going to go with FIM." Now, that was—that was my biggest defeat in recent years and it was a self-inflicted wound on the agency's part which will take years to cure.

Now, Linda Fishman, bless her heart, stuck in BIPA a provision that requires a five-year study of different assessment instruments across almost all the payment systems. And the identification of common elements and a report to the Congress on our ability potentially to base payment systems on them.

Again, something I might have had something to do with. And I think we have a couple of million committed to it this year, but it's a bigger year than I think we're going to end up being able to do.

SMITH: But you've got their—well, that's a very nice illustration of the point that you were making because in a sense Congress was not in a position to specify really what it wanted as between these two. And you were in a dilemma of trying to make the best policy choice. But there, in a sense, you had to exercise a lot of discretion and move ahead of what Congress was even able to specify.

HOYER: Well, I think that's true. I think it's—I've actually been amazed at the extent to which I have been able to—been able to get things done that I think would have been very difficult to accomplish in a longer process. Look at home health.

When they required home health prospective payment we had a home health benefit that varied state by state and region by region. And the two—the two key determiners, not the only determiners but the two major determiners of the differences were the generosity of the state's Medicaid program and the extent to which the agencies in the state were for-profit versus voluntary, with the for-profit ones providing very significantly more in the way of services.

And so we had in Medicare—and I think this is the only benefit in Medicare that's like this that I know about—a benefit that actually wasn't a uniform benefit. You have Vermont, where they have 21—21 home health agencies that were all visiting nurse associations and an average number of visits of 23 a year, as Senator Jeffords told me.

Well, I was there in Montpelier, on my knees. And, you know, Louisiana, where people were getting an average of 275 visits a year. And Texas, where the number was only slightly lower. So you actually had a Medicare benefit that was not uniform.

So when we went to prospective payment—and part of it is just the way the law describes the benefit. It's hard to think about—it's hard to take the home health benefit description and figure out how to make it uniform. So when we did the payment system, you know, what we did was analyze the utilization that we had experienced in terms of the functional status of the beneficiaries, primarily—and their diagnosis, but only secondarily, and one service category, which was therapy, and come up with 77 or 78 home

health-related groups that basically described the intensity of services required by people who have certain levels of functional impairment.

And we priced those according to the service levels those people got. And so, as a result, when we put this prospective payment system on the street, we didn't have a system designed prospectively to pay for home health care as we had been buying it previously. We had a system designed to make a price offering for home health services for people who fit in these categories.

So that at the end of the day, you started the prospective payment system with a completely non-standard benefit. Theoretically you get to the end of it several years down the road with a standard benefit, so that at the end of some period of time you would expect—I would expect—people in Vermont and Maryland and places that had low utilization a broader range of customers and a wider range of services.

Same in California, whereas in Louisiana, less. And so you use the payment system to actually create the benefit.

I'm sure that if that discussion of how that might have worked had been a part of the legislative process it wouldn't have happened.

SMITH: No, but you begin to get a little puzzled in your mind as to just how much you want to attempt to make the legislative process that descriptive.

HOYER: Well, that gets to a whole different issue. Seems to me that gets to Nixon and the alienation of the Administration and the Congress and why the national health policy forum exists. I mean, it does, you know. It gets to that and it also gets to another thing, which is, I think, the Congressional budget process.

If you have a conventional—I mean, you started having a lot of specificity after Nixon because the Congress wanted to be sure the President didn't have as much wiggle room as he had before to do something different. And after 1980-81 when they had the Congressional budget process, you couldn't get a CBO estimate of any precision if you couldn't have some fair level of detail about what it was you were enacting. So it was kind of a one-two punch. It was the alienation of the parts of government on the one hand and on the other hand the budget process. And even primitively, look at, for example, Medicare's psychiatric hospital limitations, 190 days. You have to believe that those were primarily put in there to satisfy an actuary.

If you look at the description of skilled nursing facility care, which would be—you know, skilled nursing care or skilled rehabilitation on a daily basis which, as a practical matter, can only be provided—again you have more and more words piled on there to keep the actuary happy.

And then when you looked at the benefit description that was given to the actuaries for purposes of pricing the SNF benefit in '65 it actually said that we expect that these days will be the days that are currently the last few days of hospital stays and that fewer than one percent of the population will have used them.

So, I mean, you've got even in '65, I mean, home health, the homebound requirement is another one of those. Confined to the home. Well, that limits it. You've always had statutory provisions that existed to make actuaries happy but since CBO scoring became essential you've really got lots of it.

I mean, hell, you probably remember the provision, you know, back when we were fighting the deficit but not very effectively. Somebody was trying—they had a provision governing the number of mycotic toenails that could be...

MOORE: That's the famous one.

HOYER: So that somebody could pick up a couple of savings and—

MOORE: Carry it on the other side of the ledger.

HOYER: I mean, hospice was supposed to save money. I can't imagine that it's ever saved any money. You know, there's 2,700 of them now and we paid them $2.7 billion last time we looked, and more than 700,000 beneficiaries have used the services, something I'm very happy about.

SMITH: Well, you've both done a lot of writing of rules. And—

MOORE: Oh, he's done much more than I.

SMITH: Oh, that I know. But I mean—you both experienced it.

MOORE: I mean, I did more legislative stuff. And, you know, he is absolutely right about the changes over time in that.

SMITH: It strikes me as a profound skepticism about the rule-writing process.

HOYER: It's not so much that I'm skeptical about it, although I have to tell you I was in this SES candidate program, which I have always referred to as Police Academy because of the quality of the training. But one of the parts I liked was they had all these tests that they would give you. And I've always been one of these people that said, "You know, the system works. The process works." They gave me this test and it was a bizarre test. You had these two lists of really bad things. When nerve gas falls on orphanage, plane hits the ground. You know, they were all really bad things: child dismembered. And they were separate lists and you were supposed to order them from worst to least worst. God knows how you would do it.

And as a result of that they drew some conclusions about the amount of faith you have in systems, processes. And it turned out that I have about .02 percent faith in the actual process, except if I'm operating it, in which case—

MOORE: It goes way up.

HOYER: Very significant, yeah. And maybe that's true but actually—I spend about—I spend actually about two hours on this in this class I teach on the rule-making process. Because good and bad things happen out of a rule-making process. But if you operate it conscientiously and if somebody like me is in charge of it who just fanatically is going to pursue the goddamn thing until you get it done, no matter how agonizing, I think what you end up with in the end is a true consensus.

It may not be the best but it is a true consensus. And once you have done that you can go forward confidently and make people do that stuff. You know, you are not making them do something that Bruce Vladeck dreamed up in a happy moment of civic pride. You're not doing something that Paul Willging dreamed up while he was running the nursing home association.

You know, you're doing something that a no-holds-barred, absolutely unprincipled struggle among all the parties finally led to. And—

MOORE: Forge a compromise of some sort.

HOYER: I mean, that—presumably is what democracy is all about. It's a pain in the butt to do it. But the nursing home reform, that took me from 1986 to 1992, between when the IOM issued its first report and we issued our first proposed rule and when we issued the final rule on the nursing home standards and preadmission screening and nurse aide training and competency evaluation and patient funds and some other stuff. The whole process was a process of negotiation over how it worked.

SMITH: When you say a process of negotiation, this is negotiation amongst you and your associates and the people above you in the Department and it's also the outside groups.

HOYER: Yeah.

SMITH: And this is the thing that really burns the time.

HOYER: Meetings.

SMITH: Because I was talking with Joe Manes about the original Moss amendments that got stuck in the '67 amendments.

HOYER: I haven't talked to Joe for years. How is he doing?

SMITH: He's doing pretty well. He's quite happy and he lives over in Southeast—no, Northeast—in a nice place. And we chatted for about an hour and half, two hours. He gave me tea and cookies. But I asked him what took so darn long to go from these amendments of '67 and the Moss amendments to get out a published rule.

And he said—he did not talk about all the negotiation, all that kind of stuff. He said, "Well, the fact of the matter was they wouldn't give us any budget so there were only three of us basically that could work on this at all. And the other thing was that we really had to educate ourselves because we had never done a reg.

"And so we had to learn what all the policy stuff was and then do all the policy stuff. And that was the real kicker." So there's a technical part that was hanging him up.

HOYER: I think it wasn't true for us. Let me—and of course sometimes things change. Mentioning Joe made me think of ICFs/MR. And, you know, they were started by Henry Bellmon.

MOORE: Oklahoma.

HOYER: And his intention wasn't to do what we're doing today, which is to care for the full range of people including those who are so profoundly retarded that sometimes you just turn them from facing the red wall to the blue wall. His idea was very narrowly to take people, educably retarded people, and teach them how to do—to work for a living.

SMITH: Oh, yes. A "respectable mediocrity"—as some authority once said.

HOYER: Anyway, let me just give you an example with nursing home reform because the Institute of Medicine report came out in '86 and it had, you know, a lot of principles and discussions of principles. It also had specific recommendations that went beyond the statute, but not all of them did. And some of them could have been incorporated. Some of them could have been done administratively.

At the time, I was responsible for the policy and Tom Morford was responsible for implementation. And he and I got together to work on it. The report recommended that we focus on patient assessment and care planning; require training of nurse aides; measure outcomes; and also maintain various process requirements. We developed a proposal for regulations that improvement relied entirely on current law to achieve as much of the IOM's recommendations as possible.

We hoped to persuade the advocates to support the process; hoping perhaps we could seduce the nursing home industry into biting on that hook if we could sell it to the advocates. You know, we thought we had an enormously enlightened approach, given where we had been—and one that didn't require legislation. So we put this proposed rule together and we shopped it around town. We took it to the committees. We took it to Elma Holder. We took it to the unions and others and we got kind of a passive reception.

So we published the proposed rule. And that turned out to not be as hard as I thought, in part because Willging was behind it. And the Administration under Bill Roper—I think it was Roper at that point—you know, had been so stung by the previous nursing home stuff they didn't want to be nay-sayers. But it got this enormous negative backlash immediately upon being published from the advocates because it didn't do everything the Institute of Medicine report had required. And the report itself was a masterpiece of committee activity. It started out by saying money can't buy quality. Money is not the issue.

Regulating process and proxies is a sad second to regulating outcomes. You should go for outcomes. But then kind of when you get through the recommendations it sort of says, "But, well, what the hell. Let's have it all."

Let's have your process and let's have your outcomes because all of us are interested in something. And so we had the report and as it existed, of course, it wasn't practically valuable because it would have required a reg with everything in it. Which nobody could have lived with. So after we published our proposed reg in '86 there was this enormous activity in the House centered primarily in [the] Energy and Commerce [Committee] and [the] Ways and Means [Committee] where the advocates were working very hard to write a bill that would put a lot more stuff into statute with respect to their...reform so that we would be required to write a regulation which was much more like the report.

And I spent a lot of time working with those guys on issues I thought were important. For example, the legislation as it was originally written required each nursing home to achieve the highest possible level of physical, mental, and psychosocial well-being.

And I did get them to change it to highest practicable level. Which of us is at the highest possible level?

SMITH: You know, I even noticed that change.

HOYER: There were other issues. You know, we had—the law—the statute they drafted was pretty clear that once you admitted a patient you had to provide equal treatment medically, but there were no provisions that prevented admission discrimination.

And it turned out, as Andy Schneider told me, that the nursing home industry had simply said, "Look, if we have to care for them once we have them, you can't expect us to take them all. We have to have somewhere to —" Yeah, have to do the budget.

The law had this whole preadmission screening and annual resident review requirement for patients that, because it required involving the state mental health agency and the state mental retardation agency, among others, put me at odds with them and the state budget officers and then the state Medicaid folks and OMB and myriad advocates, as you can imagine.

Because then I had the mental health advocates, the mental retardation advocates and the nursing home advocates and the National Association for Protection and Advocacy Services—utter maniacs. So they all sought legislative process, right after we published the proposed rule. And it very speedily led to OBRA '87.

And then we had a decision to make about whether to do something new or do a final rule. And so what we thought we would do is an interim final with comment where we would finalize those portions of our previous rule which were not changed by the law and propose the rest of it.

And we did that. And then it was in clearing that document where we had just endless pain. And I'll give you some examples. The regulation—the statute—I'm sorry, the Institute of Medicine report and possibly the statute, but I can't remember now, required that nursing home residents in their rooms have full visual privacy.

And apparently, you know, watching your roommate get an enema is a sport in a...nursing home but not one that both of them enjoyed as much.

And so I got this job to write the rule. I've got the Institute of Medicine report. I've got OBRA '87 on my desk and I'm talking to people about it, doing that developmental part. You have to meet with people. Well, who am I meeting with?

Well, I'm meeting with people who manufacture partitions and curtain rods and curtains and hooks and meeting with architects. Turns out a curtain that goes up a cathedral ceiling is a lot more expensive than a curtain that just goes across an 8 foot ceiling. And lots of people from the American Health Care Association who's thinking is we have a couple of movable partitions, you know.

It's like the roommate's not moving around a lot. We can just move a panel in front of him. Of course, the advocates basically suggesting, well, if you had single rooms that would do it.

And maybe a bundling board in the bed so there can be an advocate right on the other side of it. So before I even set pen to paper I got all these people meeting with me. And the ones who felt sort of unmoved by my enthusiasm wanted to meet with the Administrator and then they would be meeting in ASPE and places like that. And their Congressmen, their own Congressmen want to meet with us and—if it was a big enough issue the committee staff

would, either to make sure I was not going to do what they wanted or to make sure that I was. So I do all that stuff and then I finally get a proposed reg drafted. And—

SMITH: Now, how long?

HOYER: I can't remember now, but I have records.

SMITH: So, this is a labor of Sisyphus, can't be done?

HOYER: Well, I mean, I've done it. It could be done but—so I get it—you get the thing finally up to the Department.

HOYER: The agency itself has always been sort of leakproof, pretty much because basically we're all career employees and we're usually all on the same page and we know who we work for. But once you get something up to the department level the whole thing changes because all the staff offices of the secretary are chock full of people who are into advocacy.

The other parts of the Department are, too. So no sooner do I send this proposed rule up to the Department when right away people are figuring out, you know, what about curtains, what about partitions?

And so I [was] asked to start meeting with the people in the Department and then a whole fresh round of meetings on the Hill and with manufacturers and advocates. And, you know, do you really want some naked 90-year-old guy being looked at by everybody?

No, no, I guess I don't. What could I have been thinking? So finally I—you know, I get past that and the Secretary signs it and it goes to OMB. And then there's kind of the two pieces of OMB. There's the budget side and they're wondering how much are all these goddamn curtains going to cost? And they're particularly wondering it because, you know, the nursing home gang were well represented in the government.

And then on the OIRA side, you know, they take care of the more spiritual issues. Did it all over again. There was another issue with OIRA. I couldn't believe it. It was we had a—well, I'll finish this other one. So we published a proposed rule. I think we got like 80,000 comments.

And so now I've got to write a final rule. And of course everybody is thinking: What's he going to do? And read all the comments, write all the

answers, go through the whole process again. Well, I think, you know, we do have full visual privacy. But we weren't able to say a lot about what that meant.

There was another issue. One of the rules that I had to promulgate, that the nursing home reform required, was a list of the items and services that are included in the nursing home rate and for which a patient can't be separately billed. Well, that also is an enormous conundrum because on the Medicare side it's pretty easy, on the SNF side, but on the Medicaid side the states have all kinds of weird accommodations.

And it means something to them because they pay such low rates. So I had included, for example, shampoo and conditioner as a basic thing that you have to give somebody who is living in your nursing home.

The analyst at OMB absolutely blocked that because, as she pointed out, when she was a poor young woman trying to make it in life she couldn't afford conditioner. And it was really an extraneous thing, a luxury actually, that I was trying to extort from the states on behalf of welfare recipients. I think that's a facer.

So I was whining about it to David Cade, who is now the Principal Deputy General Counsel and who is an African American. And who said to me just offhandedly, "You mean she wants all those black people to go to bed all nappy-headed?" And I thought to myself, "A racial issue! All right!" So I rushed right back and said, "You know, there are populations that could be adversely affected by...

MOORE: That's a great story.

HOYER: So we ended up with a required provision of hair care products without saying exactly—

MOORE: Which ones.

HOYER: But it's that kind of stuff.

MOORE: Those are great examples.

HOYER: Here's another. You know, one thing you do in a nursing home reg is you require—you say what the basic size of a room is and what the

basic furniture had to be. And the furniture was a bed, a bedside table and a chair.

OMB said, "Well, you know, do you really want to have a requirement like that? There are comatose patients who wouldn't be using that chair." So Allyson—if they lived forever, a chair would never be needed in that room. I mean, you can spend a lot of weeks working on stuff like that.

Especially if, you know, the genesis of the objection is really some guy outside of OMB, something they'll never tell you. My best story actually about this is personal laundry. One of the tried and true state methods to supplement nursing home rates is having families contribute, to have a charge for personal laundry.

You know, if granny is in the nursing home Medicaid will pay. But if you want her to have her laundry done, well, you have to pay us 25 bucks a month. And it's clearly family supplementation. And clearly wrong. And so I was clearly going to do something about it.

And the word got out, it turned out because some guy who worked for us was at the time getting ready to go on the outside. And so Bill Roper, the Administrator, he gets a call from Howell T. Heflin, not just the senior senator from Alabama but the former chief justice of the Alabama Supreme Court—

SMITH: Good Lord.

HOYER: —telling him to show up at their offices at a day and time and bring that Hoyer with him. So Roper agrees and then he calls me up. So the Administrator is calling me up. That's something of a big deal in your life. And he says, "So maybe you could help me out with this. He said something about personal laundry." I said, oh, and I explained it to him. And he said, "Jeez, I like to fell off my chair when they said laundry."

So we show up there. Heflin is there. So is the other Senator. The Representatives are there. And the head of the state nursing home association is there. You know, Roper and I come in and I'm thinking I probably should be led on a chain. I admired him that day.

And Heflin leads the discussion and he says, "You know, Alabama is the poorest." And he goes over the—the bottom line was, yeah, we know what the law says but we need the money. You've got to let us keep it. And

that's that. I mean, they take a long, circuitous way to say it, but that's what they say. And they make it clear they don't care what the law says, they want the money.

So Roper starts talking to them in that great voice he has and makes them feel like every minute he's not actually like working at HCFA he is praying for Alabama and trying to make its life better.

MOORE: Didn't he work for Alabama...

HOYER: Yeah, he worked—

MOORE: That would have made it easier for him.

HOYER: Yeah. No, it was. He's from there. At the end he says, "You know, I'm not sure. I'm not sure I can, you know, let this cup pass from you but I'm sure I can buy you at least a year, maybe more, in delay." And they thank him profusely because of course the legislators don't know the details, and we're leaving.

And I'm telling him, I said, "Well, you know,
Dr. Roper, it's going to take me like two years to publish the... "

He said, "I know. Sometimes I feel almost ashamed."

SMITH: That's a wonderful little anecdote.

HOYER: But you know, there was big money in that and they really cared.

And later a woman who had worked for us who had been Bill's special assistant, Carol Hermann, was the Medicaid director in Alabama and she sent me a personal note saying, "I've gotten rid of those charges."

MOORE: Oh, well, you—

HOYER: You win. She also sent me a copy of an advertisement for a Hoyer lift. I don't know if you know about that.

MOORE: No, I don't know about Hoyer lifts.

HOYER: They are no relation to me that I know about but they are a strap you put under like a big, fat, immobile patient and then you winch him up out of the bed.

MOORE: Oh, oh, sure.

SMITH: Put him in a tub or whatever.

HOYER: Nobody does it better than Hoyer, according to the ad. Sent me one of those. It's that kind of business, you know,...nursing home regulations—every single step of the way.

SMITH: Aren't you going to find some way to write this up?

HOYER: Don't know. Haven't had the time.

SMITH: I mean, you're retiring. Get your breath back. I think you ought to do that. You haven't been retired. You could segue into that, you know. You don't have to work. I think a good rule for writing is not to work beyond noon.

HOYER: Well, see, get up. Walk down to the ocean. Pick up a paper at Browse about Books and a latte and walk back to the place. That takes about 75 minutes and then I could start working.

SMITH: Yeah. You could work from 10:00 till 12:00. Get something significant written here.

HOYER: Yeah. I type very fast.

MOORE: And after all this...
(Off the record).

HOYER: Yeah, what I think is that the pathway that was begun under George Bush, Sr., which is emphasize flexibility and federalism and this whole notion that the states are the laboratories of innovation is not a bad principle.

But the controls over it in terms of the appropriate use of federal funds and the essential notion of Medicaid as an egalitarian welfare program with a nationwide bedrock benefit I think really has been done some considerable violence to. And I think Medicaid is not what it was.

And I think that that makes it extraordinarily difficult to develop a national health care system at some point. And I don't frankly see how an effective long-term care system that manages care, how any kind of effective care system that meets the requirements of the IOM's [Crossing the Quality] Chasm report, which I have personally read four times now, could possibly be constructive without more standardization than that.

And I think there is a huge untold tale about what kind of quality you get in waivers. And it just seems to me that what we have done—what we have done in Medicaid is to choose flexibility over accountability in way too many cases. And you look at individual examples. A home health example, for example. One of the things that TennCare did in Medicaid was to drive home care out of rural areas and concentrate it where the providers were.

And as a result of TennCare there were more, quote, abuses of Medicare home health in rural Tennessee than in a lot of other places because Medicaid, which is supposed to be a statewide benefit, was not available in rural areas.

And when we went around with the interim payment system first and then with prospective payment there was very considerable pain felt. And people who were getting non-covered Medicare home health in place of what would have been—covered Medicaid care.

And I think that that kind of chasing dollars across program borders is, you know, a mistaken thing and I think it's bad public policy and it's going to cost us something because the—I mean, the pathway from where we are now to a unified system has been made a lot harder to traverse—when they started hospital prospective payment in '83?

SMITH: Uh-huh.

HOYER: Is the obsession with fixing prices really caused them to lose sight of what's required to have competitive pricing. When you asked me what I learned when I got my MBA. Well, okay, one of the things I learned is in competition what you have are fungible objects like bushels of wheat, perfect information, and competition on the basis of price.

So here on hospital prospective payment we thought fungible objects? Well, we don't know what a hospital is and we have close to 20 years of experience in survey and certification where we have been willing to certify

different floors of different buildings and various combinations of services at hospitals.

So we actually have, operationally speaking, no definition of a hospital and very few hooks or eyes or anything to hang restrictions on. So we don't know what a hospital is. And we certainly don't have perfect information about what a hospital stay is or what's included in it. All we have is, guess what? We have a bunch of categories and a price attached to them.

And what's the bundling principle? The bundling principle is: If it's done at the hospital it's included in the price. Not, you've got to do it at the hospital. Just if it gets done there—

MOORE: Or if it's done to the patient, for the patient.

HOYER: So all of a sudden we come right out of nowhere, ignoring our history of survey and certification, ignoring everything that we could know about the nature of health care and we establish a set of prices. And predictably, of course, the nature of a hospital changes immediately. Subacute care is born the same day.

You know, people start doing all kinds of stuff on an outpatient basis. The observation day is born, because once we have prospective payment and we declined to have an in-lier policy, you know, lower payments for shorter stays, we basically said, "Look, don't just do what you used to do, which is somebody shows up, you admit then and see if they are still sick the next day. Give it some thought before you admit them."

Well, we were having observation stays of two and three weeks.

MOORE: Oh, I didn't know that.

HOYER: At the worst point of it, well, hospitals were actually billing it all as outpatient hospital services and charging the beneficiary 20 percent coinsurance. And it was the formula-driven overpay so they made plenty of money.

I mean, it just seemed to me that in that respect hospital prospective payment was absolutely un-thought-out because in the whole competitive thing they had only thought of the last thing.

So that was very frustrating. And I think it was a mistake. The mistake took us a long time to pay for. Now, BBA97 has added enough PPS systems so we have a payment system or a fee schedule abutting everything.

MOORE: Uh-huh.

HOYER: Now, that theoretically can give rise to significant inequities. But at the end of the day what it amounts to is there are going to be a whole series of bright lines between categories of payment. And increasingly, we and the providers are going to become more publicly accountable for the payment and the services.

Because, for example, a SNF prospective payment, we don't pay enough to take those subacute patients too soon. We pay enough to take them at some—appropriate point. Well, you know, as we all start knowing more about that hospitals will be in a better position to argue for their payments, as will SNFs.

And we at the same point, at least on the SNF side where we have MDS data, will start being able to make more valid conclusions about this amount we paid you. That's enough to get the outcome. Not as we do now. So I'm thinking that BBA97 really allows us to start out to try and get to where hospital prospective payment was intended to get us. And—in a sense now we have 20 years to put into it. Make it go my way.

SMITH: You can capture the whole system, but it's going to take some time.

HOYER: Well, not my way, because I don't think of it as my way. But you sit there and you work and you can't not get emotionally involved and personally involved. And once you figure out what you think ought to happen, then it does sort of become your way. You want it.

SMITH: Yeah.

HOYER: I think that's one of the extraordinarily charming things about Tom Scully is he really does have an idea of how it should all work that he thinks is right and he's willing to take considerable personal risks. How often do you have somebody like that? I mean, Bruce was willing to do that. He was another one.

MOORE: Uh-huh.

HOYER: I've often thought—you'll have to turn it off for this.

INTERVIEW WITH JULIE JAMES
JUDY MOORE AND DAVID SMITH – MAY 13, 2003

SMITH: This is an interview of Julie James conducted by Judy Moore and David Smith at Health Policy Alternatives on May 13th, 2003. Let me start off and ask you—I know that you came from Oregon and were originally hired to be in Senate Finance by Ed—

JAMES: Mihalski.

SMITH: Mihalski, yes. Was it for Senate Committee staff or were you personal staff?

JAMES: No, I was Finance Committee staff working for Bob Packwood, who was the ranking—

SMITH: Ranking member at that time. And what was the date?

JAMES: I started July 1st of '91, 1991.

SMITH: And what kinds of things were you working on at that time?

JAMES: I was hired to cover Medicare Part B issues. I walked into my office and found the two-foot-high proposed rule on physician payments on my desk.

SMITH: Well, we both know something about that. That must have been quite an experience.

JAMES: Yes, it was. It was a steep learning curve.

SMITH: One of those things where you just have to jump in and swim. Well, one thing we particularly wanted to ask you about was the Oregon waiver, which you should know a fair amount about.

JAMES: You know, you would think that I would—I was actually chairman of the Oregon Health Council in the early '80s. And we started the whole process of talking about units of resources and having to prioritize in terms of coverage that led to the Oregon health plan.
But I really left—was not that active in the state when John Kitzhaber became governor and really put together the Oregon health plan. So I was

in at the initial development of the idea. I participated in the town meetings that they had all over the state to prioritize the services.

There was a gap between then and when I came to Washington. When I did come to Washington, obviously Packwood was very active in trying to get the waiver approved but I didn't handle those issues. That was Roy Ranthum.

So, there was a gap there and I wasn't that close to it so I don't have as intimate a knowledge as other people might have of doing the waiver.

SMITH: Some people criticized that sort of prioritizing by vote, as it was called at the time. The process by which you established these priorities, did you have any qualms about that? Or did you think that made sense as a way to do it?

JAMES: I think the overall concept of recognizing limited resources and trying to target those resources to those things that are most effective had a lot of support in the state, obviously. And politically, you know, it did have the support of the state and they went forward in the legislature, supported it. But having participated in the process I realized how difficult it was and what a limited knowledge the general population has about these issues. And so it was eye-opening to participate in it.

You know, I was still very supportive of the whole effort. I think it was a worth while attempt because resources are limited. I mean Oregon's always—not always, but often a trailblazer. In terms of the policy directions. Of course, now the state is just in a mess.

SMITH: Did you have a sense for how badly off Medicaid was at this point?

JAMES: Well, I can't remember. They said something about it the other day. But I sensed it's pretty bad off. I happen to have a brother who is a teacher and I'm a little more aware specifically of what they are doing in education.

So specifically, I don't know. I just know things are bad, really bad...an article, what was it, in the New York Times the other day?

SMITH: I believe so.

JAMES: About how people are getting cut off on medications and things are pretty grim like that. When we left Oregon in '91 they had just passed a property tax law. I had been on a school board for a number of years. So again I was involved in education.

And, you know, Oregon doesn't have a sales tax. And so, while there were some objections to the very high property taxes, with people trying to hang onto their homes, on the other hand, they wouldn't replace it with any other source of revenue. And it's only gone downhill, I think.

MOORE: Doesn't the state have an income tax?

JAMES: They do have an income tax but there was just an emergency—I was in Oregon in February and there was an emergency vote to try to get an increase in the income tax through...So I have kind of lost track of where they are.

SMITH: Now, when was this discussion going on in the Senate? When was Packwood working to get this waiver through?

JAMES: Well, at the end of "Bush 1," the first Bush Administration, there was an intense effort to get it approved before Bush left office. But because it was such a political...the Administration was very much against it. Bush did not approve it and so the effort continued to get it passed.

SMITH: Without much trouble, as I remember.

JAMES: Yeah, I think. I'm trying to remember back.
We had quickly shifted with Clinton into discussing health care reform and—so maybe just to get it off the plate or something. I don't know...it went through relatively soon. I don't know if it was '93, maybe...

SMITH: What thoughts have you had about how well it has worked out?

JAMES: I can't say. I just really wasn't close enough to know. I don't recall any horror stories about it. I do remember the big case when the waiver was being approved in the late '80s, I guess, with a woman who didn't get a transplant. Right now I can't remember exactly because we didn't have the waiver then. But why she didn't—she didn't get it because Oregon didn't cover it.

MOORE: It was experimental, I think, at the time.

JAMES: Maybe that was it.

And she died and her son...Anyway, her son was against the process.

SMITH: It may not be so much against rationing as that you don't want it to be visible.

JAMES: Yeah. Well, yeah, we don't want it to be explicit.

The case that Oregon made was that Medicaid gives some people everything and other people get nothing. And the idea was to cut to give more people something.

So that was the whole basis of the discussion because you drew an arbitrary line. Instead of on benefits you drew the line on income, you know. As you said, it was just a different form of rationing.

SMITH: Seems to me it was pretty rational and yet one of the things underlying is that the American people aren't rational about these matters. We thought also that you were pretty involved in some of the DSH controversies, were you not?

JAMES: Well, I was around during the Balanced Budget Acts of '95 and '97 where DSH was a—was part of the whole debate over Medicaid reform. There was the earlier DSH controversy in '90? I didn't deal with it directly where they put the cap on DSH. In the early '90s, there was all that DSH controversy over DSH and there were some states...It was obviously New York. New Hampshire, as I recall, was one of the leaders of the pack in figuring out how to be in the system or take advantage of this or that way to do it. And I can't remember what the other states were.

SMITH: Did you have any particular division—other than, say, individual states whose ox was gored. Now, Henry Waxman, for example, supported DSH pretty much at every turn. And when they tried to take it away he would attempt to intervene. Did the Senate have any kind of counterpart?

JAMES: Well, from the Republican perspective, the Republicans never liked DSH and derogatory terms were used for it, they called it a slush fund to channel money to particular providers.

With the Senate and the House you always had the urban/rural. So it was viewed primarily as a House-supported policy and it was a way to get money

into the big cities. It was cities like New York and Chicago. I think in the Senate they still don't like it.

And obviously some of them have states that are very...have gotten a lot of money...There was, you know, the Senate and the Republicans were not as supportive of this as the Democrats in the House. It was a struggle.

SMITH: There's a couple of questions I would like to ask you that go back a bit earlier. Back to '95, and afterward. And one of the things was that, in the House, you've got a revolution going on. But the Senate is slow to get on board and when it gets to Medicaid there is a burst of activity and they talk about a cap and five percent and that sort of thing.

And Dole gets on board and Packwood does also but then things sort of stall out. I would be interested in your sense of the dynamics. For example, in the House there is a big formula fight and that certainly slows things down. But the Senate doesn't have a formula fight over Medicaid.

JAMES: Oh, but they do. I can recall. I don't remember where in the process. To tell you the truth, I can't remember what happened in Committee on Medicaid. I just remember every single time they came up with a new formula. And GAO was running the numbers. They would come up with a new formula to address some state concern and of course, there are always winners and losers because there was a fixed pot of money. And so another member would go to Dole. And Dole would turn to Sheila [Burke] and say, "Fix it." So they would have to go back to the drawing board.

There was never any, "This is the way it's going to be." And so there was this constant running of the numbers trying to reallocate the dollars among the states. And they were just pulling their hair out over that...

SMITH: Howard Cohen said GAO did something like 2,000 runs.

JAMES: Oh, probably at least. At least. It was just ridiculous, it was. And the paper, you know, with the new numbers and—I can't even remember where it ended up at the end of '95...obviously ended up somewhere. They got some agreement and then...in the conference. I can't remember, you know, what all the dynamics were.

SMITH: Right.

JAMES: It was just this endless run of all these—I remember it more in '97 because I was more intimately involved with Medicaid.

SMITH: Back in '95, just to dwell on it a little bit longer, people have often described Senate Finance as a Democratic committee. In many cases, that was Republicans saying that. It didn't behave like a typical Republican committee, and you had the sense that that committee was very bipartisan.

JAMES: The committee always had a tradition of being bipartisan and it was 20-member committee. Eleven to 9, and if the chair—you know, you needed to have a majority—it was very dicey for the Chairman of the Finance Committee to ever try to do anything on a partisan basis because you lost just one vote and you were done, you know.

Even when the Republicans were in control you had some very moderate Republicans on the Finance Committee, like Senator Chafee who was a champion of the Medicaid recipients. And it was difficult to try to do anything without full support of the members of both parties.

SMITH: Did you say in '95 that Chafee came pretty close to dominating the play as far as Medicaid was concerned?

JAMES: He always held a really strong position because of—again, because of the way the committee was structured. The Chairman needed his vote and so—I think I had two days off the entire year, literally. Literally.

SMITH: We were speaking to Marina Weiss and she was saying that Bentsen's strategy when he was Chair was to keep his eye on the Republicans because he said if you tried to run it on a partisan basis there would always be someone that bolted to the other side. But if you paid attention to what the minority wanted...So that way it got to be a pretty bipartisan committee.

JAMES: Yeah, it was. It had a longstanding tradition. And of course because it's the tax committee and to members of Congress tax policy is so much more important than entitlement policy, you wanted to get along with the Chairman. Because if he had a very contentious thing on health policy, you may have to pay for it in terms of the tax stuff. So it's much more complicated than just where the votes were on Medicaid policy. It was the whole shebang and not just the health entitlement. So they always tried very hard to be bipartisan. Now, I do remember when Clinton was elected in '92 and sought to pass a tax bill and Democrats controlled both houses of

Congress and the White House, but Finance Republicans just said, "Thank you but no thank you. You go ahead on your own." It was pretty amicable though. It wasn't real nasty.

As I recall it was, you know, you're going to have to do this without us. And that was clear from the beginning. So the tax bill in '93 went through on a clear party line vote. But it was clear from the beginning that's what it was going to be. You guys are going to raise taxes. We're not going to participate. And that's the way it was.

But it wasn't nasty. '95 was nasty. '95 was just the nastiest politics I have ever, ever been involved in...until the end with the Clinton vetoes of it was just awful. And nasty, nasty, nasty, ugly, awful.

SMITH: Well, you wonder, too, how many staff were casualties of some of those kind of battles. People said really, "Do I need this?"

JAMES: No question.

MOORE: Why do you think that was? Was it very deeply-held convictions or was it just that the people got to be...?

JAMES: '95?

MOORE: Yeah, '95.

JAMES: I think it was—a lot of it was the tension between the White House and the Congress. Ultimately, you had the Congress that was Republican and the Democratic White House. And a large part of it was the Republicans getting control after so many years.

Especially in the House. As you said, the revolution in the House. The House really felt like that. I think that for the Senate, being Republican was no big deal. You know, it had switched majorities in the '80s, but with the House it was a big thing and it was like—they just had no use for the moderates.

SMITH: In the Senate there was a certain amount of disdain for this kind of revolution from these upstarts. I mean, they spoke about the “newtoids” and things of that sort.

JAMES: I think there was a lot of tension between the leadership, between Dole, who was sort of the old time, long time politician, and again, the more cooperative spirit on the Senate side. And then you had this intense revolutionary spirit on the House side. And they're—I can't remember what it was called, the...

SMITH: Contract with America?

JAMES: Contract with America, you know. And it was like everything had to be the Contract with America...
Gingrich pulled Medicare—Medicare was going to be a big thing—And he pulled the committees together into one working group over on the House side to prevent the two committees going off in different directions.

And he had this smaller group of members from both committees. I was invited to attend this task force meeting one day—one night, as I recall, starting 8 o'clock at night. And I was sitting there—I was sitting in the room, in his conference room. And the task force was meeting and they all of a sudden launched into this terrible criticism of the Senate and they were going to do all this stuff with those horrible people over at the Senate.

We're going to ruin this, and blah, blah, blah. And I can remember his staff leaning over and telling him I was there. And I can remember him sort of giving me a sideways glance. He knew damn well I was there. And they were just going on and on and on about the Senate. So of course I was supposed to relay all this back to the...Senate.

SMITH: Right, right.

JAMES: I was just—I was the messenger and it was very interesting.

SMITH: Of course the climate, the general partisan atmosphere, was much, much less in '97. I'm curious how that played out for you in the Senate. Why did it seem so different? What made a difference?

JAMES: Well, I think what happened in '97 was that both sides had made their point. And you had the election of '96. So in some ways the—again, everybody had been sort of reassured but also checked. The Republicans kept control of the Congress and Clinton kept control of the White House. And the Clinton Administration I think made the decision that they did want a balanced budget. And clearly, the Congress did. So what happened early on in '97 was that the Administration and the budget people reached a deal

on the budget resolution. And it was the first time that you had this piece of paper with the parameters of the deal on it. All that negotiating that went on before the budget resolution was even adopted pretty much sent the signal that this was serious and they were going to do something. And I can't remember what the Medicaid provisions were in that document...expanded.

But all of a sudden, as a result of that, the Medicaid, quote-unquote block grant was off the table. So I think there was something in there about DSH, as I recall.

MOORE: Yeah.

JAMES: SCHIP was actually pretty minor in the budget resolution. It kind of bloomed. And maybe it was sort of a way of, you know, allowing states more flexibility but capping the funds. All that was able to evolve through the SCHIP program.

Medicaid was going to stay as an entitlement and we weren't going to get into block grants; but there would be money for expanding the program and providing more flexibility. We were going to be able to do that for...you know. And of course welfare reform also figured into this—a lot into this, which was also part of the strategy I think of the Clinton Administration and the Republicans. And very much connected to the whole Medicaid issue.

SMITH: Early on there was a kind of a ground swell of interest in child health. There was of course a Kennedy-Hatch bill and Gramm came forward with a bill. And there were a couple of Chafee versions. Was there a sense in the Senate that child health was something that was going to get done this year?

JAMES: Well, as I recall when Clinton sent his budget up in February he had a small, quote-unquote, SCHIP...program in it. You had the failure of health reform and then you had the election of '96.

And though health reform died in '94, there was still concern about the whole issue of the uninsured and what to do about it. There was also some talk at that time among the left that, well, okay, if we can't do universal coverage all at once, maybe we ought to do it by starting with kids.

And we got the elderly coverage, so let's get kids covered. That was seen as very threatening. Any new entitlement was viewed by the right as

unacceptable because they are very, very concerned about these open-ended health entitlements that are eating up the budget.

So in '96—but there was a concern about trying to proceed in some incremental fashion to try to pick up more people and expand coverage. Clinton sent up his budget in '96 and it had this—I mean in '97—and it had this—actually—there were several bills that came along addressing children.

And this is where the whole “S-CHIP” versus “CHIP” controversy begins, if you are aware of it?

MOORE: We are exquisitely aware of it.

JAMES: Because I was just pointing out the Yellow Book to Michael yesterday where it says, "CHIP is sometimes also referred to as SCHIP."

And I said, "Well, you know, there is an act of Congress that says it is officially S-CHIP." This is where it all came from. Because the Rockefeller-Chafee-Kennedy bill—there were several bills as I recall that were called CHIP. And then Hatch got involved with the tobacco tax—this was all a huge issue on the Senate Finance Committee—to increase the tobacco tax and use the money to pay for health care.

And that was where a lot of the money for SCHIP came from. Chafee was holding out—well, this then gets into the politics of this whole thing in '97. So '97 we have the Balanced Budget Act. We basically have Medicaid off the table except for DSH and that's with the DSH allotments.

And again there is some sort of formula fight, you know, how to set the allotments. And there was generally, I think, agreement that the cap would remain at the 12 percent but the states under that, you know, these states just said, "Well, we never took advantage of this and we're going to be penalized because we are going to get locked into a low number for the rest of history." And yet that was where—that was the only place the savings in Medicaid were going to come from was the DSH cap, because there was nothing else you could do. I mean, there was nothing else under Medicaid.

The eligibility is up to the states...mandatory and...up to the states beyond the mandatory and the provider payments are up to the states. There is nothing the federal government can do on Medicaid in order to cut spending other than through some sort of capping of things like DSH if you're not

going to cap the whole program. So all the activity in the BBA in Medicaid was focused on DSH.

And then there was the issue of creating another entitlement. The Senate Finance Committee was crucial to the whole thing. Because the House had pretty much figured out what it was going to do on...But the Finance Committee had this issue of the 20 members and Chafee and Hatch, on the Republican side, you know, voting with the Democrats and pretty much putting the Chairman in the position of voting out or having a bill voted out of committee that was going to have a new entitlement in it. And he wasn't going to do that. And so there was a lot of negotiating that went on. And Breaux of course stepping up to the plate and saying he wanted to be the big mediator and find a solution. There were a lot of politics going on around what was going to happen with SCHIP once the tobacco tax got through and there was a certain amount of money that was then available to do the SCHIP program.

MOORE: They got it to a billion and it went up to—

JAMES: Twelve.

MOORE: —like 20 and—

JAMES: Oh, was it 20? It was 20, I think, yeah. The tobacco tax maybe was 12. I don't know. There was 12 in there someplace. But you're right.

MOORE: Also—the whole—the budget got more and more and more in balance. So that was more money towards the end of that year then there had been at the beginning of the year.

SMITH: And base lines were going down. Base lines were going down.

JAMES: And some of the money came from...the economy was going up. Because the budget wasn't balanced yet. But anyway, so then we get into SCHIP and...

SMITH: You didn't explain what's in—why there is an SCHIP as opposed to a CHIP. How does the S get in SCHIP? Was that Hatch's terminology or—

JAMES: No. They were all CHIP. That was all the CHIP bills. I think SCHIP got into the final version—it was either what the House had or what ended up in the final bill. But it was very clearly to imply that the states were

going to be important. To try to define what these programs would be. Roth appointed a subcommittee to—it was Chafee, Breaux, Baucus, and Gramm. And Gramm became very involved, a member of the Finance Committee...It was Gramm, Baucus, Chafee and Breaux that had to try to figure out where the common ground was.

And I remember that I was there to staff Gramm. And Chafee's looking at me and saying, "Julie, what do you think?" And I was like, "Doesn't matter what I think." Feeling like I was an ally but I was their staff. Gramm was on the other side so I had to say something, but it was a bit awkward.

But, you know, it really turned out. I mean, you had two Republicans and two Democrats. But it was really sort of Baucus and Chafee against Gramm and Breaux, I mean, in terms of where they were falling out on the issues.

SMITH: Yeah, that's interesting.

JAMES:...I mean, are you including SCHIP in your discussion?

MOORE: You need to because it's an extension—

JAMES: —you can use this because SCHIP can be used through Medicaid.

MOORE: Right.

JAMES: And then a lot of the details of SCHIP, you know, were worked out by staff in the dungeon at the House, people who drafted it in the middle of the night.

SMITH: Actually, that would seem to me in a sense to be fairly straightforward. I mean, many of the principles, parameters were kind of there, weren't they? It was a question of what you pulled out of the—

JAMES: Yeah, but there were always the policy issues in terms of ways in which SCHIP would differ from or relate to Medicaid. One of the things in the BBA enrollment of certain populations in managed care. And Medicaid issues in the BBA with what consumer protections would have to apply.

SMITH: Uh-huh. Uh-huh.

JAMES: And so we went through, you know, lots of details because obviously the members don't get into the weeds on those...SCHIP, okay,

what applies to SCHIP—to what extent is that going to be different. And as I recall, there was more latitude for the states on SCHIP than there was in Medicaid on the Medicaid managed care.

SMITH: I remember at one point Chafee pushed for and got agreement that one of the options would be at the Federal Employee Health Benefit package. Under SCHIP you had to—

JAMES: No, under SCHIP one of the big issues was, you know, defining the minimum benefits so on the extreme there were people who were willing to just give the money to the states and say provide—you decide what benefits you are going to provide. And then there were those who said no. Actually, this is...the discussion of what the minimum benefits were going to be was critical. And so trying to define what these would be, they came up with this whole idea of benchmark packages. It can be the FEHBP. It could be the HMO with the largest enrollment in the state. It can be a state employees' plan, you know. And then there was a list of services that had to be covered but they were sort of modeled after FEHBP hospital, physicians, and lab.

SMITH: And that was pretty much done at the staff level, these people working this over.

JAMES: A lot of the details were but that whole issue of actually what benefits would be in the minimum was one of the hottest issues. In the whole BBA at the end there were like 10 issues that remained, for which we had various levels of decision-makers.

There was the staff level and then there was what were called something else and then we sorted these issues out. When we sat down in conference, we literally had lists.

Okay, these are the things that clearly the principals have to decide. These are things that, you know, the…whatever that was. And then these are things the staff can work out. And the benefit, the minimum benefits, it was one of the last decisions that was made...

It was getting very close to the end. There were just a few issues left to be decided. One of the last issues to be decided was the extent of the benefit package and the issue was whether or not eyeglasses—it was vision—I think it was vision, hearing and something else were going to be included in the minimum.

And this was going to be imposed on the states. And the governors, of course, didn't want it. They didn't want to have to go that far in terms of what they covered. And the White House was pushing for it. And the Democrats and Chafee were pushing to have, you know...eyeglasses.

And so I got a call—this is probably the day before the whole deal was cut, finished—from the Leader's office and it said the Leader would like you to be in the meeting...come over here because the White House has sent us an offer. So I went over there and I read the offer, and I can't even remember what it was...

I think that the state employees' plans or something and it was somewhere where we had done research and we knew that the state employees' plans all covered eyeglasses. So if you accepted that as a requirement you would be covering eyeglasses. So I told them that's what it meant.

And so then they said, "Okay, we're going to have the meeting now and it's going to be the White House people and you are going to be the only staff person in the room."

And I said, "Well, this is bizarre. I'm going to be the only staff?"

"Yes, we want you to be the only staff person in the room." So it was a little strange. So I go into the room and it's Trent Lott and Newt Gingrich, Domenici and White House people. And they asked me to sit at the table.

So I sit at the table and then they present this offer and somebody looks at me. And I can't remember if it was Lott or Gingrich but I know that this means that if you accept this language then eyeglasses will be covered—in retrospect this seems so strange, you know...over this little issue.

And Senator Domenici turns to me and says, "Well, what do you think?"

I said, "Well, I think the governors are going to hate this. But this is what it means!" And it was like, you guys decide. So Lott's not saying anything. I am the only staff person there and Gingrich just kind of looks around and he goes, "Well, I think it's a good deal and we're going to take it. Or I think we should accept it. It's fine."

And Lott says...and they tell me to leave. And they start talking about something else and I'm not needed

anymore and so I walk out. And I go out into Lott's office. And all the staff, everybody is there—Howard Cohen is just crazy because he wasn't allowed in the room.

And you can't imagine this. There's like 50 people in Lott's office waiting to see what happened in there, in the chamber. Oh, this was the end of the world. They've got the GOP governors. They're all meeting in Reno or Las Vegas. They're on the phone. They want to know what happened.

They tell the governors. The governors are screaming. They're just, "Oh, how could you let this happen? This is awful."

So I remember standing there and all of a sudden behind me I hear this voice say, "I thought I had the best staff person I could have in the room and now I find out I've been hoodwinked."

And it was Trent Lott. And this whole thing was orchestrated to set me up to take the fall for this decision for him. That's what all this had been, my being the only one in the room and everything else.

SMITH: Oh, my goodness.

JAMES: And I turned around and I was just shocked and I said, "I do not appreciate being set up." You can't imagine how angry I was. And I left. Well, luckily—I go right over to Roth's office and I was like, "You cannot believe what that man did to me."

I am like so indignant and he was like, well, no big deal. But I was livid. I was just furious. Well, a nice thing that happened was that Domenici knew.

He had been in the room. He knew what happened and he evidently took Lott to task, you know. But it was the politics in these programs, I mean, that this issue of whether or not eyeglasses were going to be included could have risen to that level. And this is literally I think the final afternoon. And then either that evening or the next day, the very, very final negotiations with the White House happened in Gingrich's office.

I can remember sitting out in the hall outside Gingrich's office in the Capitol with the staff and Lott coming out of that meeting. And I'm sitting there in the hallway. And he sees me and he stops in his tracks and turns around and goes another way to his office to avoid me.

So anyway, that's what the politics of SCHIP were like. They were—they were incredible right up to the very end. Right up to the very end. And then, of course, it turned out to be pretty popular.

MOORE: I think that's an understatement.

SMITH: It's really succeeded beyond expectations. There was a phase there where people said there was this big dip and they weren't getting the enrollments. But it seems to me that people on the whole feel pretty happy about what's happened.

MOORE: In the end everybody took credit for this. Republicans, Democrats. You go into a state and local meeting, you know, elected school board members were taking credit for it. I never met a politician after it was passed that didn't take credit.

JAMES: Yeah, and I think the finances may change, but it's interesting because, of course, the Republicans feel vindicated in saying, "See, we told you if you just let the states have some flexibility they are going to take advantage of the money and they do want to cover people."

Because of course these were the allegations especially in '95. But then in '97, oh, well, you know, it has to be this command and control from the federal level and if you don't the governors are going to take the money and build roads with it and all this sorts of stuff. Well, in reality the governors have probably taken more of the Medicaid money and built roads with it and other such scams than they have SCHIP. And it also points out that the uniform policy that you have in Medicaid that applies across all the population groups doesn't really make sense, that certain things that you want to require be covered because of your disabled and elderly population you don't necessarily have to apply to moms and kids.

And then it also sort of highlights the huge gaps we have that don't make a lot of sense such as...who can't get coverage because they don't fall into one of these very rigid categories, you know, and that certain states have tried to have them be eligible for Medicaid.

So I do think—I do think there was a certain vindication of the whole idea that Medicaid had gotten a little out of hand. And I think you can point to, well, some very reasonable standards in that bill in terms of minimums and what they have required.

You know, I think all around it was valuable.

SMITH: I'm curious. You spent time in the Senate and had a good bit of experience there and you've had a chance to get out from there and to get a certain amount of distance and perspective. Would you have any advice for the Senate, that is, such as health policy has to be bipartisan or both sides should be able to claim a victory or whatever?

JAMES: Major health policy does have to be bipartisan. And of course that is the message that we gradually followed. I do remember in '97 another big thing that happened with Medicaid. I can remember being in a conference with the Republicans on the final DSH stuff.

Money was flowing to that end and Texas was—as I recall was a state that had a big issue with the mental health stuff. And of course Dick Armey and Bill Archer on the House side were looking out for the well-being of their state. And so again before, you know, the allocations had to be changed and so that there was a political victory there for whoever was bringing home the bacon. And of course on SCHIP the way the allocations went, again that was a formula. So the emphasis was on targeting the money to where there were the higher rates of uninsurance which really meant penalizing those states who had already done much to expand coverage.

And there was the issue of not giving money to states who have gone ahead and covered people up to certain levels and having to say, "Well, you don't get an additional match for those levels. If you hadn't done it, we would give you more money to do it. But since you already did it, we're not going to—you know, we won't."

But that's a huge policy issue and one that I did not think would survive in the end. But it did because the big issue on the Medicaid and SCHIP stuff in '97...in terms of coverage was how many kids were going to be picked up.

And to the extent that states were going to get more money to reward them because they had gone ahead and done stuff meant giving more to kids who were already covered. And that didn't make the coverage numbers look good. So there was this whole policy orientation toward CBO's estimate and the number of kids that would be covered.

Then there was...the '97 on Medicaid. There was the repeal of the Boren Amendment and there was some vague language put in that states had to

have some sort of process to turn in their payment rates, that they were no longer going to have to...

SMITH: Kind of a public hearing process?

JAMES: They were trying to get away from all the lawsuits.

Another big issue was a clarification of whether or not states had to pay the full Medicare cost for dual eligibles or only to fill in the amount that would bring your provider payment up to the Medicaid level, which has now been settled. And that was a big issue to get clarified for the states. Managed care was going to answer a lot of problems. And so there was...

SMITH: You're saying at the time this feeling that managed care was going to answer a lot of problems.

JAMES: Yeah, there was something on managed care I was trying to—

MOORE: It was made a state plan option.

JAMES: Yeah. Well, there was the mandatory enrollment in managed care but there was something else I—oh, the FQHC, the community health centers and the federally qualified health centers...kind of a big—small issue.

SMITH: Uh-huh.

JAMES: A significant smaller issue, one that Chafee was very involved in, that one. But states, you know, under the Medicaid policy at the time states had cost-based reimbursement requirements for the FQHCs and they wanted...felt like they were having to pay higher rates for the health center care than they were having to pay in the general community and they didn't want to do that.

So the idea was that the FQHCs were going to have to change from cost-based reimbursement. And then subsequently in either BBRA or BIPA Congress went further and provided another option where states were to develop a prospective payment system with a base year and then they would get some sort of inflation adjustment...where they are right now. The whole idea at the time was, okay, they are going to have to get managed care and...the states have some latitude if they can get the FQHCs to go along with it to do, to accept this rate however they want.

But, you know, FQHCs, the health centers are a big deal for Medicaid.

SMITH: Oh, they are, yes. There was quite a lot of feeling about that issue. What are you working on these days?

JAMES: I'm just trying to think if there were any other...issues in Medicaid. What I am working on now I primarily do here. You know, yesterday I was actually working on the Medicare drug benefit. I do a lot of Medicare work.

SMITH: Well, thank you so much for your time.

INTERVIEW WITH PHILIP LEE, M.D.
JUDY MOORE AND DAVID SMITH – MAY 5, 2004

MOORE: This is May 5th, 2004, a telephone interview of Phil Lee by Judy Moore and David Smith.

LEE: I can answer the written questions that you asked fairly quickly and then, if there's more to ask, we can do that.

MOORE: That sounds terrific.

LEE: Number one, when did I first get involved in government? I went to Washington full-time in the government in 1963. Before that I was consulting with the Public Health Service occasionally and had taken a trip to the Soviet Union for them for three weeks.

But I went to AID in March of 1963 and I went to the Department of Health, Education and Welfare in August of 1965. I had resigned from AID, was going back to the Palo Alto Clinic to practice and Wilbur Cohen called me and asked me if I would come to the Department to help them implement Medicare.

John Gardner was subsequently appointed Secretary. I was appointed a Deputy Assistant Secretary for Health and was assigned to do whatever John wanted me to do. But one of those items was to work with Medicare, particularly on issues relating to physician payment, which I did, and particularly with physician payment in the teaching setting, working with the Chairman of the Council on Medical Education of the AMA, who was a professor of surgery at UCLA at the time.

I became the Assistant Secretary because during the early Kennedy period when he—when the King-Anderson Bill had been introduced—I formed an organization with some others in California called the Bay Area Committee for Medical Aid to the Aged, and as a practitioner was campaigning actively for the passage of the King-Anderson Bill, which was Part A, eventually, of Medicare.

I debated various people, including the President of the AMA. The only time he would debate me was in Sioux Falls, South Dakota. I was on the David Suskind TV Show with the President of the California Medical Association and the President of the New York Medical Society. I was in close touch with the

AFL-CIO office in Washington, particularly Lee Shorr, then Elizabeth (Lee) Bamberger, who was working for Nelson Cruikshank, and providing me with a lot of very, very useful statistics that I could use in my debates.

I debated opponents of the King-Anderson Bill, usually physicians in churches, in community centers, at Stanford, at UCSF, at Rotary Clubs, and numerous other venues. I had TV and newspaper interviews and I was written up in Newsweek Magazine and things of that sort because I was a young practicing physician and a Republican advocating for public health insurance for the elderly through social security, not welfare.

I had gotten to know Wilbur mainly on the telephone through these various activities and testified before the Ways and Means Committee. When I was in AID, Wilbur had asked me to brief some congressional delegations on Medicare from a physician's perspective because nobody in the Public Health Service, none of the senior physicians, were comfortable doing that.
So I was happy to do that. So again I had fairly good contacts. And one of the areas that they wanted me to work on was Medicare. But, more particularly, there were other areas that John Gardner wanted me to work on.

One of those, right away, was to develop a family planning policy. Another one fairly quickly was to look at the adverse effects of oral contraceptives. Morton Mintz had had a front-page story in the Washington Post and it turned out that women who smoked had strokes from taking oral contraceptives, not in high numbers, but it had been an overlooked problem before.

Then we had to appoint a committee to give us advice about it. All the people we wanted to appoint were consultants to a drug company that was making oral contraceptives or some other device—there was a potential conflict of interest. And the only way we could handle that was full disclosure. And so we went ahead.

I was not in HEW when the Social Security amendments were passed but I was very familiar with the Medicare legislation because Wilbur had called me. Of course I had followed it very closely anyway because I had been very interested. Wilbur had called me to tell me that Medicare was going to pass. He called after the House had created the Medicare/Medicaid combination, Part A, Part B and then Medicaid.

SMITH: A three-layer cake.

LEE: So I was aware of what was going on, and when it was passed. I was invited to the signing of the bill by President Johnson in Independence [Missouri], but instead went to the Bohemian Grove where I met John Gardner and had some long meetings with him. The Bohemian Grove is a large redwood grove in northern California where members of the Bohemian Club in San Francisco hold an annual summer retreat and members invite guests.

It was actually a very fruitful way for both of us to get acquainted before I got to the Department and it gave me a big leg up on subsequent developments. I certainly was aware of Medicaid. I was also very aware of the Kerr-Mills law because in Santa Clara County, when I was practicing in Palo Alto as an internist, I served on an advisory committee to the county on medical care.

I trained in rehab with Dr. Rusk as well as in medicine at Mayo's and in Boston and Stanford. So the county had me as an advisor on Kerr-Mills issues and other health care issues relating to the elderly in Santa Clara County. It was the welfare department that paid for medical care of the indigent.

And Medicaid basically was an extension in some ways really of the Kerr-Mills philosophy extended to the whole population instead of just to the elderly, though it was for the indigent. It was a means-tested benefit and it followed the Kerr-Mills pattern in that regard. It was totally different obviously than Social Security, which was not means-tested. It was an entitlement and it was administered by the Social Security Administration.

It was not viewed as much of a solution because with Kerr-Mills there were only five states, as I remember, that implemented it very effectively. And I think maybe 90 percent of the spending went to California, New York, Michigan, and I think Massachusetts, and I forget what other state. But I think there was one other state that had implemented Kerr-Mills fairly aggressively.

That was one of the big failures of Kerr-Mills. It really didn't cover very many people and it only covered people in a few states. So with the implementation of Medicaid, that was done under the welfare administration and was to be state administered, often through the counties. Frank Land, as we talked earlier, David was recruited to be the director. We were not involved.

I mean, I was very involved with Social Security and with the Bureau of Health Insurance and with Art Hess, Bob Ball, and their colleagues in Social Security. I was in many, many meetings with them and many meetings with the AMA with them and with various physician groups—because they didn't have any physicians in Social Security and Medicare, at least in the Bureau of Health Insurance, initially.

So they used me and they used—John Cashman who was particularly helpful from the Public Health Service. And then they recruited people, Social Security did. But it was very, very different because it was a federally administered program.

Medicaid was considered a state program with federal aid and the federal government pretty much just paid: when a state passed a law that implemented Medicaid and they began to bill the government I think they simply sent them the money.

Now, we really weren't involved very much at all. My deputy, Dr. George Silver, you're going to be seeing George I guess in a week or 10 days, was later involved around the EPSDT issues and kids' issues. George was very, very concerned, but as my deputy for health care issues he had no direct authority over people in the Welfare Administration.

I recruited him right after the White House Conference on Health in the fall of '65. I had, at that point, been appointed the Assistant Secretary for Health. I was a Deputy Assistant Secretary before then. Congress created the position of Assistant Secretary.

The person who was thought to be in line for the job, Ed Dempsey, was the special assistant to the Secretary for Health Affairs. John recommended me instead of Ed. He was a professor of anatomy from Washington University in St. Louis, and as a matter of fact had been a teacher of histology in Stanford Medical School when he was on sabbatical and I was a freshman medical student in late 1944 or early 1945. He was much more interested in medical education issues and research. He wasn't on the health care issues. And John wanted somebody who could really take in the whole ball of wax.

SMITH: The John here is John Gardner?

LEE: John Gardner. Right.

SMITH: Now, you mentioned John Cashman earlier. Is that the John Cashman who was in Kaiser?

LEE: No. John Cashman was in the U.S. Public Health Service. He was in, I think, the Bureau of Chronic Disease. Then he went, I think, to Indiana as Director of Public Health.

He was a very outstanding person on quality of care issues and medical care issues in general and was sort of the link into the Public Health Service from Social Security, from the Bureau of Health Insurance.

SMITH: I remember now that, from the standpoint of the Public Health Service, he was one of those who was oriented toward health care and some action in this area...

LEE: Absolutely right. Now, the other people. There were a lot of people in the Public Health Service who were involved in delivering medical care to merchant seaman. And many of the top leaders in the Public Health Service, Caruth Wagner, Leo Gehrig, various other people, had come up through that bureau, the Bureau of Medical Services.

But they were not involved so much in the Medicare-related issues. They tended to stay away from those. They thought it was too political. But John Cashman was outstanding. The relationship with Medicaid and I would say my relationship with Frank Land were cordial. But I would say I had few meetings with Frank.

But we were not actively involved, but I—I don't recall—and George may recall more... The states began to enact laws in 1965 that would be implemented in early '66, like California. George may have done some more stuff with Frank around those issues than I did because I was involved more in these other areas.

MOORE: Dr. Lee, do you remember much about Frank Land? I believe he has passed away. But where did he come from?

LEE: I think he was a general practitioner from Nebraska. He was very much an AMA guy. He was quite conservative, if I remember. And when Medicare passed, as you know, the Congress said you can't do anything to interfere with the practice of medicine. Congress also established a method of paying physicians that was very much to the doctors liking.

In California there had been one county, Riverside, a small county, that had experimented with what was called usual and customary payment instead of a fee schedule where the Blue Shield determined the fees for the doctors.

In usual and customary the doctor determined it and it was what he usually charged, customary, what was charged by the physicians in the community. Reasonable was what seemed reasonable. If it was thought to be unreasonable (was too high), they tried to reduce it. Well, that led to a very, very large escalation in payments to physicians.

And the AMA and CMA, for example, said, we're advocating mainstream care for poor people so they could get equal treatment with everybody else and the same access to doctors with the same payment. But that led to a tremendous and rapid increase in expenditures for physicians' services in the Medicare program as opposed to, say, Kerr-Mills.

And by '67 Bill Gorham, who was the DHEW Assistant Secretary for Planning and Evaluation, had done his study looking at costs. Hospital costs in Medicare went rapidly up because hospitals were paid on a cost-based reimbursement. So of course they bought all kinds of new equipment, and all [of] that was billed to Medicare. So there were two payment systems that were very, very inflationary but strongly supported by Blue Cross/Blue Shield and also by organized medicine.

SMITH: Now, you said two payment systems. You're talking about cost reimbursement for hospitals and UCR for physicians?

LEE: That's correct. Two payment systems in Medicare. In addition, organized medicine was very supportive of Medicaid because it meant that doctors taking care of poor people would get money to pay for the care instead of getting nothing.

The Medical Assistance Advisory Council [MAAC], I really don't remember that. I'm sure it existed. The Health Insurance Benefits Advisory Council (HIBAC) meetings were the ones that we would go to and that was for Medicare.

SMITH: Well, that's the point I was trying to get someone to establish. HIBAC was highly visible. Everybody knew about it and—

LEE: It did an outstanding job.

SMITH: Yeah, it did an outstanding job and the MAAC really never got off the ground. About the only use was to track all the paper that had to go through it.

LEE: We may have gone to some of those meetings but I don't recall. George may recall some of those but I don't recall them.

Now, the Ways and Means Committee investigation of Medicaid began because of these rapid rises in expenditures that were unpredicted. Nobody predicted it would go up the way it went up. And that I think led to these concerns about fraud and abuse.

SMITH: Let me ask you just one question on that. Because this came out a little bit with the actuary, Bob Myers, in Social Security.

I asked him if the reason Wilbur Mills had begun his investigations so early in 1966 was because of this cost explosion. He thought it was partly that, but another reason they started was just that Wilbur wanted to know what was going on, and had made a pledge to AMA to control the costs on Medicaid, so that he was almost anticipating the cost explosion that later came. But the hearings began so early—in the summer of '66. Does that make sense to you?

LEE: Yes, because in the summer of '66 Medicare was implemented. But the Medicaid programs, some of them began to be implemented in January of '66.

Laws were passed in '65 and so they were implemented in '66, early '66. Now, that was only a few states. But by July a number of them were moving forward.

For some of the states also, there was a backlog of bills from doctors and hospitals. Geoff Hiller, when you talk to him, will describe this for you: the backlog was such that they said just pay all the bills at the 90th percentile.

So, that added, I think, to some of this concern.

But I would also say there was a—well, it's just like night and day, the difference between Frank Land and Bob Ball, Art Hess and the team that Bob had, including of [course] Bill Fullerton, Irv Wolkstein, and Will David. I mean, absolutely outstanding people working with him. They're policy

people, they're legislative people. And the management people. It was still a very, very complex task to put it all together.

MOORE: They also had a lot of people, a lot more people, did they not, than Frank Land and his group?

LEE: ...I don't know how many Frank's had but he had relatively few compared to Social Security—and, of course, Bob and Art were able to recruit more people into the Bureau of Health Insurance.
Unfortunately later, when they transferred some of the SSI folks to Social Security under Nixon, and Art Hess was the acting commissioner, they did not give Social Security the manpower it needed. And they have been understaffed, I would say, ever since. But that's a different story.

SMITH: Just one more question about the Frank Land era. Did you know Ellen Winston?

LEE: Oh, of course. She was the Welfare Commissioner from North Carolina.

SMITH: A lot of people came from North Carolina. We were talking with a person that goes back to those Ellen Winston days and saying that in fact a lot of the people who came to Washington came because of the considerable amount of quality in the Bureau of Public Assistance.
And that leads us to wonder to what extent the disparity you see between Medicare and Medicaid may have to do with some non-obvious factors. I mean, the usual opinion you got was, well, these people over there were just incompetent.

LEE: Well, no. I think first of all it was a state program, not a federal program. So that it was delegated to the states. It wasn't managed from Washington.
SMITH: Right, right.

LEE: So there was a very, very big difference in terms of Social Security versus Medicaid.

With Social Security and Medicare, you have to manage this operation for the whole country and set up a system that works through your regional offices of Social Security and your district offices and your local offices. And working with all these intermediaries and carriers, as opposed to this, [Medicaid] is a state program, once we approve the state plan and they had

a process for doing that—then the funds went out there. And it's what the states did, and the federal government was very much aware of the effect of that. Now, other people who could give you a more detailed picture unfortunately have died, like Jim Kelly who was the budget guy in DHEW.

SMITH: Yes, I remember him.

LEE: You know, they would predict Medicaid spending that they knew was low because we had to come within the President's budget. So they would predict that the Medicaid spending would be low—then there would be overruns and we would have to go in for a supplemental. But everybody knew what we were doing.

Now, I don't know that any of the people who worked with Jim are still around. But again, Bill Gorham actually might or Alice Rivlin might have some clear recollections because Bill did the studies on costs that led to a national conference and a Presidential Statement about costs and we had to do something about costs. And Victor Fuchs gave the keynote address for the conference that DHEW had on the costs of medical care.

Bill's report came out I think in '67. He was later President of the Urban Institute, founded the Urban Institute, still lives—I think it's in Chevy Chase. But they would know how to reach him through the Urban Institute, certainly.

And Bob Gross was the health guy, but I don't know who in Bill's shop really was looking at these issues. But there were certainly some people looking at them. And Alice may remember who some of those people might have been.

SMITH: Now, you were in Washington, of course, when they passed the amendments of '67.

LEE: We were, yeah.

SMITH: There were a lot of things we were concerned about, but they cut back on the medically indigent especially. And it hit states kind of differently, I think, and California was quite rich in services. How was California affected?

LEE: Oh, yes, absolutely. For California and some other states that were very generous, they had a very significant effect. And of course at the same

time you had Ronald Reagan as the governor. And he made a whole bunch of cutbacks, some of which were found by the State Supreme Court to be unconstitutional. So you had a double whammy in California.

And again, Geoff can maybe explain some of that because—but for those states that had the more generous medically indigent programs—I think New York probably. For some of the more generous states, that was a significant factor. But, Congress was very, very worried about costs.

And, of course, the President was worried about costs because by that time the Vietnam War costs were beginning to escalate. And that year we asked the President to expand Medicare to include kids. And Charlie Schultze said we couldn't do it because of the budget deficit.

And Congress wouldn't raise taxes to pay for the Vietnam War—we would have had national health insurance as a next step enacted in '67 or '68 if it had not been for those rapid increases in costs. People didn't feel they had them under control.

I don't know if Charlie Schultze is still around. You know, he was head of the budget. Then he went to Brookings. And he may still be around, too, and would be a good source of information from that point of view, of those expenditures going up very, very rapidly.

Of course, Paul O'Neill was working in the Bureau of the Budget at the time. And he certainly—from that latest book he certainly remembers a lot of stuff. Although he talks more about when he worked for Ford and Nixon but he was still there in LBJ's time.

SMITH: Hadn't thought of him. He is a good friend of Lynn Ethridge's, too.

LEE: Well, he's a very, very sharp guy. I remembered him that many years ago very, very favorably, as a very impressive, very intelligent person.

MOORE: And, you know, I bet he did have a fair amount to do with implementation of Medicare and Medicaid in the middle '60s from—well, I guess it would have been BOB then.

LEE: Yes, it was Bureau of the Budget and he was Irv Lewis's boss. Irv was over the VA and the Public Health stuff. And I think Paul was over Irv.

MOORE: Right.

LEE: And then Charlie was over—I think he reported to Charlie. I think he was an Assistant Director.

MOORE: Yeah, that sounds right.

LEE: On the '93 to '97 issues—the issue about the entitlement, all that was really in Bruce Vladeck's domain. It became much more politicized after '94, after the Contract with America with Gingrich. Ideology began to be the driver of policy. Bruce would certainly be the right person to talk to about that.

MOORE: Yes, and we had thought—we have interviewed Bruce. We have a good interview with Bruce on some of these subjects, yeah.

SMITH: One of the things I wanted to get at there was that this language of entitlement, I remember Rosemary Stevens saying rather sharply to me, "Do you understand what an entitlement is?"
And I said, "Well, no, not really."
She says, "It's used in very different ways and it kind of creeps up on us."
And one of the things I was trying to get out there was back in, say, '66-'67, was there much language about whether a thing was an entitlement or not? Did you use that kind of language?

LEE: I don't remember that. But certainly Social Security was an entitlement. It was social insurance and you paid for it while working through Social Security taxes and you were entitled to it after retirement.
Medicaid, in contrast, you became entitled if your income was below a certain level, your assets were low, and you met the other requirements such as aged, blind, disabled, or families (usually a single parent) with dependent children. It was an entitlement in a sense.

SMITH: Yes.

LEE: But not in the same way that Medicare was.

SMITH: Well, and there's that anecdote about Roosevelt saying that he wants it to be a contributory program because then, to quote him, "No damn politician can take it away."
And people often refer back to that and say, "Well, that's what you meant by an entitlement when you referred to Social Security." But you didn't have that equivalent in Medicaid.

LEE: No, you did not have an entitlement in that sense. But people call it an entitlement but it's different than Medicare and different than Social Security.

SMITH: Uh-huh.

LEE: Because by Medicare you are entitled when you reach a certain age and you retire. Medicaid, you know, it's determined by the state and what the state determines to be the income eligibility. Once you are eligible, of course with Medicaid, you could lose eligibility. And many women have done that on the welfare to work thing. They were supposed to have—you know, be entitled to it; but in fact, they weren't.

SMITH: Right.

LEE: So it's a different—it's a different use of the word. I don't know how Rosemary defined entitlement—

SMITH: Well, she was trying to make the point that it is used differently and that when you get to Medicaid it's a little bit hard to say why you think it's an entitlement, if indeed you do. That is, it's certainly not in the same sense that some of these other programs are.

LEE: That's absolutely right. One thing it is not—the expenditures on the part of the federal government are not dependent on an appropriation. In other words, the NIH isn't an entitlement. It's an annual appropriation. For Medicaid you have to spend the money if the states have spent the money.

SMITH: Right.

LEE: So in that sense it's very different than a grant in aid program.

SMITH: Yes.

LEE: Which is subject to an annual appropriation. And of course you see that now when they want to cut discretionary spending. It's not discretionary.

SMITH: Thinking back to the early days, as Assistant Secretary for Health, were you assigned any kind of specific responsibility for Medicaid or did you have—

LEE: No. I mean, simply, that Wilbur would ask me to do things or John would ask me to do things. It wasn't, here's your portfolio. It was kind of an across-the-board assignment in health policy, but I didn't have administrative responsibility for a program. I mean, one of the other things John asked me to do right away was plan the White House Conference on Health for the fall.

He'd planned the White House Conference on Education and it had taken a year. I was asked to do this in August and the meeting was going to be in November. That took a fair amount of get-up-and-go to put that all together.

SMITH: You had to do that between when?

LEE: Between August and November.

MOORE: This was 1965?

LEE: This was '65, yes.

MOORE: Okay. What was the outcome of that conference? Was it focused around the fact that the two programs had been—Medicare and Medicaid had been enacted?

LEE: The President wanted to have a White House Conference on Health. He liked White House conferences. He had one on education that was a big success. The White House Conference on Health was held in November, but he couldn't be there because of his surgery.

But that was a very big event—the Secretary of State was there; John Gardner was there. The Chairman was George Beadle, who was the President of the University of Chicago who had received the Nobel Prize in medicine. It was a very big event—we worked with the White House. Of course, if you have the White House working with you—and Peter Bing in the White House was our key guy—when you get an invitation from the

President to do something, the response rate was very, very high.
And the conference had an international, a global focus as well as a domestic focus. And I would say one of the most eloquent talks was by Alonzo Yerby, who was the Commissioner of Hospitals in New York talking about a “two

class system on health care." It was a very eloquent statement about discrimination.

MOORE: Interesting.

LEE: And coming from a New York black doctor, very powerful.

SMITH: At the time, was there a lot of psychic energy and political chips going into trying to integrate the hospitals and actions like that? It's kind of one of the unsung victories that you can—

LEE: Well, it was more than psychic energy. But it was from the President on down. And Joe Califano—as a matter of fact, Joe was in San Francisco the other day. Nancy Pelosi had a little reception for him as he was introducing his most recent book to people in the Bay area.

During the effort to desegregate the hospitals in early 1966, Joe was on the phone with, you know, either Peter Labassi or the Secretary at least once a week and often more often. Doug Cater, who also worked as a Special Assistant to the President, was on the phone with us, asking, what are you doing about Atlanta? What are you doing about Memphis? What are you doing about this or that?

Peter Labassi prepared reports for the President every week detailing progress state by state. President Johnson met with hospital and medical leaders in the middle of June and I still remember that speech where he basically said, "I expect you to all obey the law." By that he meant the Civil Rights Act.

He made it very clear that the federal government was not going to back down on the need for the hospitals to be in compliance with the Civil Rights Act. We didn't require the doctor's office to be in compliance. It was a different thing.

But many of us were involved in that. The Surgeon General of the Public Health Service, Bill Stewart, put a whole bunch of people from the Public Health Service into the effort and Bob Ball of the Social Security Administration had a hundred of their staff from the regional, district, and local offices involved in inspecting the hospitals. It was a massive effort and they did a fabulous job.

And George was sort of our point person on that but we were all involved in it. And John Gardner, I said that the one time he—

SMITH: George that was your point person?

LEE: George Silver, my deputy. You'll be talking to George. And he was really the conscience of our office. He was fabulous.

MOORE: A minute ago you mentioned child health and EPSDT [Early and Periodic Screening, Diagnostic, and Treatment] as something that George was working on, too. Do you remember the enactment of EPSDT, which was in the '67 amendments? And people have—historians have commented that it was related partially to the fact that in the [Vietnam] draft the Pentagon was finding so many young people—

SMITH: —with disabilities that might have been corrected.

LEE: Visible. Absolutely. Yes, this was an area that was very—and we thought it would accomplish a great deal more than it did.

SMITH: Actually, it did.

MOORE: Yes, eventually I think it did.

LEE: But early on it was hard to get it off the ground. But eventually I would say it absolutely did.

SMITH: Now, was it just that, in general, people were dragging their feet or was it specifically that they were sticking at “T,” the treatment? I mean, you get one sense that states just wouldn't implement it.

LEE: The states were concerned about the costs, I think. That was the main problem. And yet it was an absolute necessity because the system wasn't doing what it could and should do. Now, of course since then we have had many other developments, things like immunization and other initiatives that have bolstered that. But it was a very important, in a sense, policy statement.

SMITH: You said that there was a key—or Judy brought up the question of one of the key items was the Pentagon and what they discovered in relation to the draft and wartime health and education—that kind of thing. Were there other sources of support or push behind EPSDT?

LEE: Well, I would say—and George can tell you more about this—but I think that people in the children's bureau and Arthur Lesser probably were also strong advocates of that. But I don't remember that specifically. But George may remember that. That would have been the other focus because the Public Health Service didn't really have much focus on kids.

MOORE: That's true. Okay, good.

LEE: And, you know, why did Head Start get put somewhere else? Even though it was more education than health, but there was a lot of health in Head Start, but because there wasn't that sort of innovative productivity in the Public Health Service, it was started in OEO [Office of Economic Opportunity], which is where the community health centers were—in OEO.

They didn't start within the Public Health Service. We later brought Joe English and all the OEO health programs into the Public Health Service. But those initiatives did not begin within the Public Health Service. And that's one reason that John Gardner wanted me to be in charge of the Public Health Service. Later Wilbur put me in charge of the Public Health Service.

SMITH: I have the sense that the Public Health Service, right after World War II came out, was full of fight and fury. And then it seems to me that they and many other people were a bit daunted by the experience with attempts to get Wagner-Murray-Dingell or—

LEE: Well, the Truman Plan in '48. I don't remember when Tom Parren left. But it was not long after that. He was a very vigorous leader of the Public Health Service. But it was around a lot of the issues like venereal disease and areas that were, you could say, in the domain of public health and were not so much the domain of private practitioners.

But, you know, in 1955 they did transfer the Indian Health Service to the Public Health Service because Public Health Service was clearly doing a better job with the merchant marine and with the merchant seamen in the Public Health Service hospitals.

But their engagement in the political level I would say dropped off dramatically after Dr. Parren retired.

SMITH: That's not of course dealing with all the NIH stuff that develops, but that's a different route. You get a feeling even back in the early days

when we were talking national health insurance and things of that sort, that Parren and the PHS saw it as kind of a third rail. When you got into the practice of private—when you began intruding on the practice of private medicine—

LEE: It was the third rail for Public Health Service. That's right. Also, it might be worth looking at the report of the President's Committee on the Health Needs of the Nation. Which was published in 1952. My dad was actually on that commission. When Truman couldn't get health insurance he appointed this commission to look at the nation's health. Lester Breslow, who is still going strong at UCLA in his late '80s, was recruited to be head of the research staff. And I think basically wrote most of the report.

But that could tell you a lot about what was going on at that point and right after the—at the end of the Truman Administration before Eisenhower. Because many of those ideas in fact were adopted by the Great Society.
Many of their recommendations were what we implemented 10 years later.

MOORE: Good point. Well, this has been very interesting. David, have you got more questions?

SMITH: I think I have pretty well covered my questions. I would like to say it's been a lot of fun.

LEE: I would say one other thing, David, about the Johnson period. The level of leadership was remarkable. You look at the people like Bob Ball, John Gardner, Wilbur Cohen, Bill Gorham, Alice Rivlin, Jim Kelly, and Jim Shannon at NIH were outstanding.

SMITH: Yes.

LEE: You had—and then in the White House, Doug Cater, the guy who later became the head of National Public Radio, Joe Califano, Hubert Humphrey, and the President himself. You had, in Department after Department, smart, energetic, committed staff fully engaged with the White House on issues.

We worked much more closely with the White House in those days than we did in the Clinton Administration for reasons that are not entirely clear. But it was different—of course the politics were different.
You had a Congress after '64 that was hugely Democratic. Now, many of those guys lost in '66. And more lost in '68, obviously. And the White

House was gone. But it was—there was a period of an enthusiasm and energy that was remarkable. Like desegregating the hospitals. You know, six months, and it happened.

And then there was a tremendous social revolution. And the implementation of Medicare in itself. And then area after area that Johnson innovated in terms of domestic public policy.

SMITH: Yeah, I have to agree with you on that one. It seems to me, alas for the Vietnam War, that Johnson had the potential for being one of the greatest leaders in domestic policy.

LEE: No question. Absolutely, yes.

SMITH: It was a shame. One final question that did occur to me. What were your personal impressions of Wilbur Cohen since he's so important in both Medicare and Medicaid?

LEE: Well, I loved Wilbur. I mean, Wilbur was very intelligent, very politically astute, tremendously energetic. And yet we knew that for Wilbur—there were certain areas that were his major interest, priority interest.

One of them was obviously Medicare and Social Security. Family planning happened to be another one, and I was working on that. So I worked very closely with him on those issues. And he handled the politics of that with the Catholic Church and various other groups that were opposed to what we were doing.

And he was just a dynamo of a guy. I mean, he was—John was obviously very different, much less in some ways political than Wilbur. And some ways you felt that Wilbur would make a compromise when you thought you shouldn't. But, his judgment was so much better than ours on those issues it was just no comparison.

You know, we were like kids and he was like Joe DiMaggio, the famous New York Yankees baseball player. We were like the batboy in terms of his skill politically. He knew Wilbur Mills. He knew all these people, and they knew him.

And of course the AMA hated him. They just had these crazy ideas about Wilbur. Because of Medicare they were just bananas about him.

SMITH: If you keep getting outsmarted you don't—

LEE: Well, no. Some people would say when he was appointed Secretary...Time Magazine described him as the “salami slicer.”

SMITH: Oh, yes.

LEE: He would take a little bit to get a program started and then to get the whole sandwich—and the AMA would say, "Don't let him put the elephant's nose under the tent." Because the next thing you know, the elephant will be there. The AMA—they called it the elephant's nose under the tent. Well, it was a pretty big nose, you know.

SMITH: Well, it's clear that by 1950 when they got in the voucher payment, that Wilbur pretty much already had in mind what he was going to have in the way of a Medicaid program.

LEE: That's exactly right. It was when they decided not to go for national health insurance. And I forget the guy who was second or head of the Federal Security Agency at the time...made the announcement it was Wilbur and Bob Ball, I think basically, and a few other people, who were pushing the idea. And of course Wilbur first went to Washington when his professor from Wisconsin went to begin the planning for Social Security.

SMITH: Witte?

LEE: Yeah, Witte.
Even after Wilbur retired and left Michigan, he went to Texas and was the Sid Richardson professor of public policy. He was still...he never quit.

SMITH: No, he didn't. You would be interested in what someone said about going to interview Bob Ball. They said, "Well, he's just as lively as he can be; but he won't talk about anything but Social Security."

LEE: Well, Ted Marmor, I think, described him as one of the great civil servants of the 20th Century.

Certainly you would have to put Wilbur [Cohen] in that category even though he later became Secretary. But he was a career guy before that. With a warm, generous, energetic, wonderful sense of humor and he just

worked his tail off. I mean, if we wanted to meet with Wilbur we often had to wait until 7 o'clock at night so we could have an appointment to see him.

SMITH: Well, there's a small little story. I had a friend that did some research many years ago, about 1966 in Washington. And through Red Somers managed to get a desk in HEW. Cohen told him he was busy but to come any time late in the evening and talk if he was free—sort of a post-grad seminar.

LEE: Right, right.
Well, of course Ted Marmor came in the same way. And, of course, that made Ted's whole life professionally.

SMITH: Well, it's got to create a great sense of nostalgia when you look back and see the kind of people they had in HEW back then. Well, it's been an absolute pleasure talking to you.

LEE: Well, nice to talk with you. And I'm sure you'll find George both interesting and entertaining.

SMITH: I'm looking forward to that. He's a good friend of a friend.

LEE: Great. Okay.

MOORE: Right. Thank you so much for your time.

LEE: You're very, very welcome.

INTERVIEW WITH PATRICIA MACTAGGART
JUDY MOORE AND DAVID SMITH – JULY 15, 2003

SMITH: This is a telephone interview of Patricia MacTaggart by Judy Moore and David Smith. We're at the National Health Policy Forum. It is July 15, 2003. We would like to begin by asking you about your career in Minnesota and how you rose upward in the Medicaid administration.

MacTAGGART: Okay. We're talking about a long time [ago] here. I got into health care and Medicaid as a newspaper reporter for a twice-weekly that covered the county government, Wilkin County, which was located in Breckenridge, Minnesota.

My last two paychecks at work in those days—and do not laugh—were only $100 a week. They were not good. I went and told some of the commissioners and people that I was going to be resigning, like immediately, because I was single and had no way to pay my rent with two paychecks that couldn't be cashed from the newspaper.

And the county commissioners, who truly did not understand the welfare system or the requirements of hiring and stuff, said, "Hey, no problem. Come work for us. We have authority to do food stamps and this Medicaid program. We need somebody to do eligibility."

I'm like: Sure. I have no idea what it is but it's a job and it's a paycheck, you know—and started doing that. They only figured after they discussed the job with me that I actually had to go and take a test with the state to see if I could be a financial worker.

I became a financial worker and I started in food stamps. We started everybody in food stamps because it was the easiest program. And then Medicaid was the next one they gave me to do because AFDC was more complicated. And if you were really good at Medicaid then you got to do nursing home Medicaid.

Wilkin County was a really small county and as programs got added I think we had two financial workers the entire time I was there and I was there 11-1/2 years.

There was a lady who had cystic fibrosis so she wasn't supposed to live beyond her teens, I think she was the oldest living Minnesotan with cystic

fibrosis when she hit 21. But we never hired anybody else because nobody thought she was going to live that much longer.

So as we added programs we just added them to me and I just kind of brought up child support, brought up all these programs because we assumed at some point my coworker wouldn't be around and then we would hire more staff. But to her credit and our amazement, Cathy worked three years longer than anybody thought she was going to work.

So we had a great time. We were so small that eventually I did all the financial work with two people helping me.

In Minnesota you have a financial workers association. They do all the financial eligibility. And we brought up EPSDT [Early and Periodic Screening, Diagnostic, and Treatment]. I can't believe those days. I became the president of the financial workers so I represented counties on eligibility and EPSDT at all the state hearings and all that stuff.

SMITH: Oh, now this is the Association of Financial Workers.

MacTAGGART: Yes, of the financial workers. And I spent so much time then with the state that when my kids grew up and I was looking at my next career step...Eleven and a half years later.

And my youngest stepdaughter graduated from high school so it was a perfect time to do a move. The state folks said, "Well, you know, you complain about the state all the time so come work for the state." I ended up going to the state to develop the adult physically disabled home and community based waiver and the personal care attendant program. I started out on the long-term care/home care side and as we were just creating Home and Community based services for physically disabled, I did the negotiating with the Feds to get, of course, all the authority to do what we wanted to do.

I left the home and community waiver program to manage the Medicaid State Plan for the state. Basically I was 11-3/4 years at the state of Minnesota but I never had one specific job long enough to ever get off probation. It took a year to get off probation and by the time I was ready to get off probation I moved to the next job.

I had literally every job you could have in Medicaid from home and community based waivers and then the State Plan, which is a great way to learn from eligibility on forward, to the 1115 waiver for managed care.
My job there was supposed to be to close down the 1115 demonstration waiver because the Feds would only let us have it for three years. But I got into it and thought it was a good program and didn't want to close it down.

So I went back to Congress and got Senator Durenberger and Representative Sabo to sponsor legislation to give us the authority to continue—we got a year and a half authority and then we got another year authority and then we got three years' authority.

I had the managed care staff and then of course once we got the authority to continue beyond three years we grew that program. Then we decided to bring fee for service and managed care together and operated as a health care purchaser.

I became a multi-divisional director to do fee-for-service and managed care, the policy side—basically the service delivery side, not the eligibility side. And then eventually I became assistant director and then Medicaid Director.
I had a sabbatical—is what I call it—for 14 months when we had a change of governor and I went outside state government as the vice-president of managed care at Delta Dental Plan because it was, to be honest, the only place in health care I could go to in Minnesota and not have a conflict of interest.

I had to live with all the rules I designed and it was the best education that I've ever had in my life because it was back to doing operations, being a subcontractor for the health plan who contracted with the state. And we had said all these great things and now I had to do it.

And you and I both know...it was never an easy thing to do. So I did lots of reality checks. It literally was a year from the time I had left state government that they offered me the Medicaid Director [position] to come back and I took about two months to do the transition so I had 14 months at Delta Dental.

I went back to the state and was having the time of my life. I had the best job, the best bosses, the most fun. Had a great time. None of the states had any money back then either. It was poor economic times.

SMITH: Now, by this time—what dates are we talking about at this stage?

MacTAGGART: Let's see. Started back probably '96, '97. I'm terrible at dates but that would be about it because I spent six years at the federal level so that would be about '96 or '97. Judy Moore was there as deputy of the Medicaid Bureau and Bruce Vladeck was there as HCFA Administrator.

Bruce said, "You know, you're always complaining about the Feds. Here's your chance to come do purchasing at a federal level." That was when HCFA was doing all the redesign—how to be more like a purchaser. That's kind of what Minnesota had already done, so he gave me this great opportunity to go to HCFA and participate in the redesigning of what the Centers for Medicare and Medicaid Services turned out to be.

But at that time we were in the transition. I was hired into the Medicaid Bureau for probably three months to manage the 1115 state health demonstration waivers. That was a really great time and I loved these demonstrations.

Then we organized into groups and I ended up the Group Director of Quality and Performance Management, which was the quality and the financial areas of Medicaid. I had pieces that went across populations. We did the managed care reg which was also a reg that I never thought would see the light of day because talk about a candle in the wind—every direction. Then, the honest answer is, there was a change of leadership on the Medicaid side.

I was having a great time and I loved what I was doing but it was a decision by the leadership for me to move over to Medicare. Looking back I have no complaints about it. Probably if I would have wanted to move to Medicare I never would have gotten the opportunity because of the internal processes—pretty much Medicaid folks weren't transitioned to Medicare that often back then.

I worked for Dr. Bob Berenson who was one of the best leaders I've ever worked for. He basically allowed me to be the CMS liaison with private purchasers to learn what they were doing in quality. I was on the quality side for Medicare managed care and then worked with all the private purchasers on concepts that they were doing that we could integrate into Medicare.

After three and a half years there, I left in March 2003 to come to North Carolina where I'd done maybe two speeches before I got here. I had never spent any time in North Carolina.

Now I'm back on the operations side of Medicaid as an account executive with EDS, a new role for me. EDS is the contractor for the State of North Carolina Medicaid; designing and managing their MMIS, managing their financial reporting, medical policy determination, prior authorization, and provider relations. Basically, the operations arm for the State of North Carolina Medicaid. That's my long history and probably more than you wanted to know.

SMITH: Well, it's pretty interesting.

MOORE: So, Trish, basically you were with the county from maybe mid '70s to mid '80s and then the state from mid '80s to mid '90s with the time out for Delta Dental there for a year or so. Is that about right?

MacTAGGART: That's about right.

SMITH: One of the items that we were particularly interested in and wanted to hear from you about was your experience with managed care waivers and home and community based waivers because Minnesota puts great emphasis on managed care and that doesn't always work out well in some states.

Often managed care plans don't get along well with safety net providers and sometimes they don't carry their share of the load. With home and community based waivers we are seeing some of the problems—they have the waivers but don't necessarily honor them. And yet, things seem to have worked well in Minnesota. And we'd kind of like to know why.

MacTAGGART: Well, I put things into a people, process, and policy framework. On the people side, there was a lot of time spent in Minnesota that a lot of other states don't do in the design phase of getting everybody to the table. The joke is that an 1115 waiver in Minnesota will take you six years from concept to submitting the waiver.

Tennessee would create the idea, institutionalize it, get their waiver and be implementing it in three years in the same six years that we took from the concept to getting the waiver. So a lot of the people issues were worked out in Minnesota.

The one thing that people need to understand is that it is all about managing health care but most people start with—it's a budget thing, it's how to save money. Minnesota never started with that. Whether it was the home and

community based waivers or the 1115 managed care waiver it was: how do you better manage health care service delivery? So on the policy part it also started with a different premise, which is we need to figure out how to deliver health care more effectively and efficiently.

If you start with a basic concept that we used in everything that we did, if you have less money you either have to cut out people, which is not a thing that Minnesota likes to do, or cut benefits, or cut reimbursement. Minnesota has the broadest eligibility standards that you can have in almost every eligibility category.

Outside of Christian Science nurses, which I don't think we ever found any in Minnesota, every benefit existed in Minnesota. You cut out people or you cut services or you cut payments.

Well Minnesota is a health care state and quite frankly doesn't treat providers that way. Even when we had issues with dental access, Minnesota was paying providers and dentistry way more than California and any other state. So if you aren't going to do any of those and you are forced into a budget crunch you have basically one other option which is develop a better delivery system so you do better utilization, better management. Minnesota always took the approach that we could avoid cutting people and we could avoid cutting benefits or payments if we could figure out a more efficient way of delivering the health care.

Expanding home and community based waivers was one method for improving service delivery. My personal view is we went to home and community based waivers because the state institutions were breaking our financial backs. You can figure the financial gains to Medicaid to deinstitutionalize, but it was also based on the policy concept that people deserve to be deinstitutionalized.

If you start with that premise of deinstitutionalizing care as the right thing to do, then everything else fell into place. A lot of people came to the table and stayed at the table until we figured it out—before we implemented it. When it came to the policy it didn't start with finances first, it started with improving delivery. Because it really is a process. I think on the process there was credibility because we built structures. It wasn't just invite advocates into a meeting and then dismiss them. We figured out what we needed to have, whose buy-in we needed. If we needed CMS' buy-in, there was a process designed to get that.

On our 1115 waiver, before it or any amendments were submitted to the federal agency, the last stage included a meeting with people in the room and somebody got to play Sidney Trieger.

SMITH: That's wonderful.

MacTAGGART: If you could get it past the person whose job was to be Sidney, odds are we could get it past Sidney. If you could get it past Sidney as a submission—because Sidney did all the 1115s at that time—you knew you could get it past OMB because you had done your homework.
So a lot of what makes Minnesota work is the right kind of incentives to start with. It doesn't mean that it's not also about money. It's a very socially liberal but fiscally conservative state so the state started all approaches on that bias.

You had to understand your dollars. You had to make it work but you start out with a policy and then figure out how you eliminate as many of the evils as you can by doing the best policy. I don't know if that's transferable or not but it worked.

SMITH: Well, several points come to mind. I know Minnesota a bit, having lived there for a spell and having always been interested in the state. But it's a bit different in Minnesota because you have a lot of bipartisanship.
You have a strong sort of leadership in the private sector but you also have it at the state sector. And people respect each other professionally and you get things done.

MacTAGGART: I think that's the other people thing. There is a respect for people in government in Minnesota—that isn't necessarily so in all states—where it was very credible to have a government career. People would respect what I said on eligibility because after 20 years, they knew I knew the eligibility parameters.

Only once in my entire career at the state legislature did I tell a committee in the legislature “no,” because my job was not to tell them “no.” They actually were presenting a policy that I believed was so bad for the state and for the Medicaid program that my answer to them was that if they chose to do it, somebody would implement it, but it wouldn't be me implementing it.

And the credibility was there—you can only do that once, quite frankly, and probably not even once. But the response from the committee members was pretty amazing because what they did is they called the committee to

adjournment, and went in the back room, and the word that came out was, if we felt that strongly that it was bad, it must not be good. They came back with an amended policy, which I don't think would happen in a lot of other states. I just don't think that there was that kind of credibility.

SMITH: What was the issue?

MacTAGGART: It was health care delivery, one of personal care. The other part is that our state legislators who were on health care committees had been there, on both party sides, for years and knew the Medicaid program policy. I don't think in a lot of state legislatures it is necessarily the committees that people seek to be on long-term, whether it's just because of their career paths or because of the politics.

But for some reason Health and Human Services became a sought-after committee and people who had leadership roles on both sides tended to know Medicaid. I still say to this day Lee Greenfield, who was on the House side and was a Democrat, knew Medicaid better than I did after 20 years because he lived and breathed it as a legislator for over 20 years.

You have that kind of executive branch and legislative branch with that kind of knowledge base. Then on the Senate side Samuelson and Bergland had the same kind of maybe 15 or 20 years of history.

Parties could change but people also knew if you really believed in health care, you could not bring it up, pass it, and actually implement it, all within a two-year cycle. So you had better have some top quality policy that could survive a change of leadership.

SMITH: I'm very intrigued with what you said about Sidney Trieger, and finding somebody to play the role of Sidney Trieger, because it suggests to me that you did not find the federal or—maybe you did—but it seemed to me from what you were saying, you didn't necessarily find the federal waiver requirements all that onerous or unreasonable.

You just thought maybe you had better meet those and you met them. And maybe it made sense.

MacTAGGART: There were a lot of questions that Sidney and CMS or HCFA would ask back then that were fair questions, and if I was on their side I would have asked the same questions. It doesn't mean as a state that you want the questions asked.

Now, [it's] like contract negotiations. You want to be on your side of the table more knowledgeable than the person on the other side of the table. You don't disregard what they say and they might actually be right. You just need to understand that perspective going in. I truly believe that you get better products when you've got diverse points of view. So we never looked at it as bad.

For example, our Minnesota senior health access program was initially thought of by Pam Parker and myself as a nursing home, small, rural waiver. It was six years from the time we started the concept before the initial paper was submitted to CMS. And after we talked this through with so many people, for Minnesota there wasn't anything the Feds could ask that somebody hadn't already put on the table in one shape or form.

And as for OMB folks, they really are money folks, but within the state you've also still got your finance folks. You've got the same kinds of things. In fairness to Sidney, because I really do have a lot of respect for that person, it was never that he disregarded state policy. He just wanted to make sure you knew what you were doing and that you could make it work.

And some states were more prepared and others weren't. So you're right, we just never thought it was bad. We just thought it was part of the process. If you did your homework, you were okay.

SMITH: Well, that's certainly refreshing isn't it?

MOORE: Would you carry that over generally to the whole subject of federal/state relationships in a larger perspective?

MacTAGGART: Yes, with one little caveat. People are busy doing and if you are going to do something new you need to always go back to what is the legal authority you have for what you are doing. Have you looked at the regs? Have you looked at the law? In almost anything there is probably two ways to read every piece of statute.

The caveat is every now and then you will have people who will read a statute and if it doesn't say you can't do it, will allow you to do it. Where the issues arise is where you have someone who, unless it explicitly says you can do it, won't allow the flexibility to try it.

I think that's probably another caveat I'd put in. Whether it's people, policy or politics, I don't know actually which it is, when you have a state coming in

with a creative idea and they've got credibility, there is a risk in doing something very new.

What you want a state to do is to mitigate the risk as much as possible. But there is no way to assure you that it's going to work 100 percent because it's the new thing out. I mean, that's part of the lessons learned.
If you get somebody who is the authority to sign off, unless there is a legal reason or budgetary reason that they have to say no, and it is a credible process and a credible policy, then let them try it.

Where you see frustration with the states is every now and then you will have someone with a federal perspective who, unless they can see it in black and white explicitly written that you can do it, go with the default that it's a "no" unless you can prove it has to be a "yes."

I think that's where you have a little bit of friction between state and federal government. It's depending on where you fall on that. Clearly, states will want to read it the most beneficial way to them. For the Feds, depending on a lot of parameters, it may or may not be to their benefit to read it the most liberal way possible.

My view, and I think this has been true of Minnesota and a lot of states, is if we told the Feds and if we were explicit and they signed off on it, it was their problem later. They couldn't come back on the state.
We didn't ever worry about trying to sneak anything by them because it was in such black and white you couldn't miss it. [The] Minnesota State Plan is like eight books long, and it is probably longer by now because Minnesota's approach was, we put it in writing.

Other states have had a different approach—they preferred to put little in their State Plan and argue with the federal government afterwards whether it was in there or not. It may be in general, but not as explicit as Minnesota. But those are different states' approaches. It doesn't mean that their answers were any different or their policies were any different. It was just how they documented—maybe.

SMITH: As I'm listening to you I get the sense that for a State Plan to be an effective instrument of control and prodding people towards progress and good policy, it takes an important element of state and federal collaboration in the right spirit. That is, it's probably going to be a tough instrument to get much out of unless people kind of want such things to happen.

MacTAGGART: It's a living document and particularly on the state side you have to have people who work with the policy folks in each of the areas from rate settings, to eligibility, or whatever. But it is somebody's job to make sure that the State Plan is consistent with the federal law and that the State Plan is consistent with your own state law and your implementation policy. Where things tend to fall down is somebody writes something in the State Plan, it gets approved by the Feds and (oh, you'll love this one). Back in the '70s and '80s, (remember these days, Judy), State Plan policy was approved. Then later on lawyers, because of an incident in a state, would say we need to relook at this. At the time it didn't seem like a very big deal.

It was approved but the environment has changed. It's got huge cost implications.

People now understand what really happened. Consultants got involved, maximized things probably a little farther than anybody ever envisioned along the line. And now people are back looking at the State Plan.

You can argue that if you are explicit in the State Plan you are covered, but if the environment has now changed then people get worried about the context in which it is now read. If you were less explicit it may have been exactly what you meant at the time and it evolved because policy does evolve.

It is still what you're doing but what you're doing is very different than the original implementation but the words are still the same. I think that's where you are having all sorts of friction between state and federal government, because some of these policies have been out there, or the authority for them has been out, there but people have reinvented how they use that authority.

Depending which way that goes, it either becomes a potential expansion opportunity, or it becomes a critical barrier, for either the state or the federal government.

In general, I'm referencing back to the whole role of provider taxes and some of the inter-governmental transfer and DSH concepts. If you were around at the time, what was done was totally legal, totally within the scope. I'm just not sure that people understood that whoever wrote the regulation or the legislation intended it to be that broad, but as people were playing it out, and kind of growing it within the context of the new environment, the issue then began to highlight.

SMITH: Yes. Another area of Minnesota experience I was curious about is managed care. Many states with their managed care waivers have been getting more and more people into managed care and often pushing it as the program of choice. You see them running into trouble with the safety net hospitals, and care may be suffering, because sometimes as the managed care sector grows, they don't take care of other people as well as they might, some of the disabled and so forth. And yet one doesn't seem to hear complaints with respect to Minnesota.

MacTAGGART: Well, remember the policy going in for moving managed care forward was to integrate people on public assistance into the same options that privately employed people were getting. I've been a state employee and I've been in managed care my whole career.

If you were at IBM in Minnesota you were in managed care. So the goal was to get Medicaid folks into the same facilities that the private folks were getting. The door to doing that was managed care.

The fact that Minnesota's health care, particularly managed care, is not-for-profit, means that it's got a different flavor to it in the state. It was the norm for everyone in the community. I could go to Mayo under managed care. It was not a filtering-out. It was a filtering-in. It was an opportunity to go where I couldn't get in necessarily, on fee-for-service, because I was seen as a Medicaid person.

What it also bought the state, is a care delivery system that was working, so nursing homes, hospitals and doctors actually talked to each other. It wasn't an insurance structure that was called managed care. It was a health care delivery system, that had an arm to it that became an infrastructure, that could add things like nurse lines, and things that are efficient, that in a fee-for-service world didn't exist.

Now, when you look at Minnesota, you will also see managing health care in areas where we didn't have health plans. We took the health plan managed care concept and put it into the fee-for-service world. It's still managing care. For example, we added a nurse line.

We added transportation. However, a lot of the creativity came from the managed care plans because they had sufficient funds that they could move around to address the clientele needs. They were doing it for everybody. It

was not designing something just for the Medicaid folks in that geographic area. It was the way people got health care.

SMITH: How important do you think it was that you didn't have any for-profit managed care plans, that they were all not-for-profit?

MacTAGGART: I can tell you my personal view but that's the only thing I can do. I believe totally that it made all the difference in the world. Minnesota has no clue of how good a health care system it has because it is built on a non-profit capability.
Yet one of the big debates in Minnesota constantly, is why doesn't it allow for-profit in? Well, I do think that there is a different mission-vision approach that exists in Minnesota because it started that way.

That is not to say that I haven't seen in other states, for-profit work exactly that way, and in other states, where I haven't seen not-for-profit work exactly opposite to that. So I think it's the Minnesota not-for-profit mentality.

I also think it is the Minnesota mentality that health care is like education. It is a right, it's important. It needs to be the highest quality that it can possibly be. You can maybe do it in a for-profit, but it's just not the way it works in Minnesota.

It started from that historically, so it's not like it is something that legislatively, all of a sudden, you had to be not-for-profit. Even in our fee-for-service, remember this: Minnesota passed a law that said every provider had to take Medicaid recipients.

They could limit the number once they get to a certain percentage level, but until you were to that percent, the first person came to you, you had to take, even if they were Medicaid.

So there wasn't a provider in Minnesota who didn't have to take Medicaid. More importantly that legislation never blew up because nobody as a provider assumed they had the right not to take Medicaid. You can't legislate that. That's a philosophy that people who get trained in the state, that work in the state, that believe in the state, just kind of inherently have. I don't know how you create that.
SMITH: Well, it goes back in their history. That's for sure. I mean much of these attitudes of respect between the public and private sector, and we're all in this together, is strong in Minnesota.

MacTAGGART: It is and it works. Again, health care like education is a priority for the state so that does make a difference. The state actually funds and budgets for things. You know, if you look at Minnesota versus other states, for people in need whether you're low-income or just chronically ill, there is a program from birth to death in Minnesota.

Minnesota has not only the Medicaid program of Minnesota Care, it has always had a General Assistance Medical Care for the 21 to 65 who weren't disabled, who were just plain low-income.

For the State of Minnesota, Medicaid was a way to get federal dollars for things that we were doing under state dollars. If you are in a different state where you don't have a state program there is a debate when you move to Medicaid because you're not only having to create a program to go after the federal dollars, but you have to create the state dollars to go after the federal dollars.

In Minnesota every population had a state program. So the real issue became how to maximize the federal dollars. That's much easier to sell as part of health care policy.

If you are starting from scratch you've got to come up with the state dollars. In Minnesota we could sell a HCBS waiver arguing for deinstitutionalizing patients while using a little less health state dollars. Get people in the home and use federal dollars. Who doesn't like that?

SMITH: When you were in the Clinton administration was there a strong policy of encouraging waivers? Was there a gradient there, a rather distinct change of policy? Or was this just the trend?

MacTAGGART: Well, here's the world that I lived in under both administrations. I think there has always been a push for waivers. I think state innovation is supported. I think both administrations tried to balance, but the difference in the Clinton administration and especially in the early years, was that Medicaid waivers were about eligibility expansion, and alternative care for service. So the flexibility and innovation had not only been supported, but I think [were] well received by both administrations.
I think some states are now looking at waivers as cost containment strategies.

The reason Minnesota may seek a waiver was very different than another state. There always are different incentives on why people pursue a waiver. Some states' approaches were to expand things and some were to constrain things.

I think the other part on waivers is there was also a big push from states for flexibility. But if you have done it and done it well, why do you need a waiver to do it? Why can't you just do it under your State Plan?

There's been some contention about how much is it worth, what's the gain of having the waiver with the oversight and the separate policy structure and processes of a waiver? What's wrong with the State Plan process that you can't get it through that versus spending money on creating the waiver?

You know, that's a balancing thing. But if you believe that the State Plan is how you operate your state program, it's a legitimate question I think to ask, why is a waiver process better than a State Plan amendment process?

Everything a state does, the federal agency has the authority to watch and look at. If the state is credible, and has created something new that works in their state, why can't the state do it as its mode of operation under the State Plan versus a separate vehicle?

I think that's kind of the real question. It's not should you do waivers, or shouldn't you do waivers? Is that the best mechanism for the state presenting its plan to the federal government, or is there alternatively the same kind of ability to do it under a State Plan and the processes that are evolving there?

MOORE: Trish, say a little bit more about the stresses and strains of working in a state where the counties have the eligibility process and perhaps a lot of other responsibility with regard to health care programs and other facets of the world like mental health and so forth.

MacTAGGART: The issue on counties, I would frame into government entities also being providers. Because I separate eligibility—eligibility is local, having it done by the counties under a state supervised and state requirement, state structure.

Medicaid eligibility is Medicaid eligibility in Minnesota and you should be able to do it by criteria and it doesn't matter whether you're in Clay County or Washington County. The fact that it is at the local level for people who have

that familiarity with the people is a plus. I have no problem with that and I actually think that's a good model because it's local.

But all the eligibility policies are not locally determined. A county such as Clay County can't decide to have different eligibility requirements than Ramsey County. So it's the operationalizing of the policy at a local level in a local office with local people that is actually a potential plus.

You get people more like the people in the community and have a better sense of the service delivery system around and those kinds of things. So for that, I absolutely think that there are not only no minuses to county government doing eligibility, I think that there are probably plusses.
The more we can automate and the more we can simplify eligibility, the less there is a need for face-to-face and then some of those issues go away totally. But when you step into health care delivery that's where the rubber hits the road.

I would argue that it's not a county government role, it's state government. With Medicaid program policy, setting the benefits, eligibility and reimbursement, there is always a potential of conflict of interest that needs to be addressed by states or their counties if the counties are also providers. The conflict that I see is that you can't have the person setting the rules being the person who abides by the rules. It just inherently has the potential for conflict of interest.

If you want county managed health care, in concept you know what your community needs, but you also have a fiscal responsibility as a taxpayer, and running a government agency on taxes, to make sure you stay within a budget.

I'm not sure I want my managed care contractor to be worried about my taxes. The same thing if they are responsible for teaching hospitals under the managed care plan. They have to debate amongst themselves what's more important, getting the money for the teaching hospital, or getting money for the managed care plan, or providing the services.

I don't care if that's county or state. It is the issue that we had for state institutions for years, which is why states had to put in firewalls between people who ran Minnesota, the state regional treatment centers or the state institutions, and the Medicaid program—because Medicaid set the policy and the state institutions had to operate a business.

If the same person is doing both, every decision has a potential for conflict of interest. And it just plays out because your mental health providers are either county or state employees in a lot of areas, as well as some of your teaching hospitals, and even some ICFs-MR.

The other thing in ICFs-MR is, if you don't do it under Medicaid, you are probably providing it under social service grants, and truly there is a conflict of interest there, because you may be inclined to make it Medicaid-eligible when it's not, because you've still got the DD person in your community. You're still going to have to provide services and if you don't find a way to make them Medicaid-eligible, doggone it, you're going to be using county and state dollars, making them DD-eligible under the social services.

So that's, from my world, the framing issue. It's not county government, it's not state government, it's government operating as a provider versus government operating in a government role of eligibility and policy and management of a program. Am I being clear?

SMITH: Yes, I think so. It seems to me to make a lot of sense.

MacTAGGART: And it's not that states and counties haven't found ways to create those firewalls, but you've got to be very cognizant of such and up front, because you can't wait and do it when there is an issue.

I mean it just—it will bite you unless the infrastructure is so designed that the perception as well as the reality is that there is no conflict of interest. Even when there isn't, the private providers are going to have the perception that there is unfairness, that it's not a level playing field for the private providers and the community providers because of the need to take care of your own government entity, so to speak.

SMITH: What thoughts, if any, do you have about what's currently going on in Medicaid, and some of the suggestions for the kinds of waivers that have been coming through today?

MacTAGGART: I think the—I've always believed this. The innovation is at the state level. Every state has got different parameters that they have to work within. I believe in waivers. I also believe that once you've done it under a waiver, and you've proved it, I don't know that you need to keep doing it under a waiver.

I think there should be an easier mechanism. I don't much care if it's a waiver, or State Plan, or what it is, but a mechanism should be there for those who have done their homework and are trying to make state policy work to be inclusionary of their Medicaid and not exclusionary. I'm not even talking about eligibility but that their system works as a whole versus piecemeal. I think we should allow that. I actually think it's the ground floor for even Medicare policy because you'll learn it in the local setting. State Medicaid is always more local than Medicare.

I think the future issue—and I have believed this for a while so I will admit a bias—is we have got to figure out how to do dual eligibles. We have got to figure out the Medicare/Medicaid intersection much better because they are the same people.

I don't know if Medicare reform will, in a sense, force some of that to happen or if it will go the other direction. But I do know that that's where waivers are still needed, because we don't have an answer yet.

I think when some states are willing to try something innovative we all benefit from the education that will come from really implementing some innovative ideas. I also think that more states can integrate with some of their private folks, and do some demonstrations in that area.

My version of demonstrations is not the traditional research demonstrations, and I think that's probably the other terminology clarification that would help everybody. I think states look at operational demonstrations as operational research, and they want to try to be innovative. I think if you go back to what true 1115 research demonstrations were first designed for, was for five-year research projects, and two-year write-ups, and seven years later distributing the results. The problem with that is—health care doesn't have seven years.

State government doesn't have seven years so we don't have the luxury. We need some waivers that are true research. We also need a lot more operational research and innovation. So there has got to be a way to do both. I don't know if I answered your question though.

MOORE: Good enough?

SMITH: I think so, yes.

MOORE: Have you—and I know you haven't been in North Carolina very long but have you picked up insights or concerns or problems working there that you might not have seen before?

MacTAGGART: Yes, every state is different. It's a beautiful state. I love it. Very smart people. They have—let's see—they don't have managed care plans. They have a terrific piece of managed health care through their Access Program. They have much more rural and mountain areas than Minnesota did.

They have a lot of the right incentives and right now I think they are struggling with the same things every state is, which is in a tight economic time—they are back into the days when I was in Medicaid in the state, which is not a terrific economic time for states.

So instead of trying to figure out how many new creative expansions you can do, they are trying to keep their health care system whole and do so with no new money. It's a tough time but it also allows people to be very innovative.

Well, the tighter the finances the more people are open to some innovation. It is also something that I have observed that is true, not only in North Carolina, but I've seen it here.

So there is also the fact that it is harder but doable right now. People are making changes and having to learn on a faster track in a very complex time. I notice that everywhere. There is just a lot more turnover and a lot more changes so people don't have the historical view. I have been doing Medicaid almost 30 years. There aren't a lot of people staying in Medicaid leadership roles for a long period of time. A lot of the Medicaid staff are not people who have been doing Medicaid for 20 years.

That may be good and that may be bad but I just think it's something that I'm observing. It could be good in that they don't get tied to any of the old ways of doing it, or it may be not good in that they are recreating some of the strategies that we already found didn't work.

MOORE: Re-creation of the wheel maybe from time to time.

MacTAGGART: Maybe that's just inevitable. Sometimes I just want to say, you know, can we just bring out the old white paper? Maybe the environment has changed so the answer is no longer the answer, but the issues and the facts are still the issues and the facts.

So we start with re-creating that. That becomes the basis and then you figure out what you want to do different now because the marketplace or the environment is a little different.

I think the other factor that is different here in North Carolina, that has actually got my juices going, is people are much more open now to automation and innovation. I do think we have to think beyond the Medicaid system in health care delivery.

You know the tough issues, such as how do you handle privacy? If we really believe in electronic medical records, and we did 20 years ago but we just never got anywhere with it, maybe the environment is such that we can simplify things and make it a health care system that allows better quality of care for consumers because we have automated and fostered innovation in the IT areas.

So for me this is a great time to be on the implementation side because it's the piece I've always complained about. I thought IT was the answer as a user, and I'm going to be eliminating my ability to blame anybody else soon if I can't make it work.

I do think it's not just North Carolina; that's the environment we're in. There are all kinds of possibilities of doing things that we only once dreamed about doing, that really are possible with the electronic IT capabilities and the web.

You know, we never thought of a web doing anything when I was doing eligibility 20 years ago. It never even existed. Now you can do lots of things there. So I think that's the environment. I also think—remember the days of Y2K?

SMITH: Yes.

MacTAGGART: States are facing HIPAA October. And that creates this cloud all over everything else. It's like Y2K. You can't do policy changes because you have to kind of freeze the policy to get through Y2K. Whether people realize it or not, policies are being frozen in states everywhere because they need to implement HIPAA this fall and the only way they will do that is in a sense to freeze their system. There are policy and budgetary implications of HIPAA, and if you're really looking at health care, HIPAA has got a bigger impact than Y2K ever did.

So that's kind of a sidebar. But I also think it's affecting decisions being made on how people can move forward with things right now. It's short term but it's a big short term. I think providers are still reacting to all the data privacy concerns with a little bit of fear that they are going to do something wrong.

So the tendency when you're fearful is to kind of pull back a little bit and let somebody else be first out there. So that may affect people enough to limit their desire to take other risks.

SMITH: A matter I wanted to ask you about briefly. When we were talking with Bruce Vladeck, I asked him about this piece he published in Health Affairs. He was saying that the future lies in the area of the growing disabled population and their problems, and particularly that it's going to take a lot of creative work at the local level.

But he was also stressing the notion that the states had to be in this and playing a very thoughtful role. It seemed to me that some of the things you were saying about the kind of conflict of interest that could develop suggest somewhat the same thing, that you may need—not necessarily design from the top down—but areas in which the states look at these problems and say thoughtfully, "Well, you know, we need to do this kind of thing to make these people function a little better in relation to each other."
Am I making any sense to you?

MacTAGGART: Yeah, and I would just take it to the other part, that if we don't get people at the table that are doing the policy and some of the private parties—I mean, if we are really going to deal with the disabled population, well, there are implications because everyone, either themselves or a member of their family, are in the employment market.

And the reality is we can't keep tearing these families apart. We need to figure out how to bring the systems together. And if we're going to sit down and do some designing we need them at the table, too. They come from a different perspective, but different perspectives aren't bad.

SMITH: I wish we had more states like Minnesota but in some ways I think that what Minnesota has done is almost unique.

MacTAGGART: I don't think it has to be.

SMITH: No, I wouldn't think it has to be, but there are some things that are quite special about Minnesota.

MacTAGGART: Yeah, and I think in fairness I would say if you broke states down and looked at different things I have discovered—this is kind of my federal hat and my learning experience when I started with the private purchasing—in the marketplace where Medicaid is also playing in that geographic area or in a specific policy area, almost every state is doing something really cool, very innovative, very creative but they aren't on the radar screen because it's not as broad and massive and in depth as

Minnesota's strategic approaches which are statewide health services.
It's almost like Minnesota, again piece by piece, has over time has managed to hit the whole spectrum. Other states, because of where they started or where they're at, if you pick a specific area, there is creativity. Some of the biggest creativity in home/community-based waivers are in some of the states you wouldn't have expected it.

So I think the pieces are there but the states have not gotten the recognition from those sub-pieces.

SMITH: At one of the meetings I was attending, Bruce was saying that he thought that something like the old Advisory Commission on Inter-governmental Relations could function for Medicaid.

I think one of the concerns that he had was that many of these innovative little ideas don't get visibility. And theoretically 1115 waivers were supposed to turn into real demonstrations and then people would pick that up and copy it but that doesn't seem to happen.

And I just wonder, do you think it would be useful or is there any good way to give some of these bright ideas more visibility? Maybe these could spread from state to state a bit more. You can point out examples of where states have copied each other but in other cases they simply don't.

MacTAGGART: Well, we've gotten to the point that some states do massive things like Arizona and Tennessee, whether you think they are good or bad, that the little projects in the one geographic area in the county X of one state that's really creative may be overlooked; but here is my best example to give you an illustration.

North Carolina's Access program for the primary care physician, I've watched for years because I did the managed care plan for CMS that had the PCCM program. When I was in Minnesota, we stole concepts from North Carolina in that PCCM Program, because they were doing new and creative things. They don't get the publicity because it's a subsection of a subsection. But if you are a state looking at doing that kind of program, there are great things to learn from it. Minnesota gets more visibility because it's done so many things that you can pretty well—if you don't know where to go it's a cheap phone call to ask Minnesota and there is probably something going on in that area, where you have to know another state well to know that they have done something really creative in this area. So you're right, I think—and again, every state will adapt it a bit.

There are creativities in every state; it's just in different areas. And some are really creative in the developmental disability community. Some are in the physical disabled community. Some do really neat things with moms and babies.
I think the truth of the matter is there was such desire to do things that were bigger and broader, because again it's a bigger bang for the buck if you can do more. That doesn't mean that if you can't do the big leap, that you can't do some baby steps.

Some of those baby steps are really good ones that can be moved from state to state. I think if Medicare would watch what some of the states are doing they would benefit some as well.

I just don't know that that's the way to do it, because people are so busy doing that they don't have the time to read, and look, and see, unless they are ready to go down that path. So we need to do it real time.

SMITH: Yes, I think that's an interesting point. We were talking with Gail Wilensky a couple of days ago and asking her how she felt about some of these waivers and some of the studies of waivers that had succeeded and so forth. And she said they were really interesting, and that she enjoyed reading them and liked keeping up. But she said they are often not useful simply because as you were saying, they weren't in real time; that the demonstration was already four years old.

Meanwhile history had moved on and people were picking up ideas on the fly from what someone was doing right now.

MacTAGGART: Much of our value added is because what a state or a purchaser really wants to know is *how* to do it. You want the general policy direction that you're going in, but the real tools, are the tools to help me get it done quickly. How do you get the buy-in? How do you operationalize?

That, you don't need a research process to do.

You basically need to know, here are the steps they took, and here are the ones that work, and ones that didn't, or they may be working, but here is what I know so far and, you know, here are some of the glitches I've run into. It doesn't mean it still won't work, but I at least have some sense of things I need to consider if I'm going to go down this path.

SMITH: Do you have a sense that state Medicaid directors and a lot of these Medicaid civil servants are becoming a kind of a profession with a sense of shared aspirations and a sense of corporate unity?

MacTAGGART: My fear is that that isn't what is going to happen.

SMITH: It's going the other way?

MacTAGGART: Yeah. I'm finding—when I was at the staff level some of the leaders were, like Vern Smith and Bob Baird who were Medicaid directors for years, weren't necessarily political appointees. I was a Medicaid director and I was not a political appointee. That's unusual. In this day and age it's almost unheard of. I think there are only a couple of states where that's true. As a result, with the change of administrations, there is often a change of Medicaid leadership. The learning curve of Medicaid is very complex. Bruce Vladeck used to laugh at one of my slides in which I said, "Medicaid is not rocket science. It's way more expensive and way more complex."

SMITH: Yes, and we wouldn't dream of making our rocket scientists political appointees would we?

MacTAGGART: No, people don't tend to concentrate on how intrically complex this program is because it's everything. I mean, it's from birth to death. Every kind of eligibility, every kind of service. Health care is complex. Just by definition health care is complex. Then you've got the delivery of it, which makes it doubly so.

As a result of that, it has huge human implications and it has huge resource implications. It takes a while to learn it. I had the luxury to learn the

components of Medicaid, and health care delivery, before I needed to manage the whole. I have seen how the pieces all fit.
I also had an unusual luxury in that I worked in a great state that was innovative, had all the right parameters. I had the best mentors one could ever have.

I had every opportunity to have the best jobs at wonderful times. I have never had a bad job. I have had the most fun and the most creative jobs. That's the kind of luck that—you know, knock on wood—doesn't happen to a lot of people.

In this day and age, most Medicaid directors are not growing up in Medicaid. They are coming in at best at management level, one level down from the Medicaid director. In some cases they are coming in as the Medicaid director with no previous Medicaid experience.

They have health care experience but not necessarily Medicaid. To expect them even in a four-year appointment to learn it and do it and understand anything this complex is kind of asking them to be super-humans. They need to have good teams and be good managers, with a necessary skill set.

A skill that is very important is good management skills. Oftentimes we promote people who are good policy folks and put them in management positions. But there is a skill to management, and you've got to love it, on top of it. What makes Medicaid work is when you've got a leader who knows who they can trust, how to put the pieces together, and then knows how to manage their leaders so they have the flexibility as well as the accountability to really manage.

I think that's the critical piece for all of us going forward. It's my fear that management isn't something promoted enough in Medicaid leadership, whether it's federal or state, because I do think that's how you make it work.

SMITH: Well, it's very interesting. I just wanted to follow it up with one final topic, because as you are talking about that, it raises in my mind one other reason why it may be pretty vital to keep Medicaid as an entitlement, so it is something that people count on being there.
MacTAGGART: I've always wished it to be an entitlement for recipients. By the term entitlement, do you mean it as an entitlement to beneficiaries, or do you mean it as an entitlement to providers?

SMITH: Right.

MacTAGGART: Is it an entitlement to the state? I think the term entitlement is not going to be the issue, but getting some clarity as to what does entitlement really mean. That is really the debate.

SMITH: Well, thank you so much. It has been a pleasure to talk with you. I enjoyed talking with you earlier about Y2K or something like that. But it's been fun to talk with you again and I'm sorry Judy couldn't be here for the end.

INTERVIEW WITH J. PATRICK MCCARTHY
JUDY MOORE – MAY 25, 2004

MOORE: —This is Judy Moore and I am interviewing J. Patrick McCarthy on Old Dominion Drive in McLean, Virginia on May 25, 2004. And, Pat, I would like to ask you to start by telling us about the early days of your career in West Virginia.

McCARTHY: I guess my first encounter with purchasing medical care was in 1953 in vocational rehabilitation. We did both training and physical restoration. But I was fascinated with the purchase of care and lining up physicians.

What we would do really was to line up the newest doctors in town with specialties and they usually were hungry and needed revenue right away. So, they provided good services and we were able to get physicians that way until they built up a good practice and then they would drop us and we would have to go searching for another doctor and specialty.

Well, by 1955—no, '58—there was a big change in the state politics and the guy who was the deputy director of rehab in charge of physical restorations became the director of the Department of Public Assistance. So they wanted to beef up the medical assistance program and spend more money and have more ideas about where to spend it.

So the guy who had been heading that was in Fairmont and he wouldn't move to Charleston. So how would you beef this up with a director so far away? So they talked to me about their medical assistance program. So they said, "Well, Vincent said if you take the job he will teach you how to do it." So I would go to Fairmont often and he would come to Charleston. A very nice fellow. And I kept that job until '61.

But in the interim I had really become fascinated with the job. I remember once when I first took the job, a hospital association guy came up to see what kind of fellow was heading up this new program. And—

MOORE: This was the Kerr-Mills program?

McCARTHY: No, before.

MOORE: It was before Kerr-Mills. Okay, so it was a West Virginia medical assistance program.

McCARTHY: Well, this guy, we talked, and I was just pouring out all my honest thoughts about it and I thought I would want him to know, when he said, “You are an entrenched in socialist medicine.”

Well, it's because I've had the belief, I guess, since the Army at least, that everybody ought to have medical care. They do in most civilized countries. So I got so I would attend these meetings that the APWA [American Public

Welfare Association] held.

They were the driving force then. A woman named Lula Dunn was the head of it and she was powerful with the Congress, ye, Gods. Now, keep in mind back in those days the state directors were very powerful—the one in Texas, John Windsor, I think, and the one from Oklahoma.

MOORE: Lloyd Rader.

McCARTHY: Lloyd Rader. Yeah. The one from Wisconsin was important in that group. But anyway, in going to those meetings, then I met Karel Mulder at those meetings and Karel headed the medical program in California at that time and he was, you know, a brilliant guy.

MOORE: Is he still living, do you know?

McCARTHY: Well, I've heard that he is dead. I don't know. Anyway, Lula Dunn was head of APWA and her little assistant, who was running around to help out, have coffee and everything like that, was Pearl Beerman. You remember Pearl?

MOORE: I do, yes.

McCARTHY: Well, Pearl's demeanor changed when she came to Washington. Anyway, I got very interested in that and then was offered to take a course, a summer course, two weeks, three weeks, at the University of Michigan School of Public Health and Chronic Disease.
So I went up there and met lots of people in the health field and became fascinated. And I got home and my wife said, "Did you enroll in the school?"

I said, "What do you mean?"

And she said, "I know what you've been reading, the material and so on. I thought you went to enroll."

I said, "No, but I rented an apartment." But I didn't have a grant at that point. And so when I came back I started talking to these friends I had made in the Public Health Service and they worked out a grant for me.

And the West Virginia department was very generous. They let me go off on this year-long educational grant. But I was paid when I came back, so I'd come back and catch up on things.

But Sy Axelrod and Wilbur Cohen were the principal ones up there at the University of Michigan. But the professors I had, my God. I was looking at a catalog I got—once you go to a school you are never off their mailing list. But when I look at the School of Public Health, so many of the professors I had, they have chairs named after them now because they are gone.

MOORE: Yes.

McCARTHY: But Walter McNerney was one of them, John Griffith, Phil Hill, it goes on and on. I was up there about a month ago to get back to Ann Arbor for a reunion.

Well, so I took that course and then went back to West Virginia because I felt an obligation to them. My God, they had been so good to me. But everything had changed by then. The administration had changed and Democrats would come in. The Republicans had run a very honest fellow there I knew very well, Harold Neeley. But he lost and they elected

Chauncey Browning, who was an absolute thief and went to prison. Neeley, he was the head of the big institutions, which was all the hospitals and prisons, and his assistant was—what's her name? Rusty something.

She was there at the time. Anyway, so I didn't care for this new head, and I had been getting some letters from people over here suggesting that I come over, and I did.

MOORE: Suggesting you come to Washington to work, you mean?

McCARTHY: Yeah. So I came over here and took a job with the Bureau of Public Assistance, the agency back in those days. Katherine Goodwin was

the head of it, a great lady. And at that time they weren't too keen on medical care, having given their lives to money payment programs. And in those days, other than school teaching, bright women didn't have a lot of opportunities. And this bureau was full of very bright women. And they had real strong feelings about families' income and that sort of thing.

MOORE: What year did you come to Washington?

McCARTHY: '61. There was a little division called medical care. And it was headed by Dr. McNeeley. And there were some women in there: Serino, some very capable women, and one guy. Guess who he was?

MOORE: Was that you?

McCARTHY: No. He was there when I arrived: Charles Kubler.

MOORE: Oh, Charlie Kubler.

McCARTHY: You remember him?

MOORE: Yes, I do. Is he still around here?

McCARTHY: He's at home, crippled up.

MOORE: Oh, is he?

McCARTHY: Yeah. But he has had one of the most colorful, high-level, disastrous experiences in the military. High-level. And then crashed. The same thing with us later in medical services—crashed. Well, we'll get to that. Let's see. McNeeley stayed with us and then there was a reorganization that changed the Bureau of Public Assistance to the Welfare Administration, it was created with what's her face from North Carolina, as director.

MOORE: Ellen Winston.

McCARTHY: Ellen Winston. She was a nice lady. And Dr. Joe Gerber was the head of our organization there.

MOORE: The medical part?

McCARTHY: Yeah. A very nice guy. Bright, Yale graduate, and he was a public health officer. And all was going well but Joe was so enthusiastic about things. And we were having a big meeting of state directors with outside people in the industry.

And Winston had said something to the people about something we would carry out as soon as we could. She turned to Joe and said, "See if you can do that."

And he said, "Honey child, we'll do that right away." And that was the end of him. Really. "Honey child." That cost him his career. She was no honey child.

Fred Steineger was the head under that administration. There was a Children's Bureau and then there was the Bureau of Family Assistance. And we started taking on a few people there and it was under the Bureau of Family Assistance that we developed—well, we had the Kerr-Mills that went along for a while.
And then we started working on a possible expansion—we didn't know what it was. It was going to be a big change in the medical assistance program.

MOORE: And what year was that that you started working on an expansion of medical services?

McCARTHY: I'm thinking. Well, let's see. The Act came in '65 so it must have been right at the beginning of '64 or at the end of '63. I'd say '64. And Karel Mulder was brought over from California by Fred Steineger. And they had been in all these meetings that I talked about earlier where state leaders came and met in Chicago under the auspices or aegis of the American Public Welfare Association, which was really powerful back then.

MOORE: So did the APWA have regular, annual, or more than annual meetings?

McCARTHY: Yeah.

MOORE: And they talked about welfare, and I guess the health stuff, too?

McCARTHY: Yeah.

MOORE: So it sounds like they were a powerful organization.

McCARTHY: Oh, they were.

MOORE: Did you think they were more powerful in terms of their voice and effects on policy in Congress than the federal people?

McCARTHY: Oh, yeah. In that day? Oh, yeah.

MOORE: Interesting. So what was the stance of the APWA towards expansions of medical assistance or towards Kerr-Mills, for that matter?

McCARTHY: Well, they were for it.

MOORE: They were?

McCARTHY: They were for it, yeah. As a matter of fact, had they not been for it, it wouldn't have been. They were that powerful then. Lula was from Alabama, of all places.

MOORE: Oh, was she?

McCARTHY: Yeah. But she was a real autocrat, my God. But she had to be in order to have influence with those heady state directors. Then when we started pulling together ideas, the Bureau of Family Service people, their concept was to let people have a portion of their money for health care.

Well, in West Virginia I was way ahead of that one because when we had taken that very money and pooled it, it was like an insurance plan.

And then we came up with the federal proposals with a more expansive view, and that was that we won't take it out of the grant, we won't set aside a special amount for a pool fund, we'll just spend anything they want to spend, knowing that the states ain't going to go wild. But anyway, when this was first presented to the staff, they went wild.

MOORE: The federal staff or the state staff?

McCARTHY: Federal staff. Good God, this is radical—with no controls. But Karel and I both had been with states and we knew damn well then you could say to the states, "Spend all you want and here's the matching." You don't have to worry about it. But it caused months of arguing and finally Karel was able to persuade them that that was the way to go.

Then we had another change and Karel left and Dr. Land came. Because we needed a doctor to head the program.

MOORE: Where did he come from?

McCARTHY: He came from Indiana. Fort Wayne. He was a physician, he and Amos Johnson. Amos Johnson was a big, powerful guy in the AMA at that time, friend of Charles Kubler.

MOORE: Dr. Land was close to Amos Johnson?

McCARTHY: Oh, yeah. He was—actually, Land was the AMA's man. Land was an interesting guy...intellectually he was sort of like our President, however you want to interpret that.

MOORE: But he must have had a political agenda.

McCARTHY: Oh, he did. He did. As a matter of fact, you know, I told you about Puerto Rico? Well, they had a system down there that would help almost anybody. We screwed that up. We put it on fee-for-service with Dr. Land's help. And I'm sure all his friends at the AMA thought that was just great.

MOORE: So Land was the first head of the Medical Services Administration.

McCARTHY: Yeah.

MOORE: In SRS, right.

McCARTHY: Yeah.

MOORE: So that was when Ellen Winston left and SRS was created, Mary Switzer became the head of SRS, right?

McCARTHY: I was never comfortable with SRS.

MOORE: It was an odd amalgam of organizations.

McCARTHY: It was, it was.

MOORE: Always. So at that point in the beginning of Medicaid, there was a medical services unit. How many people were there at the beginning of Medicaid to work on the policy and implementation.

McCARTHY: Well, we had about 12.

MOORE: Twelve people?

McCARTHY: Yeah, and we had—we were hoping to have one in each region.

MOORE: Ah. But did you or not? You had 12 in D.C. and then you wanted to have 10 more or 8 more or however many regions there were? So with that many people and a whole new program to run, you must have been mighty busy.

McCARTHY: Yeah, but it was so much fun, really. You talk to people in Baltimore now and there is no fun left.

MOORE: Yeah, it's not fun anymore. So how did you go about getting things started? Did you write guidelines or regulations or just kind of answer people's questions, or all of the above?

McCARTHY: Well, starting out, you answer questions because nothing is written down. But then we got more formalized and our people for policy were—Sid Robbins was the one in charge of that. And on financial management and all that was Henry Spiegelblatt. And then my job was the program evaluation. Then we started hiring people for each one of those branches. They were branches and the whole thing Land headed was a division. And then we became a bureau and then our branches became divisions as we got more and more people.

And Land was—Wilbur Cohen enjoyed having Land there because he was a very savvy guy. Wilbur knew that having a leg up with the AMA that he could get more out of them. Well, that worked for a while but then the job of Under Secretary for Health came open.

Now, had Land stayed right where he was he could have stayed there till Wilbur Cohen was gone. But Amos Johnson and Charlie Kubler started blowing smoke in his ear.

MOORE: Uh-huh.

McCARTHY: Boss, this is the way you've got to press hard. You're going to get this job...Assistant Secretary for Health. Well, it got in print and...Charlie was big on getting things to the press as an unknown person. And of course Cohen is not dumb. He knows where it's coming from. And first thing you know, Land didn't have a job. He was gone. And after him came—oh, God, what's his name?

MOORE: Howard Newman?

McCARTHY: Howard Newman. And I'll tell you, I was so pleased with Howard. He was bright. Now with Land, he had to give a lot of speeches. And we all had to be prepared because if it sounded stupid, he would present it just that way.

But Howard Newman was bright and was quick on his feet and was a good speaker. I was so proud of him after what we had gone through. Then the Medicaid program expanded and he survived the change over to the Republicans.

MOORE: Let me go back to those early days, '66, '67, '68. One of the things that David Smith has done a lot of research on was Supplement D, which I guess governed a lot of the public assistance programs. Did you all write the regulations as part of Supplement D or how did that work?

McCARTHY: It sounds familiar but I wasn't—

MOORE: You weren't involved with that.

McCARTHY: Sid Robbins' staff was involved in writing that, what we did. Yeah, our organization did. My group, we were over there busy writing a proposal for programs mostly having to do with computers, yeah.

MOORE: How to process claims. How to do the payment stuff?

McCARTHY: Yeah. Now, see, when we first started...back when I was in West Virginia and Karel was there, states did the claims processing themselves. We had big computers in those days...1401's by God...big sorters, what they were. We used state employees to keypunch. But as a matter of fact I can remember when I first came here I went to visit CMA out in Chicago, a big insurance company who wanted to be a fiscal agent.

And I'm shocked. I mean, they had health insurance and they had folders for each one. And they were running upstairs and down—

MOORE: So they were all paper.

McCARTHY: Oh, God, yes. Or copied on a piece of paper like a claim in a folder. And we were computerized already. We were ahead of the game. But some of the smart computer people started looking at this and said, "Hey, there's money to be made in this." As a matter of fact, I was sent to Texas in the very early days.

John Winters was the head of that Texas Medicaid program and he was one of the smart ones. Well, I had been there twice. First time, Wilbur sent me down there to see whether he would be receptive to even the idea of expanding Medicare/Medicaid. At that time, they had already hired a fiscal agent in their medical assistance program, the first in the nation.

Guess who that was? EDS. And a fellow named Gene Awney was the head of the Blues who was the primary insurer in that arrangement. And later Gene and Charlie Kubler got together in some kind of arrangement, I don't know what.

MOORE: So Texas was the first state in the country to have an outside fiscal agent run the program or process claims?

McCARTHY: Well, they were doing the processing.

MOORE: Processing.

McCARTHY: The computer work, really, as subs for the Blues, really.

MOORE: Yes.

McCARTHY: But then they learned that this is a place to make a lot of money. And it seemed like in no time all of the states were shoved out of that business because that's socialism. And the contractors poured in there.

Then the contractors, it didn't take them long. They would sign any of these damn contracts saying they will control the cost and stay right on top of inappropriate medical use. Then they learned that nobody was watching, just open up the gates, pay the damn things because the compensation was based on per claim.

MOORE: Uh-huh. Uh-huh.

McCARTHY: And I don't know if we're away from that yet. I know that the last one that I remember—Pete something in the District—he was trying to investigate questionable medical cases...

MOORE: Yeah, it was the late '60s when the costs were going up so dramatically. And that original thought that you all had, I think, that states wouldn't spend that much, became questionable because the Feds then got worried that the program was going to be out of control.
And then they started all the fraud and abuse investigations and more push towards computerization, and as you say, contracting to these other organizations.

McCARTHY: And now it's all under control.

MOORE: Oh, right.

McCARTHY: Yeah.

MOORE: Not really. Do you remember the 1967 amendments where they kind of ratcheted back? Because the way the law was written in '65, it was just the first step towards some kind of a universal coverage. And then in '67 they pulled that back in the law and that kind of went away as a goal.

McCARTHY: Well, the farther we get from the very first days when I was at Karel's knee practically, the farther away we get chronologically the less I had to do with policy, other than having to do with program evaluation. Those things you are talking about, I have a pretty vague recollection because I wasn't terribly interested in that level of detail.

MOORE: Did you end up with people in regional offices and did they deal with the states mostly? Or did you deal with the states mostly from D.C. in those early—

McCARTHY: Oh, in the early days? In evaluation our staffs were out all the time. But we didn't have but like one person in the region. As it turned out later, the thinking went like this. Let's have more staff in the region and they are closer to the states and we'll improve relationships. Well, as it turned out, the first damn thing they did as soon as they got staff out there was to cut off the travel money. So they just stayed at home.

MOORE: They couldn't go out and meet anybody.

McCARTHY: No.

MOORE: And that didn't happen till the '70s.

McCARTHY: I know. Our people were pretty specialized in claims processing and some of our guys weren't happy because I had them on the road all the time. And I thought I was being generous when I gave them comp time for Sunday. But from a staffing standpoint it was very efficient. And it was hard to replicate that kind of knowledge that this small staff was picking up. And they would exchange it back home on what they had found and...

MOORE: There must have been huge differences from state to state in terms of the sophistication of the states.

McCARTHY: Yeah.

MOORE: What states presented the biggest problems? Where did you put most of your efforts?

McCARTHY: I guess it had to do with smaller states that had less capability. And we spent a lot of our staff time in helping them with contracts with fiscal agents because they didn't know what to require. So we spent a lot of time helping them with requests for proposals and that sort of thing. And again, that was again one of these specialties that you couldn't replicate in every region.

MOORE: Uh-huh. Uh-huh.

McCARTHY: And even after they got people there, when it got around to that kind of a function they would call for help.

MOORE: And that's still—that's really still true today. Those are hard things to know all there is to know about and...

McCARTHY: And there were changes taking place in the approaches that contractors were taking. And if you only dealt with one, that was the end of your knowledge. But if you were dealing with all of them, then you could advise more wisely.

MOORE: Let's see. So then, you must have stayed in the Medical Services Administration until the late '70s, until HCFA was put together. Were you doing program evaluation that whole time?

McCARTHY: No, no. I was sort of off on the side, a special assistant doing contracting. I started that contract stuff back with Howard Newman and had even thought about going to law school at night when one could do that at G.W. [George Washington University]. And I was really headed that way and they would have paid for it. But a neighbor of ours was a school teacher and she put her husband through law school, and she talked my wife out of it. It just wasn't worth it.

MOORE: That was a hard life.

McCARTHY: So I wound up doing that until HCFA went to Baltimore. Well, I still did the same thing in Baltimore. I worked as an assistant to Williams. What the hell was his name?

MOORE: I know who you mean. I don't remember his first name.

McCARTHY: He was a nice fellow. And then we went over there and they were really nice. But it's like all of the big organizations—and you see that at the corporate level today when it's a merger of equals like Chrysler and Daimler, you know?

MOORE: Uh-huh.

McCARTHY: Now, they ain't equal.

MOORE: Uh-huh.

McCARTHY: So when we went to Baltimore we were sort of lost. And that was Califano's deal. Bring them together, Medicare and Medicaid. We went over there and they were organized and I'll bring them together. So every time somebody got an assignment they went to Medicare, even if it was a Medicaid question. So they would run around and do that. And it was years of their running back and forth that way, and finally they reorganized.

MOORE: What was the relationship with Medicare like before HCFA? Was there one? Did you all talk back and forth at all on contracting issues, for example?

McCARTHY: Well, on a guarded basis.

MOORE: On a guarded basis.

McCARTHY: No, really. I mean, Medicare staff always talked to people in medical assistance like they were poor cousins. No, this is for the poor people...

MOORE: Sort of second-class citizens?

McCARTHY: Yeah. Medicare people knew how to do everything. Then they got into the claims processing and they found out they didn't know how to do everything.

Well, you didn't have any coffee, for God's sake.

MOORE: No, I didn't. But thank you for a most interesting and valuable interview. And I will turn this off.

INTERVIEW WITH DON MORAN
JUDY MOORE AND DAVID SMITH – OCTOBER 16, 2003

SMITH: This is an interview with Don Moran of Moran and Company on the 16th of October, 2003 with Judy Moore and David Smith doing the interviewing. I wanted to ask you about your background and remember that you had done an undergraduate major in math and then you had done some labor economics.

MORAN: That's correct. When I left Illinois in '73 after doing my math degree my parents had retired to southwestern Michigan. So I wandered up there and wound up staying in the area for three or four years. Shortly thereafter I started wandering into local government and got a job as the administrative assistant to the Cass County, Michigan board of commissioners.

My primary responsibility at that point was to help the county administer grants that they were getting under employment and training programs—this being with CETA and the '73-'74 recession. And so I got actively involved in the administration of various types of CETA programs, ultimately a couple of years later wound up as the executive director of a tri-county consortium based out of Coldwater, Michigan running the full gamut of CETA programs.

As part of that the Department of Labor—at that point the Manpower Administration—was funding graduate programs in manpower program administration. So I went to Michigan and did that, supposedly leading to a master's degree in occupational education.

I finished about 27 out of 30 hours for the degree, at which point I wound up going to work for [David] Stockman in Washington. So I attempted to finish the degree, but never did. But that was basically labor economics public administration and occupational education stuff.

SMITH: How did you connect with Stockman?

MORAN: During a part of the period when I was working in this area I was an independent consultant and therefore not subject to the Hatch Act. So I got involved. I had a history—when I was living in Illinois and at the University of Illinois—of being involved in Republican kind of stuff.

So I volunteered to serve as the deputy head of the Cass County Republican Campaign Committee about the time that Dave resigned from John Anderson's office to come back in '75 to begin running for office. He challenged the incumbent Republican Congressman in a primary in '76 and was successful and then went on to be elected in November.

So I met him during the campaign but quickly thereafter became Hatched again when I became the executive director of the tri-county consortium. So I couldn't work actively on his campaign. But then he asked me to serve on an advisory committee of local district types that he was putting together to maintain his visibility.

And so I did that. About six months after he took office in '77 he called me up and asked me to go to work for him. So I said, yes, I would.

SMITH: In Washington or—?

MORAN: In Washington. So I moved to Washington as his legislative assistant in the summer of '77.

SMITH: One event that intrigued me, it was right about that time that Stockman put out a blockbuster of an article called, "The Social—

MORAN: Pork Barrel."

SMITH: Did you have anything to do with that?

MORAN: I did not. That was written more in the '75 era, while he was still segueing out of working for John Anderson and becoming independent. So I was not personally involved.

SMITH: And then you joined him about '77 in Washington. **MORAN:** Right.

SMITH: And about that time or a little bit later there was this interesting liaison between Stockman and Gephardt.

MORAN: Well, certainly the basic story was that in '77 and '78 Stockman was on the energy and oversight and investigation sub-committees in Commerce but got interested in health policy in the spring of '78 when the Carter Administration was attempting to move its hospital cost containment legislations through the Congress.

At that point in time, we got involved in that at the full committee level because Stockman was not a member of the subcommittee. He became actively involved in that—not to make this part of a long story short. He ultimately went on to the Health and Environment Subcommittee in the 96th Congress, became much more active in health policy and at that point was put together with Gephardt by John Horty who was a lawyer in Pittsburgh who was very active in health policy and who also had founded something called the National Council of Community Hospitals.

And so at that point in time there was sort of this first kind of public iteration of a debate about whether or not regulation versus competitive forces was going to be the driving, organizing principle of cost management in the health care system.

And Stockman became a leading exponent of the competitive point of view. Gephardt was somewhat attracted to that idea at the time. He had also been involved in the efforts to defeat the Carter administration's hospital cost containment legislation in '79.

And so he and Stockman hooked together to produce a piece of legislation, sort of as a think piece, demonstrating how you might use competitive market principles as a cost containment mechanism to make comprehensive health insurance for the population affordable.

SMITH: There are various objectives you might have in pushing managed care HMOs. One would be increased access and another would be cost containment and the third would be as a way of shifting risk and some of the conflict.

MORAN: Well, I think at that point in time, different people had different views of this. I don't think Stockman's and my view of this was so much that we were attempting to promote HMOs or a particular form of delivery organization per se. What we were trying to do was promote competition among alternative forms of delivery systems with an attempt to find some empirical reality as to what works and what doesn't.

Because as I think we have seen over the last 15 or 20 years of subsequent history, that which seems to work changes from time to time. And different people have different enthusiasms for different models and each model has some strengths and some weaknesses. So ultimately I think the Stockman view, which I strongly shared, is that a continual market test is really what

you are looking for, as distinct from trying to pick a winner in advance and then rig the race so that your horse wins.

SMITH: Well, the big story of course is OBRA of '81. And I would be interested in what was Stockman's brief. And how much of this related to simply budget and deficit reduction? How much of it really was also an attempt to push back entitlements?

MORAN: Well, I think it's clearly all of the above in the sense that a very important part of our remit at that point was to bring down federal outlays however we could. There was a very strongly held view on the part of a lot of people, certainly on our side of the aisle, that the rapid accumulation of new mandatory spending programs was an endemic problem and if you looked at what the structure was, there were a whole pile of things that are no longer with us today that were mandatory spending programs that were hemorrhaging because of the economic circumstances of '79-'80.

And so, when we took office in '81 there was a clear imperative to (a) get spending down however we can; (b) take on these mandatory spending programs to the extent possible; (c) in the Medicaid world there was also sort of a flavor of enhanced federalism because of the president's personal enthusiasm for that theme, among other things.

And so, if you put it all together, obviously Medicaid was going to be an important part of the story. It was a very rapidly growing program at that time, though not growing, in retrospect, as rapidly as it subsequently has grown.

But it was a very major area of attention. The challenge with Medicaid at that time is that unlike a directly federally administered program where the Federal government through statute and rules specifies the control handles that drive how the program worked, in Medicaid, of course, it is a permissive structure that basically is determined by each state in terms of how they establish and operate their program.

Now, that is certainly true today. It was at that point in time a lot less true because of the way in which the rules were structured. Basically the Medicaid statute at that point in time said, here are certain things you must cover in Section 1905(a) 1-5.

And then there are other optional things that you can cover. But in each area it said, with some few exceptions, that when you cover something here

you must use the same basic principles of payment as applied in the Medicare program. So particularly in hospital reimbursement they had to basically use the hospital payment methodology for Medicare, ditto physician reimbursement.

All these other areas were in effect dictated to a high degree. Now, states could vary the exact manner in which they could do them, and they could, for example, with respect to benefit mandates, as you know quite well, limit the amount, scope or duration of the benefit.
You've got a whole pile of different control handles that states have to moderate that. But the basic structure of it was essentially to be Medicare for poor people, 50 percent or more funded by the federal government, 40 to 50 percent funded by the states.

And so one of the thematic issues that we took on in OBRA of '81 was that specific question and whether or not it might make sense to give the governors a substantially greater degree of latitude in terms of what they could do or couldn't do with the program in order to spur some degree of innovation, assuming that since we are in it with them that their incentives to contain their own costs would translate into efforts to contain our costs.

SMITH: So you really saw it as a new direction in Medicaid.

MORAN: In that regard, yes. Obviously, the whole story of eligibility changes and expansions really comes as a later chapter of history. But, we had been involved at that time. There was a children's health insurance program that had been debated in the House of Representatives in the 1979-1980 year, and we were actually involved in that debate.

So the issue of eligibility expansions was on the table at that point in time. But frankly, given the circumstances between '79 and '82 when we were kicking the unemployment rate upwards towards the sky and eligibles with an 18- to 24-month lag were coming onto the program in droves, at that point no one was really contemplating major eligibility expansions.

People were contemplating efforts to do eligibility contractions, but most of that was coming off of the AFDC side. So there was not really a heavy interest in looking at Medicaid-specific eligibility, which in that context was mostly the medically needy program, and say, "No, you must curtail this." It was more of an effort to try and give states the fiscal handles they could to stamp down on the program.

SMITH: Let me back up just a little bit on OBRA of '81. In many ways, it seems to me, it was the most remarkable strategic coup in modern history, I would think. And I wonder how much of that was Stockman's planning, how much of it was work at a higher level for which he was sort of the field commander that carried it out.

MORAN: Well, I think the thing you have to appreciate about OBRA '81 was that it was—if nothing else it was analogous to a two-minute drill in football. Which is to say you are down six points with two minutes and 13 seconds left to go in the fourth quarter.

SMITH: What do you do

MORAN:...to make seven points. So OBRA '81 was essentially the seven points we were looking for.
You can say that the strategic vision of how you bring it about was principally engineered by Stockman and Jim Baker, and that would probably be right because ultimately what OBRA '81 was about was creative use of legislative tactics, which was much more their metier than anybody else's in the administration at that point.

Probably in that regard Stockman's more than Baker's. But it was really basically an attempt to get a major spending bill on the floor, we are going to work backwards from that. What do you have to do in a Democratic-controlled House of Representatives to make that happen?

Well, first of all you need a budget resolution that is going to contemplate that there is going to be major change. Under the statute at the time a few people recall that it was primarily contemplated under the Budget Control and Impoundment Act of '74 that reconciliation was a statutory activity that was supposed to take place pursuant to the second budget resolution.

SMITH: That's right. And they collapsed it.

MORAN: And that in fact had been used that way for the first time in 1980 by the Carter administration when they withdrew their budget and came back with other stuff.

MORAN: So basically we were talking about the kind of budget reconciliation and saying that the notion of bringing that forward to the first resolution was really kind of jointly engineered between Stockman and Pete Domenici with Baker's active acquiescence.

And so—well, it's active acquiescence. Jim Baker chaired this thing that they called the legislative strategy group, which was basically himself, Ed Meese and Dave Stockman, who met really daily during the first six to nine months of 1981 and subsequently to kind of plot the day-to-day things of how you are going to get the tax bill done and how you are going to get the budget reconciliation—

SMITH: Uh-huh. Uh-huh. You said the '75 Carter was a precedent?

MORAN: 1980 Carter was not a precedent in the sense that Carter—the first time reconciliation was ever done was in the fall of 1980 and it was done pursuant to the second resolution.

SMITH: Right, yes. But the collapsing into one stage was a..., right.

MORAN: So that was basically the technical innovation that was thought of to execute this two-minute drill because what that did was basically to permit the Senate, which had just of course come under Republican control, to attempt to get out ahead of the process.

Because they could adopt legislative reconciliation instructions on their own budget resolution, which would bind their committees regardless of whatever subsequently happened to it. So they did that. They then went rapidly forward to produce their own reconciliation bills, putting pressure on the House to respond. Then the Gramm-Latta episode in the budget resolution was really sort of the first hurdle in that process.

And we had to have adopted a resolution that contemplated that the House committees were going to have to do this as well. And so we did. And so they did. And then of course the question then coming from there onto the floor was how you were going to engineer all this. And there's a lot of specific history.

SMITH: Now, Medicaid in this picture. There was a lot of money you had to squeeze out of other areas. Was Medicaid seen as a big cost-saver in this picture or were you more interested in the restructuring of Medicaid?

MORAN: Well, I think certainly the answer is both, in the sense that in the formal score-keeping process we needed every nickel we could get our hands on. In the interim, if you have the opportunity to do what you consider to be good policy at the same time or to achieve budgetary savings

through what you think of as basic policy reforms, that is a worthwhile thing to do.

I think the intersection, interestingly in that context, is that when you are dealing with a whole host of budget cuts—and obviously time goes by and you think about these things differently than I did when I was, say, 29—which is the year we were talking about. But there is a sort of a tradeoff between specificity and dollar magnitude. The good news about specificity is, you can explain to people what you are not cutting. And the bad news about specificity is you are also in the process making quite clear what you are cutting. And there is a sort of a basic law that says that the more unusual or strange or antisocial a budget cut looks the bigger the dollar amount associated with it has to be in order to make it tempting to people to do it. Because if you hand members of Congress a list of a whole pile of antisocial things to do to widows and orphans and each one saves you $6.3 million, they are going to say, "Please get out of my office. This is not worth it."

So rule 1 is that the more antisocial the budget cut looks, the bigger it has to be. The second rule is that the more amorphous you can make the specific policy outcome by delegating the actual decision-making to the states the more political cover you have against the charge that you are producing specific consequences.

Now, you also are creating an environment where people can be much more creative about their allegations about what the consequences will be because you don't have the pretense that you are proposing something specific. So the other side could of course explain that we were ending the world as we knew it by delegating these authorities to the states.

And they can make that argument and we can make the counter argument and everybody can go around in circles on it and reach no conclusions whatever, because it is almost by definition what we were doing for the most part was permissive in Medicaid—and partly as I have gotten older there is a weird sort of permutations and combinations that turned on what happens at different levels in terms of what people are required to do, permitted to do, or prohibited from doing.

And it is possible for the Secretary—the statute to require the Secretary to permit states to prohibit acts. And you can come up with whole different chains of things running from the statute to Secretary down to the state and

then down to providers, where there's lots of these permissive handles on things.

You have to decide which way you are going to play things. And the way we decided to go is rather than attempting to statutorily specify prohibitions or changes in Medicaid, we basically permitted the states to do the same thing and by doing so hoped that the incentive structure was such that they would go ahead and do it.

SMITH: Meaning that you had to have a pretty firm and stringent cap.

MORAN: Well, there was.

SMITH: Eventually it came out in this kind of National Governors Association—Waxman proposal for 3-2-1.

MORAN: Right.

SMITH: Which was later changed somewhat, but was very different from the flat cap that was originally conceived.

MORAN: Right. And certainly part of the theme of 1981 was block grant everything you can get your hands on that was going to the states. So that was going on simultaneously. We were certainly pushing for a hard cap. The Commerce committee was not going to mark up a hard cap. So one of the technical things, when we finally got onto the floor with OBRA '81, was we had to structure the thing so that the Commerce committee amendment was going to be offered separately and ultimately was not offered because we didn't have the votes to pass it on the House floor.

So that's why the Commerce committee package as reported became the policy. But in the process what they had done to attract Republican votes and get the thing through is they had picked up all of our permissive stuff without picking up the hard cap, so that by the time the thing got to the floor we got what we thought were a fairly reasonable set of policies even though we didn't get the cap.

And that's part of the reason why we didn't, and basically asked Broyhill not to offer it; and Broyhill agreed. I don't think we told Broyhill to do anything. But he and the leadership agreed with our concurrence that the amendment need not be offered because we had done enough at that point.

And the challenge is, that with the passage of years, a lot of the specific details about the detailed mechanics of all that kind of process all kind of run together because we did five years' worth of this stuff.

And at some point you have seen enough budgets so you can't remember which one was—what was in which one.

MOORE: Right.

MORAN: And so it's a further challenge that subsequently I spent probably close to 20 years doing an awful lot of work in the Medicaid system. So some of this history is more fresh in my mind—

SMITH: Some people said that about the only major deflection or defeat in OBRA '81 was on this Medicaid hard cap issue.

MORAN: I think that's fair. Now, technically speaking I could counter and say, well, it wasn't a defeat because we didn't bring the vote up so that we didn't lose it.

But as a practical matter, the fact that we couldn't get the votes for that put us in a situation where we got less than we originally hoped for. On the other hand, passing the thing in the first place was definitely miraculous.

MOORE: Did you ever go back and think about another hard cap or different kinds of caps after that '81 compromise?

MORAN: Well, in the sense that every year you go through something called spring review at OMB where the staff comes forward with a long list of creative ideas for doing something. And certainly in the context of subsequent spring reviews we contemplated the notion of doing something.

Probably you have to recall that the next innovation was the grand swap coming into 1982. And there the notion was if we can—now here I have to step back and tell this story carefully because I don't want to be unfair to anyone.

Stockman's basic idea was that we were going to—and here the numbers will be just impressionistic—raise $30 billion in taxes, turn it over to the states so it was okay to do it, from the president's viewpoint, and then give them about $50 billion with the programs at the same time for a net budgetary change of $20 billion.
And so the big piece in the mechanics of the swap from the Stockman perspective was the attempt to convince the president it was okay to raise taxes, particularly excise taxes, if the purpose was to create a financing source for devolution of these programs to the states.

And so that was his innovation, cooked up one night over dinner at Nick and Dottie's. But the sequence of events was that he and Meese, who got very enthusiastic about this, managed to convince Baker that they should be able to take it to the President.

So they took it all the way up to the President in the form in which I have just characterized it, which is this big programmatic swap, but then you do this tax increase to finance it. And there is a net savings.

And the President agreed to that in principle, at which point the folks in the Treasury Department, who were sort of the supply side theologians, managed to get the chamber of commerce and other parts of the business community activated about all these excise tax increases. So they came in and started jumping on everybody's desk.

And at the end of the day what the President did is, rather than approving the program in final form, basically said, "Well, let's go ahead and do the program swap but let's not do the tax increase." So at that point we were stuck with a program in search of a rationale. And so the new rationale became, well, maybe if we can federalize Medicaid we can then offer that as a sufficient inducement to the states to take all the rest of this stuff. And so that then became the subsequent innovation that led to this protracted negotiation with the National Governors Association over three or four months, which Rich Williamson and I had the dubious honor of co-chairing.

That ultimately wound up in a conclusion that the governors thought that taking on AFDC and food stamps, in exchange for a federalized Medicaid program, was a very bad idea, demonstrating what a high discount rate governors have.

SMITH: Well, in the original proposal for the swap it wasn't clear to me, were they going to lose $20 billion or gain $20 billion in that?

MORAN: Well, the states were going to lose $20 billion in that.

SMITH: But get a lot of flexibility.

MORAN: Get a lot of flexibility.

MOORE: Why did you need to raise the taxes?—oh, but you were going to give the taxes over to the states. I have it. Okay.

MORAN: Right. So in other words, I take $20 out of your pocket.

SMITH: Right.

MORAN: Give you $20 and then take $30 for me.

SMITH: Yes, right. Related to this, because it came with increased flexibility, was the budget-neutral requirement. Where did that come from?

MORAN: Well, the budget-neutral requirement came in various manifestations. First of all—and you are talking budget neutrality with respect to Medicaid?

SMITH: With respect to waivers.
MORAN: Oh, with respect to waivers. That was negotiated between Schweiker and us in 1981. Previously OMB had not asserted the authority to routinely approve waiver applications.

We were advocating greater use of waiver authority to give the states greater flexibility even prior to the adoption of the block grant provisions, the OBRA provisions that did that. And so, as part of that basically Dick Schweiker and I worked out a deal under which there were classes of things which were programmatically going to be program waivers.

And this extended beyond Medicaid, more broadly to Medicare and a few other things. Well, basically, what the intent was, to start a new program or activity, basically the treaty would be that they would submit anything significant to OMB for review.

In return, the general principle is that we would approve everything that was budget-neutral unless we had—or we undertook the burden of trying to explain to them why it didn't [achieve budget neutrality]. And they had

appeal rights up the chain if we were trying to do something to them that was not enforcing budget neutrality.

SMITH: Was part of the motivation of this to have kind of advance warning in what they were doing with waivers and R&D?

MORAN: I think clearly there was a whole theme of attempting to find greater centralized control over decisions in the executive branch that caused people to spend money. Certainly after I moved to the budget side of the agency in '82, for example, we instituted an annual review program where the Justice Department would come over once a year and review with us all major pieces of litigation involving the United States that had significant fiscal consequences and talk to us about what their posture was on the case and where they were.

And particularly the treaty was that they wouldn't settle anything that had big fiscal implications without, you know, review and approval, because there were some big things like toxic tort cases involving the United States or Agent Orange with veterans where the potential budgetary exposure was gigantic.

And so what we were attempting to do is to come up with mechanisms, similarly the executive order 12291 process which established the—

SMITH: Was that all part of that package, the 12291 as well?

MORAN: It's the same theme. It just played out in different areas. Now, in that particular area that happened early in the administration because the President delegated Vice President Bush to set up a regulatory task force. And one of the first things they did was recommend that this kind of process be put in place.

And so they prepared and drafted the executive order. We concurred in that and in fact agreed to use the Office of Information and Regulatory Affairs, which previously had been the statutory agency to implement the Paperwork Reduction Act as the administrative mechanism for that. And so at that point, Jim Miller picked up that responsibility as well. He was staffing the vice president's task force.

SMITH: So this is kind of executive center top down initiative. I mean, you really jumped into that very rapidly. That wasn't something you planned to evolve over four or five years. You were going to hit the ground running.

MORAN: You may recall that there was an exercise sponsored by the Heritage Foundation in 1980 called Mandate for Leadership that got hundreds of people involved in different aspects of thinking through what it might mean to—what we would do if you took over control of the executive branch.

And a lot of the thoughts and ideas that were generated as a consequence of that was basically taking the collection of people who then subsequently went down to the executive branch a year later, and putting us all through an exercise a year earlier of having had to say, well, if we were going to do this, what would we do.

And a recurring theme of that was greater centralized executive control over discretionary decision-making in Departments that had significant fiscal consequences either for the government—

SMITH: Now, that wasn't all coming out of the Heritage Foundation, was it? Did they write it?

MORAN: It was a Heritage Foundation activity, though they brought in all of us.

I served on the group that did HHS and my specific mandate I think at that point was to do the Agency for Children, Youth and Families. So everybody was sort of scrubbing budgets and doing all that kind of more mundane stuff in addition to doing bigger think policy.

SMITH: HHS was seen pretty much from the beginning and straight on through as kind of the main domestic target.

MORAN: Well, to the extent, certainly most of the programs ran through HHS. Obviously Food Stamps was also an issue. That's an Ag Department program. But most of the action on the mandatory stuff does sit in the HHS.

Now, also you've got federal and military retirement stuff. And the entitlements kind of broadly construed was a very big theme both of the pre-administration efforts and the first couple years of the Administration. In fact, I wound up chairing an entitlements task force for a couple years that basically was charged with doing an independent policy development as a senior interagency group for the executive branch. And I did that both in '81 and '82.

SMITH: Now, once you put in place the series of cuts and the rollback of the AFDC and that kind of change did that have an important impact in reducing Medicaid expenditures.

MORAN: Uh-huh.

SMITH: And that was pretty clear. Was this in any sense too much of a good thing? And what I have in mind here, of course, is that you begin to get a counter-movement and you have Waxman and you have the southern governors and all of this sort of business.

MORAN: Well, I think to a certain extent, sure, because every solution to a major public policy problem carries the seeds of the next public policy problem.

SMITH: How true.

MORAN: And so from that perspective, you know, obviously anything you do has consequences. And not all the consequences are positive. In retrospect, you can argue about whether this is a good or bad thing. We enacted major changes in the safety net infrastructure, if you will, just about six weeks prior to the onset of the '81-'82 recession.

And if you think the fiscal consequences of that were bad, you should have seen what it would have looked like with 46 months of extended unemployment benefits and other kinds of things that we got rid of in that OBRA '81. So you can argue whether the glass is half full or half empty. But the essence of it is that there were a lot of pressures then to say that the social safety net was not as responsive as it would have been previously.

And that, over a period coming into '84, '85, '86, created the pressure for other stuff. And the Waxman thing was an interesting sort of Faustian bargain between Dick Darman and the House leadership in the sense that Darman needed stuff coming out of the House every year in order to achieve his budgetary objectives.

And the basic treaty was, they would do a budget resolution that gave the President some of what he wanted on the fiscal side as long as you could have a Medicaid expansion in there so all of the guys on the left could basically say that they got their stuff.
So every year basically the Administration acquiesced in some kind of Medicaid expansion in the '88-'89-'90 time frame as sort of the price of

getting a budget resolution through the House of Representatives. And Dick, of course, was committed to wave at it when it came by from a statutory perspective.

Of course, that was also the time that the miracle of the loaves and fishes was being discovered, so—

MOORE: Oh, yes. It meant that the state financing strategies.

MORAN: So that was just coming in the '89-'90 period. And then really from there on out Medicaid policy had and has become more about that than it has about anything else.

SMITH: But the first kind of time you see the camel's nose under the tent was really in '84?

MORAN: Uh-huh.

SMITH: And then it begins to crank up.

MORAN: Right. Well, and different people—this is one of those “success has many fathers” kind of thing. Five or six different states claim credit for the first effort to do that. And you can look back at this. This is kind of like finding the original Indo-Europeans, you know. Lots of people have lots of different opinions about that. But as a practical matter, the reason why that happened is part two of the Waxman story: that the Commerce committee had to acquiesce in that—whatever they thought about it—because that was the financing mechanism for the state match for all the Medicaid expansions.

Particularly if you think about it, most of this stuff hit the southern tier pretty hard because you had a bunch of states that were—Texas had an income eligibility level of 18 percent of federal poverty standards. Going from there to 100 is a lot bigger jump than it was in New York when they were at 85 to begin with.

And so the southern states in particular got really hosed by all the Medicaid expansions of '88 to '90 and the creative financing stuff was really the mechanism by which they came up with the math. And if you look at the states that ultimately became the biggest DSH players like Louisiana, and say, "Well, why Louisiana?" And the answer is because they had this huge fiscal problem that this was the only way to fix.

SMITH: You, I am sure, remember Lynn Etheridge from the old days?

MORAN: Uh-huh.

SMITH: Lynn said be sure to ask you about the significance of the Hyde amendment in Medicaid politics and where that came from.

MORAN: Okay. Well—

SMITH: And we all know where the Hyde amendment came from but then it was used periodically in the legislative process.

MORAN: Well, see, the thing about the Hyde amendment that you have to remember is that in the '70s it was offered annually as an appropriations rider.

So basically none of the funds can be used to implement yah-da, yah-da, because nobody brought the Medicaid statute up on the floor after 1972 to give these guys a shot at it, okay? The reason why the CHIP program got blown up in the House of Representatives in 1980 was because of the Hyde amendment. We orchestrated this legislative process so that in the Commerce committee as the thing was marking up there was a Stockman amendment which basically would have had the effect of rather than making this child health insurance program an entitlement to make it an appropriated program with annual disbursements of funds to the state.

And so we offered that in the Commerce committee and lost narrowly and made it very clear that we were going to make it the substance of the floor debate. So that, when we went into the Rules committee basically the thing was structured so that they set it up with a modified open rule and basically geared up then to try and beat the Stockman amendment on the floor. What happened five minutes before the Stockman amendment was offered was that the Hyde amendment was offered. And unfortunately at this point they had Title 19 up on the floor of House of Representatives.

So the Hyde amendment was now actually embedded in the Medicaid statute, at which point they took the bill down and threw it away. So that may be one of the things that Lynn is thinking about, the fact that Hyde amendment has its own life in politics...

SMITH: And it's one of those poison pills that you can bring in whenever it's needed.

MORAN: Right, right.

MOORE: Was this a well articulated, quite understood policy that Title 19 would not come up on the floor?

MORAN: No, I don't think so. I think it was just a matter that it didn't. Certainly thinking about it from the conservative side, we were always the guys for whom this was an important policy issue. We were not among them; but for those for whom this was an important policy issue they were constantly looking for opportunities to get at the statute itself rather than this appropriations rider. And then we found one.

SMITH: Certainly Waxman was very important in this.

MORAN: Correct.

SMITH: Apparently he was almost invincible in conference.

MORAN: Well, you have to remember that this was a different era and maybe this is outside the scope of what you are interested in.

But Henry Waxman became Chairman of the Health and Environment subcommittee in the 96th Congress in January of '79 because he made enough campaign contributions to other members of the Commerce committee to get passed over the head of Richardson Pryor who was—going to be the next subcommittee Chairman—and made him subcommittee Chairman, in reward for which he was given some interesting Democrats on his subcommittee as freshmen.

He got Democrats like Phil Gramm. He got Democrats like Dick Shelby and he also got Jack Murphy from the docks of New York. So basically the story was in 1979 and '80 in the 96th Congress, when he could get Tim Lee Carter, who was the ranking Republican to vote with him, he had nine votes. And other than that Madigan and Stockman who were kind of leading on the Republican side, were in the subcommittee. So from that standpoint when the child health insurance thing was done it was never reported from the subcommittee. They brought it up in the full committee dealing with hospital cost containment, when they tried to run that up.

But the subcommittee basically blocked it. So to say that Henry was invincible in conference in many cases was because he was...O for O. He never got to conference.

SMITH: Oh, right. Right.

MOORE: Well, now, but I think you were referring to Waxman in conference later on.

SMITH: Yes, it's later.

MORAN: Oh, yeah, but the 96th Congress was a very different story.

SMITH: Well, you have covered a lot of ground for us, I must say. Let me see if there is anything else that we would need to ask you. Oh, there was one item I wanted to ask you about.

Under the Clinton administration there was always this constant warfare between are we going to take OMB numbers or are we going to take CBO numbers? And it seemed I can remember you saying at one point or someone telling me that during much of the Reagan administration CBO numbers were taken very, very seriously and they really—that was kind of the gold standard.

MORAN: The thing you have to appreciate is that the real question—there are two questions here. One is the operational reality and the second is the political rhetoric. On the political rhetoric side there was always an argument back and forth between OMB numbers and CBO numbers because we would have a given forecast. They would have a different forecast. Our forecast would show deficits of X amount, so from a critical standpoint there was always an argument going back and forth on whose numbers to use. As a practical, real world, operational matter, OMB numbers are executive branch numbers and CBO numbers are Congressional numbers. And in executive branch processes OMB numbers are controlling. And in Congressional processes CBO numbers are controlling. And everybody understands that.

So from that standpoint certainly in 1981 we attempted one of the weirder technical things we ever tried and this was one of the biggest failures. We attempted to score appropriations bills on the basis of OMB outlay estimates. And when the appropriators quite correctly explained to us that they don't do outlays, that the executive branch does outlays, we do budget authority.

SMITH: Yes. And you saw their point.

MORAN: Yes. So from that standpoint, we found that we couldn't control that because what we did is, we created a monster.

Because basically what they did is they cut all the salary + expense accounts of the agencies which have an 87-percent spend out rate by 15 percent and then quadrupled the budget for construction spending, which has a first-year outlay spend out of 3 percent. Outlay score: a wash.

SMITH: Yeah. Right, right, right.

MORAN: So we never did that again. But that was the only time that I can specifically recall where there was a real, operational kind of battle back and forth between OMB scoring and CBO scoring, after which we agreed that the only rational thing to do was to have standard budget authority scoring. And then it was our job to keep track of the outlay consequences of it and argue against budget authority allocations that we sought that were inappropriate in light of the spending...

SMITH: Uh-huh. Uh-huh.

MORAN: Well, the challenge we were in is, we were in a very difficult era on the appropriations front that people, I think didn't recognize because we were always in a posture of asking for about $35 billion more in military appropriations after 1981. So starting in '82 into the fall we were always asking for $35 or $40 billion more than the Congress was going to give us. Which meant that they could take the president's aggregate appropriations request, slash $35 billion out of this phony defense request, spend $30 billion out of it on their favorite charities and explain that they were bringing the appropriations bills in under the President's Budget. And they would be right.

But we did that to ourselves every year because of our own internal imperatives that we couldn't fail to ask for it because the defense contingent wanted to ask for it. And so we did. And we got over-ruled every year and then they spent it.

SMITH: And so it goes.

MOORE: How long were you in the administration? You were there at the time that all of the so-called creative spending—Medicaid creative spending...

MORAN: No, I left at the end of August of '85. And so really, it didn't kick off until it became a tidal wave in '90 and '91.

And at that point there were no limits on DSH and so there were no limits on creativity. And when you had states like Texas mounting $3-, $4- and $5-billion DSH programs as a means of basically laundering provider contributions it becomes a major policy issue.

The Medicaid budget at the federal level rose by $20 billion over a couple years due solely to the federal share of financing all this stuff. And so that really became a major issue. Ironically, at that point in time I was out in the world as a consultant and I was consulting to state governments on how to do fiscal enhancements.

It does come around. But obviously, if my former colleagues were idiot enough to leave the stuff up on the table my clients had a statutory and constitutional responsibility to try and get their hands on it.

SMITH: Yeah. There is a wonderful phrase where Martin Luther tells Philip Malancthon, who was one of his disciples, "Philip, if you are going to sin, sin vigorously," because it's the only way you will get the good out of it. But—

MORAN: Or the other bumper sticker is, "If you must drink and drive, drink Schlitz."

SMITH: Very good. You said you worked quite a lot on Medicaid since you left the government. And I wonder if you have changed any of your philosophy about Medicaid, or come to any particular conclusions about where you think Medicaid should go or is going to go?

MORAN: Well, I think—if you were looking for the broader philosophical question I guess I will take us back to 1982 when we first put this swap idea on the table. I think the reason it failed is that we put the wrong swap on the table.

SMITH: Uh-huh.

MORAN: The swap we put on the table is, you take these programs for poor people and we will take this program for poor people and we'll call it a day.

When in fact the swap, at least intellectually makes more sense is to think about this in population terms rather than programmatic terms and really try to ask yourself the question, given the nature of the fiscal commitments and everything else, wouldn't it be more logical to say that the federal government has primary responsibility for the elderly as a class and that states therefore have the primary responsibility for the low income under 65 population, and settle it that way? In that case what you would do is, you would federalize the dual eligibles under Medicaid and basically devolve the non-duals to the states. And—

SMITH: Well, but this—including the SSDI people.

MORAN: SSDI are duals. The feds would take those.
The biggest chunk, there is a fairly substantial chunk of non-SSI disabled who are not on cash assistance but are on Medicaid that you have to sort out.

But, thinking about this philosophically, as long as you have split jurisdiction for these programs and these populations the game always becomes the feds generally kind of pushing down fiscal hurt on the states and the states having to innovate different ways to get around it.

And that's always going to be a bad bargain from a policy standpoint and create all kind of operational headaches. And at the end of the day nobody is really at the wheel in terms of deciding what these programs cost because the ultimate cost is a population issue. It is what subset of the population are you going to decide is going to be worthy for what level and type of assistance.

And nobody is now in a position to make those tradeoffs intelligently and rationally because nobody internalizes 100 percent of the cost of any one population. I'm sensitive to the fact that my budgetary friends who—and I remain imbued with that viewpoint—would actually say, "Well, that's fine and dandy but please show me the fiscal consequences before you ask me to sign up for this."

And that's a legitimate question. But I guess I would point to the fiscal consequences of the preceding 15 years, suggest that's what you get in the absence of some kind of rationalization of all this.

SMITH: Right. I like that. I find it very interesting the way you put it. Any further reflections? Have you left anything unsaid that ought to be said? It seems to me this has been very rich.

MORAN: I think the key to Medicaid is to understand that it really isn't a federal program. If it's a federal entitlement, it is a federal entitlement for state governments, that they have the right that if they submit a state plan and the Secretary approves the state plan and they incur expenditures under it that they have an entitlement that the Secretary is going to pay their share with.

It's state law that creates entitlements for people and it is this lack of a nexus between federal law and state law which creates an environment where you have a de facto state entitlement that operates as an entitlement at the individual level that you can't reach directly from the federal side. And that's really why at the end of day I think you have to think about, in effect, chopping it up from a population perspective and having the federal government take control of that which people agree they should take control of and let the states go where they will with the rest of it.

SMITH: Well, I can see—I endorse that you did your undergraduate work in mathematics. That's very clear.

MOORE: Great. Thank you so much.

MORAN: It's been a pleasure. Nice to have seen you again. I have enjoyed it.

SMITH: Thanks a lot. A great pleasure.

MOORE: Thanks for—

INTERVIEW WITH ROBERT MYERS
JUDY MOORE AND DAVID SMITH – APRIL 15, 2004

SMITH: This is Judy Moore and David Smith with Robert Myers in Silver Spring, Maryland. And we are doing another one of these interviews for the oral history project. And I know, Mr. Myers, that your expertise in Social Security and Medicare is formidable but you were also around for a lot of these events that dealt with Medicaid. So we wanted to ask you about some of the things that we think you might well have known about and certainly know a good deal more about than we do.

One of the first questions I would like to ask you goes back to Kerr-Mills. One of the reasons it came about, as I understand, is that they wanted something to sort of counter propose for national health insurance and you report that in some of your writings. Were there other things involved there?

I mean, for example, people have said Senator Kerr maybe had some presidential aspirations. In any case, he was running for re-election. And Wilbur Mills may have had his own particular concerns. Would you have any comment on that as to why Kerr-Mills came about?

MYERS: It's really difficult to give single, concrete, authoritative reasons. There are many factors involved. Some of them are, as you indicated, the political ambitions of the two authors. But that's not really, I would say, a major factor.

I think it came about in part as an offset to the arguments of the American Medical Association that when they were arguing against adoption of a social insurance program such as Medicare, where people got benefits as a matter of right, the American Medical Association said that any sort of compulsory plan like that would mean, sooner or later, undue control of the medical profession by the Federal government. They didn't want to see that at all. So the AMA proposed—said, if you're going to do anything, do it on a public assistance basis, and in essence that's where Medicaid came from.

And Kerr-Mills took them up on that, said that's a fine idea, we'll do that. We'll do all these things—to the shock of the AMA, because they weren't really too anxious to have Medicaid. But they thought if there was going to be something, it would be much better if it were on a voluntary, needs-test basis.

So the AMA really got caught out on a limb that way because Kerr-Mills said, well, that's a fine idea. Let's do that, too. And the AMA never thought that they would do both. So the Congress therefore adopted both the public assistance basis, Medicaid, and a social insurance basis of Medicare. And then in Medicare, the fact that Part B was voluntary, they said that should please the AMA. They don't want any compulsion.

But that really didn't mean anything because Part B is such a bargain that everybody would take it—as they did. Virtually everybody takes Part B, because it's just such a good buy, because they don't pay the entire cost. So the AMA got it coming and going.

SMITH: A lot of people have said Medicaid was just an afterthought. It almost didn't happen. And yet, if you look back, you can almost draw a line from some of those recommendations in 1947 and '48.

And then Wilbur Mills got hold of the idea of building on Kerr-Mills and there were several amendments to Kerr-Mills. And it was almost much less than an afterthought; Medicaid was the fulfillment of a long train of events.

MYERS: Well, as I was saying, Medicaid was reluctantly sort of suggested, I think, by the AMA. They didn't expect that they would get that as well, also getting the social insurance approach of Medicare. So the AMA got caught out on a limb. They really weren't enthusiastic about Medicaid. They just thought it would be good instead of Medicare. And instead, they got both.

SMITH: When they were considering Medicaid, and I was reading in your book, for example, you get the sense that it's pretty much a matter of a few key figures like Wilbur Mills especially, and to some extent Wilbur Cohen, but that very little thought was given to anything like Medicaid within the Department.

The action was over in Congress and maybe Wilbur Cohen was a significant figure. But what about within the Department? Was any thought much given to Medicaid before it happened?

MYERS: In the Department, they adopted the strategy of going all out for Medicare, and they didn't want to dilute their energies. But I'm sure that most of the people in the Department thought that Medicaid was a good idea but they wanted to get Medicare first. They didn't want to have their influence weakened by supporting quite a number of things. It's just the same way, unfortunately, that nobody back then considered prescription

drug insurance, because it wasn't as important and it wasn't as costly as now. Drugs are so much more expensive with all the new drugs that have been developed. But again, within the Department if they could have added drug insurance, they would have done it.

But, as I say, they tried to concentrate on getting just one thing, Medicare. And if they got more, as they did much to their surprise, they were really inwardly enthusiastic about it.

SMITH: Once you get Medicaid passed and it is barely up and running, the Ways and Means Committee wants to start investigations to find out why it's costing so much.

Now, is that just Wilbur Mills being proactive and far-sighted? What other kinds of things were there?

MYERS: Well, I think it was mostly that. But there was pressure from the AMA to downgrade the social insurance side of it. And so in answer to that, Mills said, "Well, we'll keep a close eye on it." If it's going to be as expensive a cost overrun as you say, we'll check on that first. And if it's going to be a bad situation, we'll do something about it. So a lot of things are done not for the reasons stated, but as window dressing or cover-up.

MOORE: Did you work on cost estimates or cost projections for Medicaid as well as for Medicare? Did anyone in the Department?

MYERS: I don't think they really did.

MOORE: Nobody looked at that in those days?

SMITH: On the Medicaid cost aspects, I remember that you said one reason an actuary wouldn't have much to do with that is because so much of it depended on what was done at the state level and there really wasn't any very good way to estimate that.

And then another thing of course is that at one point you said that the biggest player of all, New York, waited for quite some time to weigh in. So, there was very little that could be done by way of estimating what Medicaid was likely to cost.

MYERS: Yes. Well, that's quite true. It's really almost an impossible task to say what a public assistance program is going to cost before it gets

started. You don't know really what standards are going to be applied, which people are going to be covered, and which people aren't going to be. So it depends so much upon the administration, whereas with an insurance program you know who is going to be covered under it.

SMITH: And you've got millions of individual units as opposed to sort of 50 large, blocky, contrary units.

MYERS: That's correct.

SMITH: Yes. You and I at one point did kind of agree with the terminology that Medicaid was a “sleeping giant.” And that was a popular phrase around then. And I got a little bit of suggestion from what you said in your book that one of the reasons you thought of it as a sleeping giant was because it had that medically indigent provision in it and no one could quite tell what was going to happen with that.

MYERS: Yes. The question of who is medically indigent depends so much on personal judgments and depends on what each state does, and it's just a can of worms.

SMITH: Do you know if the medically indigent concept was in Kerr-Mills? And do you know as between Mills and Kerr who was more responsible for that? It seemed to me like that would have been a Kerr contribution.

MYERS: I couldn't say. It came about because the AMA sort of suggested it.

SMITH: Well, did they suggest the medically indigent concept?

MYERS: Yes. As I recall. And then everybody that hopped on it said, "Fine. Let us do that, too." And the AMA didn't realize it. They thought it was going to be a choice, one or the other. Instead, Kerr-Mills and the Department happily leaped on it and said, "Let's do both. They're both good ideas."

So whether they thought so or not, if it had been just the medically indigent, just the public assistance in play, the Department and others would have opposed it strongly.

That was a good supplement, a good floor of protection or net of protection to have. And so they happily went along with it. But the last thing they would have wanted would have been solely a medically indigent program.

Of course, any of them would have liked a national health service like Great Britain has. But again, that wasn't a choice because that would definitely have been killed and the AMA would have been extremely strong against it. So a lot of times, as happens in life and particularly in politics, you do what is expedient even though it's not 100 percent satisfactory.

SMITH: Right. Well, it was true I think at that point that some of the states like New York really were almost pretty much preaching that gospel that we were going to use this to get as much as we could out of national health insurance and some of the hospitals were behaving somewhat that way.

MYERS: I suppose so.

SMITH: Yeah. Within the Department in 1966, you get Wilbur Mills, with kind of amazing speed, deciding we had better start an investigation of what's going on. Was there a response to that within the Department?

And alternatively, or put another way, what did the Department think about this problem and what, if anything, were they proposing to do? What you often hear about is what Congress does here, and not what the Department might have been thinking.

MYERS: Yes, it's sometimes hard to know just what the Department is thinking because what appears on the surface is not necessarily what is really happening behind the scenes.

SMITH: Absolutely.

MYERS: And I think the Department didn't want any further investigation. They had enough on their hands getting the program up and running without an investigation going on at the same time. So they were less than enthusiastic about it.

But again, they can't oppose it because then it looks as though they are afraid there's something wrong and they don't want to admit it.

SMITH: Judy and I were talking as we came over and saying that in the initial phases of implementing Medicaid you have state plans coming in from states that had already done Kerr-Mills and probably that would be a template for that. It would be sort of a handle for the Medical Services Administration to try to get these states started in the right direction.
Did they put a great deal of emphasis on this initial phase of state plans? Did they see that as a very important piece of leverage?

MYERS: Well, I don't think that they were enthusiastic about having states play that role but there was nothing else they could do. It was again part of a whole package of things and it was either take it or leave it. And they wanted to take it because the Department got the main thing it was after, Medicare.

MOORE: Did the Social Security Administration and the Medical Services Administration and the Welfare Administration people work together much in implementing the two programs at that time?

MYERS: Of course at that time Medicare was under the Social Security Administration. And there was a separate Welfare Administration. Well, I suppose they worked together. But like typical bureaucrats they avoided it as much as possible.

MOORE: Well, they were physically in different places. And they were very different kinds of organizations so it would have been—

MYERS: They couldn't say publicly that they didn't have the time to waste bothering with those welfare people and vice versa.

SMITH: Well, these '66 hearings made a number of proposals that then became the basis for the '67 Social Security amendments.
And it would seem that about the only thing that gave you much leverage right then would be saying, for example, how much you could do with this medically indigent concept that we're going to make Medicare the primary payer, and things like that.

I guess two questions come to my mind with this. Once this would obviously be seen as the most direct route to make some changes and to get some response: Was there sort of an awareness that this is about the only really powerful tool we've got or were there other things that they thought you might be able to do here at this stage?

MYERS: Well, I think they thought that the amendment process that evolved in 1967 was the best way to do it. It was something that was in motion and so you hop aboard and use it.

SMITH: Was there any sense of alarm at this point that this thing was really—in this language like a sleeping giant—to sort of mobilize the troops or was there a real sense of alarm that this program was—

MYERS: I think that was mostly propaganda. They foresaw the possibility that it might be a sleeping giant that would turn into national health insurance. But there's no good way of predicting where it's going. So that sleeping giant phraseology was just convenient, and a very sensational way to describe the situation.

SMITH: Right. Another concept that was around about that time, and I don't remember whether you commented on it particularly, but the notion of moving toward comprehensive care or comprehensive programs. There has been a dispute about what was the meaning of that.

Some people said, "Well, what we meant by comprehensive was simply that, by going back to Kerr-Mills, you couldn't just do hospitals. You had to do the inpatient, the five basic services."

But other people really were sort of tying that in with the notion of complete continuity of care. And we've run into different views on what was really meant. Clearly, Congress says, "Well, we didn't mean that this was supposed to turn into national health insurance."

But people in the Department, some of them said, "Gee, we thought that it was going to go considerably beyond just this idea of five basic services."

MYERS: The people in the Department who really would have liked to have national health insurance wanted to do anything they could to move in that direction, but they didn't want to lose anything they had already. So again, it's very difficult to say precisely, and completely accurately, just what was behind the thinking that didn't appear in print.

SMITH: Well, I know that Wilbur Cohen said—I think he was one of the main people that got that language in there—that he really thought that's what it should be, that we get as much of this as we can. Would that seem reasonable?

MYERS: Yes. It's like collective bargaining. You get as much as you can. You don't ask for too much for fear you'll get nothing. So it's a delicate balance between how much you think you can get and what you really want to get.

There were those who really wanted national health insurance, and those who really wanted nothing, and those who wanted just public assistance, and those who wanted what actually came out. You had such a division of opinion that you had no clear majority or anything like it.

So, the best tactic sometimes is being really quiet about what you think, and what you want, and instead, take what you can get.

SMITH: Was there a point at which the actuarial analysis of what was going on with Medicaid became much more reliable or was it pretty much the case that Medicaid was just not something that was going to yield to anything other than projecting some trends?

MYERS: That's what I think.

SMITH: Even after it got in place—

MYERS: After it got in place you still needed quite a length of experience before you could do anything at all with it. And even with that, anything that depends on subjectivity needs to be tested. You can't be sure that is what's going to continue in the next administration, particularly when you have all these different states and the state administration can change from being quite lenient to quite strict. Any actuarial prediction of it is a very difficult area to work in.

SMITH: I remember reading in one of the HEW memos that you at some point sent a letter to Robert Ball saying, sorry, but the fact of the matter is you really couldn't tell how much states were going to go for this medically indigent stuff. Therefore, our estimates were off; which seems to me to be stating an obvious truth.

MYERS: Yeah. I still think that's the true situation.

SMITH: In the performance—I thought this was true, but I would sort of like your comment on this. Now, with Kerr-Mills you had about five or six states that were most of the action. And especially there was New York and California, a few places like that.

Then you get into Medicaid and for quite a period it's kind of the same story, that a lot of these same players are where the action is. And that would lead you to think that a very large part of the early administration was, on the one hand, "Hey, what do we do about these big guys that are eating up all of the money?" which is kind of a cost containment problem.

But on the other hand you've got all these other states, which are barely coming on board. How do you educate them and get them involved in the program? Was it that kind of dichotomy or kind of biggies versus the laggards?

MYERS: Well, sort of. And you don't know whether they're going to be laggards all the time or whether they will all come up to the level of New York and California. So it's just, as we've been saying, to make any decent sort of actuarial analysis is really virtually impossible. You could always see later and say, this is why this happened in the past. But you can't say that would necessarily be replicated in the future.

SMITH: Right. A lot of people have said that—and we found in our own past interviews that when the administration turned over and the Nixon Administration came in, that on the whole, the people in HEW that were appointed and whom you were working with were surprisingly non-partisan and kind of interested in the best solutions possible under the circumstances. I wonder what you found that change of administration meant.

MYERS: Well, maybe I'm wrong again. As I say, I can't provide factual evidence of what I'm about to say. But I think many of the people in the Department were not at all sympathetic with the Nixon Administration; although they acted that way on the surface, they were strictly non-partisan and strictly neutral and unbiased. But they were going to keep on working the way they always had in the past, as though the Administration didn't change. They just would do it more under cover. They didn't, I think—some of them at any rate—play it fair and honest with the new Administration.

MOORE: You're speaking of the career people now in the Department.

MYERS: Yes.

SMITH: Was there a change—well, I guess the second Nixon Administration is where you saw the big change, that for a while they tried things and they said, okay we don't like this; it's a different ball game.

MYERS: Yes, that's true.

SMITH: From the standpoint of Medicare and Medicaid, the kind of big action on the scene at that point was of course the Social Security amendments of '72 and then they really were almost four years in gestation, so to speak, were they not?

MYERS: They were developed after quite a lot of work and thought and debate back and forth and it was much more open.

SMITH: Now, the people we have talked to on that—there's the Social Security amendments and a lot of the background on that—some of them have been Medicaid administrators and some have been on the Congressional side. But we haven't talked to too many people that were within the Department.

Were you consulted? Were you actively involved in a lot of that? Were you working collaboratively with Congressional staff on the background stuff for those amendments?

MYERS: Yes. Well, I was always told that I should work in an unbiased manner with Congressional people. And in fact, if the Congressional people wanted what they were thinking at the moment kept secret, then I had the authority not to repeat to my superiors what I was doing for them.

My job was just to make the best possible unbiased actuarial cost estimates that I could. And as to whether the proposal was a good one or a bad one, then my opinion shouldn't and didn't enter into the situation.

SMITH: In their approach to you, did you have a feeling that they were genuinely trying to solve problems in this area, or was it more that there were partisan agendas?

MYERS: Well, there was some of each, but I think predominantly they were trying to solve problems. But as always, when you are dealing with anything that is political there may well be some partisanship aspects of it too.

SMITH: I guess from the standpoint of Medicaid, the big thing that comes out of that is the SSI category and the poverty line and that sort of thing. But what were your thoughts about the amendments, the part of those amendments that affected Medicaid, because the other thing was giving the AFDC part to the states? Did these seem alarming, sensible moves, or—

MYERS: Well, as best I can recall—and that's maybe not too good—I thought that what was being done made good sense. But I didn't get into it deeply. That wasn't my responsibility. Personally, I'm always very strong on the insurance side, doing things on the insurance basis rather than the needs-test basis. But I realize that you've got to have some sort of safety net of a needs-test system. But my personal view, which as I say I didn't express at the time, was that the insurance program should be such a solid one that it didn't need much supplementation.

SMITH: I remember there was a point when you either testified to Congress or you wrote a letter in which you tried to point out that what people were calling Social Security wasn't necessarily social insurance and that there were some important conceptual differences. You seemed to be offended that people misnamed things and blurred a lot of these distinctions. Probably just what you're saying here is that there's trouble down the line.

MYERS: Yes.

SMITH: If you go back and read about the history of the development of Medicaid and things like that, certainly there are some very important steps in the past like H.R. 4740—is it 4740? 4640?—those Social Security amendments. And then there's the 1950 amendments.

And a great deal of this you could see as incremental changes along the way, that we're kind of marching in a path that seems fairly logical given where we started. Another interpretation would be that an awful lot of this really belongs to Wilbur Cohen with his salami tactics. You get enough slices of this salami and you can build a pretty good sandwich, as he said. Was he an enormously important figure in that way?

MYERS: Oh, yes.

SMITH: Would you comment on how much of this you think was his personal contribution versus how much you think this was the march of history, so to speak?

MYERS: Well, I had a great liking and respect for Wilbur Cohen and I think he largely acted properly because he was not a career personnel guy as much as a political appointee. And I think he usually made this clear and people understood it that way.

SMITH: I think you could say that if there is a major problem with Medicaid it is its tendency to march on incrementally indefinitely.

MYERS: Yes, I suppose.

SMITH: What about the role of Wilbur Mills? He is there no matter what happens and he seems to be such an enormous presence. Is he the great shaper of Medicaid, so to speak?

MYERS: Only to its broader aspects. I think that he didn't go into the details of how the program was to operate, and so forth. I think I said previously he was not particularly enthusiastic about Medicaid. But once again, if support of having a Medicaid program was essential to having the package be accepted, then he was for it. But I don't think he was ever a very strong supporter of Medicaid. He more or less considered it as, you might say, a necessary evil.

SMITH: Obviously a great deal of Mills' authority simply turned on the extremely strategic position he was in, and the Ways and Means Committee was in, at that stage. But I have also read people like Randolph Paul, who was a very distinguished tax expert, that Wilbur Mills knew more about the subject, of whatever subject was involved, than almost anybody in the scene.

And how much of Mills do you think was sort of institutional authority and how much of it was this formidable expertise?

MYERS: I still think very highly of Wilbur Mills. I just don't believe that he was a great technical expert on each and every subject that he dealt with. He looked at the overall picture to see how the pieces fit together.

Some things, particularly I guess from the tax code, he was a technical expert too. But not on every subject that he touched, by any means. But if people thought he was, he didn't dispel the illusion and say, "Oh, no, I really don't know anything much about those details. You go see this guy over there about it."

SMITH: You had a feeling that he knew when to keep his mouth shut.

MYERS: Yes, indeed. A great politician, in a good sense of the term.

SMITH: ...Senator Kerr during this phase? People often don't pay much attention to him and yet he seemed to have been a very powerful figure because he was on the Senate Finance Committee. So this was a huge range that he was covering.

MYERS: Yes. I didn't work as closely with him as I did with Wilbur Mills so I can't speak very authoritatively on it. But I don't think he was at the same level of expertise or even broad general knowledge as Wilbur Mills. But he was very necessary. They needed somebody on the Senate side that knew something about the subject and was willing to stand up and be counted.

SMITH: Before this one slips my mind, there was one little piece involved in the Social Security Amendments of '67. I haven't seen much comment on that.

But where they actually had to say in these amendments, you're not supposed to be giving this kind of aid to people that aren't categorically eligible, was it the case that this was really left up in the air, that this wasn't clear in the Medicaid legislation?

MYERS: Yes, I think it necessarily is that way whenever you are dealing with a public assistance program as compared with a social insurance program. A social insurance program can have very exact and precise provisions.

A public assistance program, particularly one involving each of the states, must necessarily be somewhat elastic and therefore somewhat vague.

SMITH: I'm wondering whether you have any kind of final reflections about where we maybe made mistakes along the path in the Medicaid program or what they could have done to make it better in the course of its development, particularly in its early years.

MYERS: Well, as I've been saying, public assistance programs like Medicaid will inevitably be sort of messy. And they can't be all right in all respects because each state may want to go its own way. And that's the intention of the legislation when it puts it on a state-by-state basis. So sometimes you get contrary results. And there's just nothing you can do about it. I just keep coming back to this thing of—I don't like public assistance programs, and I think they should be kept as small as possible, so that anything that is wrong with them won't have as much financial implications, if the public assistance program were of a different size.

I keep thinking of it from the actuarial analysis standpoint, but public assistance programs are just messy and there's nothing that can be done about it.

SMITH: Right.

MYERS: It's their very nature.

SMITH: When you found yourself in this situation, you were the Social Security actuary, and you found yourself in a situation in which you were working more with the Medicaid people and the public assistance. Was it really a difference of two cultures there?

People have often said that the Social Security people were kind of almost one breed. And a lot of these people from welfare and public assistance were different in the way they thought, different in their sensibilities and their—

MYERS: I don't think that's true to a considerable extent. Of course, they aren't as completely different as different species of beings. But they do have different approaches, different philosophies based on their differing experiences. But again, as I said...biased on the social insurance—

SMITH: Right.

MYERS: I think those other guys are a strange breed of cat sometimes.

SMITH: Whether we were going to talk about social insurance or whether it was going to be Social Security, they picked this language of Social Security because that was kind of fuzzy, and maybe warm and fuzzy. Was that, in your view, a mistake or was it kind of right to think in the rather broader terms of Social Security?

MYERS: Well, a broader definition of terms is an art in itself. But personally I don't see any great difference between whether it's called economic security or social security. They are both branches of social insurance.

Social insurance, as I see it, is a broader term which covers a lot of things. I don't usually use Social Security to include Medicare. But people do and say that's what they're doing. And that's okay.

SMITH: Right.

MYERS: It's a matter of definition.

SMITH: Well, they got a bit more exercised about some of those distinctions back then as you are aware. I'm just wondering, have we missed anything here that you think worth of comment or that ought to be added?

MYERS: The only thing I can think of right at the moment is a little extension of what we've just been talking about. I think the reason they used Social Security, as compared to economic security, which I think would have been a better, more descriptive name, is that Social Security is very alliterative. It rolls off the tongue well.

And so that's why they chose it. But I don't criticize that harshly. As I say, it's all a matter of definition. In some other languages it might not be that way.

SMITH: It seems to work fairly well. We've lived with the language for quite some time now.

MYERS: We have.

SMITH: It's really been a pleasure to come out here and see you.

MYERS: I hope you didn't come all this way just to see me, that you've got other things to do.

MOORE: Well, we have other things to do.

SMITH: We have other things to do, but at any time I'm happy to come out and see you.

MYERS: Good. Thank you very much. It was nice talking with you.

SMITH: Well, thank you.

INTERVIEW WITH CHRISTINA NYE
JUDY MOORE – AUGUST 8, 2003

MOORE: It is August 8th. I'm here with Tina Nye at her office at Advanced PCS in Phoenix, Arizona. And, Tina, why don't you start with you just telling us how you got started, your affiliation with Medicaid or, you know, how that came to be.

NYE: I worked for the State of Wisconsin and began my career there in the aging division, running the Title 3 program; I became interested in long-term care. The aging agency was and still is part of the WI Dept of Health and Social Services (now Family Services), which is the department within which the Medicaid program is located. I moved from the aging division to the division that was responsible for the department's long-range planning and budgeting. In that division, I worked on long-term care policy and budgeting at a time when WI was implementing major reforms intended to divert and relocate individuals from nursing homes—called the Community Options Program. As you know, long-term care is all about Medicaid funding and, as a result I became increasingly knowledgeable about and interested in Medicaid.

I also at the time had a personal concern with infant and child health and decided that I wanted to be more involved in the health care area. Consequently, when the position of Deputy Director in the Medicaid Division opened I applied for and was offered the job. This was 1984 and Steve Handrich was the Medicaid Director. After several years, Steve took a job running the WI VA Home where he worked for many years and I was offered, in 1987, I believe, the Medicaid Director position, which was a civil service position. I was hired during the Earl Administration; Gov. Earl (D) was a one-term Governor who was followed by Tommy Thompson and we all know the story there. During the mid-80's, as always, the concern was the dramatic increase in Medicaid costs with a focus on nursing home and hospital costs, primarily. Later, the focus was in implementing so-called "unfunded mandates" which I always felt were much needed programs, by the way.

MOORE: So when you were at—well, let's just go through your career. So you went then from being a director in Wisconsin to being a director of the Medicaid bureau in then–HCFA.

NYE: Right. I was the Wisconsin Medicaid director at the time the administration in Wisconsin changed from Democratic to Republican, from the Earl administration to Tommy Thompson's administration.

After Tommy Thompson was elected, I had the opportunity to get to know him and he came to recognize my knowledge of and commitment to the Medicaid program. Also, at that time, Gail Wilensky was appointed to the position of HCFA Administrator and one of her goals was to consolidate all Medicaid-related activities into a Medicaid bureau. Gail also decided to hire a director who was a state Medicaid Director. It is important to note that in the very early days of Medicaid, there was a separate Medicaid unit, which was then later combined with Medicare. The states, as a result, always felt that Medicaid was largely ignored and understaffed by HCFA. Gail understood this and wanted to make a change, which she did.

Since the Director of the newly created Medicaid Bureau was a political appointment, Gail knew it would be easiest to hire a Director from a state with a Republican Governor. Since Tommy Thompson had influence with Pres. Bush, his recommendations counted; I believe he was the first Governor to give his support to then Vice President Bush in his run for the Presidency.

Also, at that time, I believe, there was internal lobbying with Gail to hire me by some of the HCFA staff. Wisconsin had some issues around IMDs—remember those? And, I developed some good relationships with HCFA staff while negotiating a bad situation with them. Gail called and asked if I would be interested in interviewing for the job and of course I said yes and was very excited to have the opportunity.

Tommy Thompson's people then got into the act, recommending me for the job to the Bush Administration. Tommy Thompson sent a letter of recommendation and that handled the political side of the appointment. This was the summer of '90. I started at HCFA in September of '90 even though the FBI clearance had not been finalized. I stayed in the job until the day Clinton was sworn it. It was very difficult for me to leave at that time, but that was the way it was.

MOORE: And when you left [HCFA] Medicaid you continued to work closely with Medicaid in other outside private organizations, haven't you?

NYE: Yes, although there have been several jobs where I was diverted from Medicaid, I always came back to it. I think most people who have had significant jobs in Medicaid will tell you that it is very difficult to find a position that is as satisfying and meaningful as their Medicaid job. After I left HCFA, I worked for Johns Hopkins Health System and helped them develop several of their managed care programs and programs related to the elderly and disabled. Hopkins at that time was a leader, and still is, in geriatric care. It

was a very interesting position and I was thrilled and honored to work with the many committed physicians I met at Hopkins. We developed a PACE program, became involved with the National Chronic Care Consortium, worked with EverCare and a number of Foundations among other things.

During that time, I was recruited by United Health Care and moved to Birmingham to work in their SE regional office where I was responsible for Medicare managed care development and operations. United ended up with multiple Medicare plans in the SE for which I was responsible. At this time, I saw first hand the value managed care brings to integrating care for the elderly. I believe, from a service perspective, this is the best job I ever had and I had an extraordinary and committed team to work with; it was great fun, too. We developed impressive care/disease management programs and customer service programs which were individualized to each member.

Later, Schaller Anderson, a Phoenix company, recruited me; Joe Anderson was interested in developing a Medicare managed care product. Also, I had a personal reason to move to Phoenix, so I accepted the job and we moved once more. I have come to understand that I have a bit of wanderlust in me. As a result, I ended up becoming more involved with Medicaid since Schaller Anderson's primary focus is Medicaid managed care.

MOORE: Okay, as you think back on your priorities when you were Medicaid director and deputy director in Wisconsin, what were the problems and the challenges and the initiatives that you were most involved in then?

NYE: In Wisconsin during the mid to early '80s, one of the primary objectives was to establish and manage 1915b waivers and the various Medicaid managed care plans in Milwaukee and Madison, where the program was well established. As a result, our time was focused on the variety of activities related to getting managed care up and running well. Wisconsin had one of the first managed care programs in the country. In Wisconsin and nationally, Medicaid managed care was very new and there was little if any Medicaid expertise relative to managed care at the state or national level. We had to learn about capitation payments, reinsurance, mandatory enrollment and assignment, encounter data, etc. We had to learn as we went along and there was no one to really assist us. Mary Dewane was the manager of the program and later moved to HCFA when I did and served as the national 1915b waiver program manager.

Another priority was nursing home reimbursement and policy. At that time, Wisconsin and the upper Midwest, in general, had the highest number per

capita of nursing home beds in the country. As a result, Medicaid spent a tremendous amount on nursing home care, when what we really wanted to do was develop community-based programs as alternatives to nursing home care.

So, we were taking on the nursing home industry—reducing payments and diverting patients—at the same time we were establishing what was a controversial community based program, the Community Options Program. We wanted to determine how to fund a broad range of community-based alternatives, not just the Community Options Program, and fund them through

Medicaid. We implemented a broad-based case management program for the mentally ill. EPSDT and eligibility expansions for women and children were also major issues. This is the period when Congress was very active and the Children's Defense Fund very influential in obtaining passage of legislation for these groups. Many states were very concerned with "unfunded mandates", but, in Wisconsin, our leadership, including the Governor, generally accepted these mandates as needed programs and didn't complain about them too much. The issue was getting everything implemented correctly and on schedule. It was a busy and exciting time.

MOORE: You mentioned the Community Options program. Did that grow out of the aging area? Or where did it come from? See, I think of it as a home- and community-based waiver program but it sounds like it started before that.

NYE: Yes, the Community Options program was an outgrowth from advocacy groups for the elderly and the disabled; the advocacy groups for the disabled were the more active at that time relative to community options, however. The movement, and it was a movement in WI, started in the early '80s and was quite unique. It was a new concept nationally in that both the elderly and disabled were served through the program. The coalition of these two groups was very effective in advocating for funding and ensuring the success of the program. Tom Hamilton managed the program in Wisconsin, although there were many, many committed individuals involved. And, we received a waiver from HCFA for the Community Options Program in the late '80's, I believe.

Another issue at that time related to funding "disproportionate share" hospitals. The first fax I ever received was a release about the Supreme Court decision about a VA DSH issue and the Boren Amendment.

MOORE: Uh-huh. Go back to the managed care stuff. You must have been one of the first states to get a freedom of choice waiver.

NYE: Yes.

MOORE: And so you were kind of inventing things as you went along?

NYE: Yes.

MOORE: Did you have a hard time getting those waivers?

NYE: I don't remember it being particularly hard or taking a long time to obtain the waiver; I felt the waiver process and requirements were reasonable. I remember having to be very careful about the contents of the waiver itself and budget neutrality. I don't know how much more or less difficult it is to get a waiver these days. I was always very sympathetic to the difficulty of HCFA's job in reviewing and approving waivers.

Paul Offner, I would like to point out, was the legislator in Wisconsin who was instrumental in passing the legislation to allow Wisconsin to pursue managed care for Medicaid. He was instrumental in several other important pieces of health care legislation in the state, as well. This was the beginning of Paul's career in health care. He was always very innovative in addition to being very funny and his death is a great loss.

MOORE: Did you have DSH and donation and tax issues in Wisconsin?

NYE: Wisconsin did not adopt any of these programs—DSH, taxes, and donations—at this time. Maybe we were naïve, but we didn't feel it was the right thing to do. I must say though the issue of donations and taxes was unfortunately a major focus of mine when I was the Medicaid Director at HCFA.

MOORE: Yes, HCFA.

NYE: When I started at HCFA, the primary goal was to extract Medicaid administration from Medicare administration. Rozann Abato, the Deputy Medicaid Director at HCFA, was key to establishing the operations of the Medicaid Bureau. You can imagine the resistance to this change within HCFA, and Rozann was able to finesse this given her relationships with key HCFA staff. It was hard for some HCFA staff to accept this change because Medicaid was getting a lot of attention and they no longer controlled it. Plus, they did not agree wholeheartedly with some of the changes that we made and policies we implemented. Gail Wilensky recognized how important it was to develop a

Medicaid and state focus given the significance of Medicaid to the health care of our country.

My priority was to establish a culture in which HCFA staff understood the concerns and opportunities states faced so they could help them solve problems. The culture was changed; HCFA Medicaid Bureau staff was to serve as facilitators and not as barriers, to serve as team members and not solely as regulators. The interesting thing was how quickly HCFA Medicaid staff adapted to this new culture. Funny, they would rather work cooperatively than be in an adversarial position. The cultural change happened quickly. Gail expected me to develop a culture that listened to states and worked cooperatively with them whereas previously the relationship often was hostile.

I accomplished this change and I hope it holds true to some extent to today. Obviously, I was very comfortable listening to states and was sympathetic to state issues, so it was easy for me. I have always respected what government has to do, how important it is and how hard it often is to manage programs, as well.

HCFA was always very suspicious of states and I tried to reach a middle ground. I must say, however, that some of the things I hear that states are doing today to take advantage of various loopholes are disappointing. Medicaid is not a game.

MOORE: Actually, you know, in at least one other interview we have had people talk about the change in culture among people who worked on Medicaid issues after you came and the Medicaid bureau was established.

NYE: Right.

MOORE: So that was very much felt, I think, among employees.

NYE: And, you know, some people didn't like that. And for other people it was almost like a religious conversion. For example, take Bob Wardwell, who managed the home and community based waiver program. I don't think he would mind my saying that he was disliked by the states and I think he disliked them in the beginning. But, with the change in attitude and culture, he become committed to what the home and community based waiver program was trying to achieve and became a great advocate for states. He enjoyed his job much more and the states came to heavily rely on him. The whole context was a shift to—Let's help the states set up managed care. Let's help the

states figure out how to work with families and children. Let's help them get community- based waivers, etc., etc.
MOORE: I must say that OMB did not appreciate this attitude at all. If you look at that period, a lot got done.

NYE: So the whole purpose of—and I felt my being there was to establish a sound partnership with the states and really help them do the many things that they needed to do for the Medicaid population.
There were also a lot of really great people at HCFA, some of whom to this day, I believe, are the best people I ever worked with.

MOORE: What else was happening at HCFA during that period, beyond establishing the Medicaid Bureau?

NYE: OBRA 90 happened which included the drug rebate program, which had to be implemented in a very short time period. It was a huge effort contracting with all of the manufacturers who wanted their drugs covered by Medicaid and answering all of the questions left unanswered by the legislation: what should be excluded, included, etc. Bill Hickman, Larry Reed and a host of others managed the implementation of the program.

You can imagine all the lobbyists who visited me during this period wanting this and that exception. I felt strongly that HCFA needed to take a strong hand in managing the program and fulfilling the intent of the Congress. Again, this all happened very quickly.

MOORE: Uh-huh. Uh-huh.

NYE: And, then there was the legislation that was passed to regulate states' use of DSH funding and donations and taxes. I must say that of any issue, this issue took up more of my time than any other. But, it was extremely interesting and I thoroughly enjoyed negotiating the regulations with the NGA and the states. Chuck Miller was the states' lobbyist on this issue.

At this time, OMB was going crazy, really, because Medicaid expenditures were going up by 20-30% a year, largely due to state's use of donations and taxes to fund the state share of Medicaid. At the same time, the Administration also wanted to work with the states so there was a lot of push and pull around this issue. Bernie Truffer and Charlene Brown, among others, were the HCFA staff primarily involved in this effort.

However, when the regulation was issued, although I knew it was not perfect, I felt it was a reasonable compromise with the states and the federal government being equally happy and unhappy. It was a major accomplishment to get this regulation out at all and it did stop what I considered to be major abuses by the states; no one could really argue that.

MOORE: Uh-huh. Uh-huh. You talked about how the mandates—the mandates that many states were very concerned about weren't as much of a problem in Wisconsin. But, when you took over the Medicaid bureau there must have been a lot of complaints from states about some of the so-called mandates that I think grew out of the QMB-SLMB catastrophic stuff and maybe some of the child and maternal health legislation.

How did you handle that and was that—did you ever feel like that got settled in any way or [was it] a continuing problem?

NYE: You know that's a really good question. I believe I had a tremendous amount of good will from the states and had a lot of credibility with them. We were always able to reach a compromise and my point of view made sense to them. Also, at that time, most of the Medicaid Directors, although they knew the revenue issues the states faced, also felt the programs were worthwhile and wanted them to succeed. It was mostly the Governors and their budget staff and not the Medicaid Directors who were upset about the “unfunded mandates”. I think that has changed so that now Medicaid Directors are more in line with their Governors, which is probably a good thing. At that time, the Medicaid Directors stayed out of this fight.

I never had much of a problem with a state or the Medicaid Director’s Association. We worked through everything pretty well and this is not an exaggeration. We looked at all sides and made the required compromises to reach an approach or a decision. We saw our role as implementing federal legislation in the best way possible. Ray Hanley was the Medicaid Association Chair at that time and John Rodriquez, Vern Smith, Donna Checkett, Gary Clark, Linda Schofield and other important contributors that I can’t name off the top of my head were involved; and it was a good group of people. We had our issues, but we just worked it out! I believe it was a very successful period in state and federal cooperation in terms of the administrative entities.

MOORE: This was a time when the first of the big kind of health reform 1115 waivers came along.

NYE: Yes.

MOORE: How were you involved in that?

NYE: I wasn't. The Oregon and Tennessee waivers were handled by the HCFA Office of Research and Development and they kept pretty tight control of this area. I would have liked to have been more involved, but frankly, I was incredibly busy with other issues.

MOORE: Oh, okay. We were talking 1115 waivers when—

NYE: Yeah, the Oregon waiver was hot then and right at the end of the Bush Administration the Tennessee waiver was coming in.

But I remember in the fall of '91 or whatever Manny Martins and—I can't think of his name—David, whoever was the leader for the Tenncare initiative, came and talked to me. And, frankly, although I was all for state innovation the waiver did not sound sufficiently well thought out and the implementation timeframe was short. But, the state had their reasons and I know Manny was being pushed to get it done quickly. But I wasn't very involved at all in these waivers.

MOORE: Other big issues?

NYE: At that time, OMB was giving close oversight to the Medicaid budget and two analysts were assigned to work closely with us to ensure we had processes, procedures, etc. in place to better manage the program. The impetus was the enormous increase in federal Medicaid outlays, which had little to do with how the Medicaid Bureau was managed but more with what states were using as match to claim the federal share. We did everything OMB suggested to manage the program, but outlays were still enormous and increasing. Bill Lasowsky was involved with this, if I remember correctly. At the end, I think the OMB analysts felt there wasn't much we could do without legislation to control this growth, except really review the heck out of what states were doing. A lot of the financial forms (HCFA 64), submittal timeframes and reporting requirements, etc. changed at this time.

MOORE: As you look back over the years of your involvement in health care policy and Medicaid specifically, and particularly since I know you have been involved in Medicaid managed care over a sweep of those years, what do you see as the continuing potential or lack thereof for Medicaid managed care in the next 5 to 10 years?

NYE: Well, I obviously support the concept of managed care from two aspects. One, I think it's a reasonable way to contain costs and control inflationary increases. Also, my experience tells me that it's really a preferred way to help people manage or interact with the health care system. That is, if it is done right. The health care system is very complicated and people obviously find it very difficult to deal with. My experience with United helped me see the value managed care can bring to the elderly population.Managed care, if done correctly and with the right "heart," can very much maintain and even improve an individual's health. However, the question becomes, can you do the right thing and still make an acceptable profit on Wall Street under a capitation scenario. I must say that many publicly traded companies are successful in managing the profit angle and the "heart" angle. More recently, I have come to believe that a state could find success operating an ASO model, acting as its own managed care company and contracting out with vendors for assistance in managing the state-wide plan. But, I think the jury is still out about the best model for the Medicaid population. And, that is frustrating since it is clear that we have not made much progress in developing a delivery model for providing health care to our country's low-income population.

MOORE: Uh-huh.

NYE: Interestingly, in the employer health care area, managed care plans cost the employee more than other plans, at least that has been my experience. And, certainly we don't think about managed care as something that costs more, we think of it as something that costs less.

MOORE: Do you think that managed care organizations, at least some of them, have the expertise already to do the care coordination for people with chronic conditions and stuff?

NYE: Well, I think there are Medicare managed care plans and some Medicaid health plans that have the expertise to work with the elderly and disabled population. Poverty, however, brings a whole new dimension to managed care. I have been shocked with how little progress has been made in developing managed care programs for the disabled. It may be that self-directed care is the way to go for parts of this population. After being away from chronic and long- term care issues for many years, I attended a recent conference and was disappointed to learn how little progress has been made.

MOORE: Okay. Anything else you want to add that comes to mind that I might have forgotten to ask?

NYE: You know, there's just so much to think about. And, talking about it, which I haven't done for years, makes me sad to not be as involved in Medicaid policy as I had been. It is a fascinating and incredibly important policy area. I think the reason people like me stay involved in Medicaid, even if on the periphery, is because every day you feel like you're doing something good, something to help out, although it is never easy.

The other absorbing thing about Medicaid is that you never know everything about it and it is a continual intellectual challenge. And, there is still so much that needs to be done.

INTERVIEW WITH JANET LEE PARTRIDGE
JUDY MOORE AND DAVID SMITH – MAY 12, 2003

SMITH: We are interviewing Lee Partridge on May 12th, 2003 at the National Health Policy Forum. And we had said that we particularly wanted to talk to you about some of your District of Columbia experience with the Medicaid program and also your experience with the National Association of State Medicaid directors.

PARTRIDGE: Right.

SMITH: Well, as to the District, give us some dates on that and how you happened to find yourself in this place.

PARTRIDGE: All right. I was the Medicaid Director for the District from August of 1983 until July of 1992. The mayor for most of that time was Marion Barry. The last two years it was Sharon Pratt.

MOORE: Not sure what she's calling herself now.

PARTRIDGE: And I got there because I had been following Medicaid issues from 1973 when I was a member of the staff of the old appropriated D.C. City Council, before we had home rule and an elected City Council. I worked on financial issues and we started looking at the Medicaid program as a source of income, federal income for the District. At that point the District was not really mining this source of income.

In 1974 we elected our first city council. The late Polly Shackleton, who was elected as the member from my own ward, was named chair of the Committee on Human Services. She hired me as head of the Committee staff. The Committee had very broad jurisdiction, including health, child welfare, AFDC, and Medicaid.

I had that job until 1980. And a lot of it involved Medicaid.

I should explain here that the Medicaid program had a unique situation in the District government. At the time the Medicaid statute was going through the Congress in the sixties, the District government was also changing and we moved from a three-commissioner form of government to an appointed mayor that was Walter Washington. As the Medicaid statute was going through, the decision was made to treat the District of Columbia like a state.

The appointed mayor would be—have the role of a governor, similar to what a governor would do in a state. Because we didn't have an elected legislature, essentially the mayor had both functions. That is, the Medicaid program operated essentially without any local authorizing statute or regulations. The only oversight the Council had was through the budget.

SMITH: Was the budget set by the District of Columbia committee in Congress or was the budget set by the Council?

PARTRIDGE: Well, actually both. It's still that way. The Council approved a budget which went to the mayor, which then went to OMB, which was then submitted to the Congress. And all of the dollars that are raised locally through our taxes are appropriated back to the District of Columbia together with a lump sum called the Federal Payment. That process is still in place today.

MOORE: Let me interrupt with one clarifying question. And this may sound stupid, but what would be different about the legislative role in a state versus D.C. in terms of Medicaid?

PARTRIDGE: From the perspective of the federal government, none. But as the way the District was functioning at that time and throughout the period when I was on the Council staff and then Medicaid director, the Council never exerted any substantial effort to try to shape either the content or the direction of the program. There was nothing like the kind of oversight that you get in some states where even what I would consider to be things as simple as guidelines would have to be enacted specifically through state statute or regulations.

SMITH: Uh-huh.

PARTRIDGE: So I had an extraordinarily free hand as Medicaid director. In the mid '90s, the Council took quite a bit of that away, but through my tenure and a little beyond, program authority rested almost wholly with the executive branch of government.

So we just published regulations—and probably not nearly enough of them—when I was Medicaid Director to try to have some rules that people could follow.

In 1980, one of my closest friends was appointed Director of Human Services, a man named James Buford.

I moved from the Council staff to work with him on legislative and governmental affairs for the Department.

I also was the final eyes before proposals went before the Council. In 1983 I was asked to take on the job of Medicaid Director. So, I left my beloved legislative and regulatory affairs job and went to the new one with five days' notice. That experience gave me great sympathy for people who walk into that kind of situation, particularly if you are following somebody that the staff had liked very much.

You're the new kid on the block and it's tough.

SMITH: Well, then you would have been Medicaid Director from what dates now?

PARTRIDGE: July—August '83 through—July '92. The early part of the Reagan administration. In fact, the last thing I did prior to becoming Medicaid director was shepherd the legislation through the Council that would conform to the Administration's changes in AFDC.

SMITH: Were you able to do much with the waivers when they began to get these new waivers in place? That was one of the big Reagan initiatives.

PARTRIDGE: The first significant waiver—short answer is no.
The first significant waiver opportunity was actually the home and community-based waiver program, which was enacted in 1981. And we looked at that and concluded that we had such a broad statutory base with the programs for the mentally ill and for the mentally retarded that we probably didn't need a waiver. So we never...

SMITH: Partly I would think that with so many hospitals and so many medical facilities that would be a lot of direct services and services under Maternal and Child Health, and so forth, that this would help fill in a lot of the gaps.

PARTRIDGE: We had a lot of direct services. Of course,—at that time we also were the beneficiaries of Title V programs and all the other federal grant in aid programs. And we had Howard Medical School, which has substantial federal funds, and Children's Hospital, which does considerable research.

SMITH: ...a lot of these would be public hospital or safety net institutions.

PARTRIDGE: Well, D.C. General is...was absolutely the public hospital.

SMITH: But I get the sense from listening to you that you didn't feel that you were at the bottom of the barrel for safety net institutions.

PARTRIDGE: No.

SMITH: You had quite a lot of facilities—

PARTRIDGE: Oh, yes.

SMITH: —and pretty generous support.

PARTRIDGE: Probably too much.

SMITH: That's interesting. Now, what do you mean by saying "probably too much?"

PARTRIDGE: Well, I think one of the things that was true for us then and is still true was that we had—such strong hospitals that we relied...too heavily on hospitals to be the source of primary care for a lot of our population.

MOORE: What were your priorities when you went into the Medicaid Director's job in this environment of so much change or supposed change of direction on the part of the Reagan administration?

PARTRIDGE: To get our MMIS system certified, and to get a handle on our costs, get them predictable. The latter was perhaps most important to Mayor Barry from his point of view because he was very comfortable in the world of numbers, which I suppose isn't too surprising because he was trained as a scientist. It drove him crazy that our Medicaid expenditures could be—could swing so widely from one minute to the next.

What he wanted was a fairly predictable cash flow for the way the city would spend their funds. We concentrated very heavily, even prior to my becoming Medicaid Director, on structuring a hospital reimbursement system we called the periodic interim payment, which allowed a smoother cash flow for the city and the hospitals both.

SMITH: And you did it independently of HCFA.

PARTRIDGE: They had to approve it. We had a very hard time getting it approved initially because we and the hospitals agreed collectively they could not exceed a cap.

SMITH: Right.

PARTRIDGE: There was a lot of concern about whether or not that was consistent with the statute.

MOORE: Do they still have that system in operation?

PARTRIDGE: No. By year three several of the hospitals were uncomfortable with the overall ceiling. So we couldn't negotiate a continuing arrangement and reverted to the old system.

SMITH: Any kind of special or unique problems in the District as opposed to, say, Medicaid—Medicaid elsewhere? When one thinks about the District, your imagination runs wild. But maybe it was more like others than one would suppose.

PARTRIDGE: We were—we were unusually fortunate in the sense that we had a very liberal legislature that was fully supportive.
When I went and talked to some of my colleagues, I realized as I said, our Medicaid benefit package is very, very broad. We were funding substantial community-based MR services five years ahead of most other jurisdictions.

SMITH: You had a big M.R. decision, too.

PARTRIDGE: Closing Forest Haven, yes. The Forest Haven decision was an old one...but we were well along in putting the Medicaid structure in place to deinstitutionalize Forest Haven. And I did a lot of “bread and butter” work just implementing the appeals process and putting nursing home rights in place, and with quality issues as well and with monitoring, and creating transitional arrangements. Some of these processes overlaid each other, making them very cumbersome to implement.

I did not have the survey and certification responsibility under me, thank God. My colleagues in Maryland did and that is a real bureaucratic problem. Because it's very awkward to sit there and say to your colleague, "You know, I'm going to close you down because I'm going to deny you Medicaid reimbursement."

SMITH: That would be awkward, I think.

PARTRIDGE: It worked much more easily if you were talking to somebody in another department.

SMITH: Right. It could put a permanent kink in a relationship.

PARTRIDGE: Right.

SMITH: Yes. Well, I was wondering because you were administering Medicaid in this little city-state that we call Washington, D.C. and I'm sure there were many things that were unique about it.

But then you go on from this to be Director of the Medicaid Directors' Association. I wonder if you took anything away from the D.C. experience, that informed your later thinking about Medicaid, other than that it's a complex and difficult problem?

PARTRIDGE: Oh, I think the principal thing I took away, was that it's a tremendously flexible program. It had capacity to be stretched and used in many, many different ways. It's a great tool and—

SMITH: That's interesting to me because what you take from that, too, is that a creative Medicaid Director might not have to have such a very flexible waiver policy and could think of a lot of cute things to do even without a waiver.

PARTRIDGE: Yes. What you need the waivers for, I think, or a lot of them, is to expand eligibility to populations not traditionally covered under Title 19. That's the big opportunity, I think.

SMITH: An interesting observation to make, yes. Well, then how did you get from this situation to being the Director of the Medicaid Director's association?

PARTRIDGE: Well, of course, APHSA had been around a long time and the Medicaid Director's association became an affiliate in the late seventies. And because I was here I knew the staff well and worked with them often, so I felt fairly close to them.

And when the third time early retirement walked by in the District of Columbia, I decided that it was time to take advantage of it, and I went to the APHSA and said that I thought I could be useful. This was '92. They said yes and I joined them for two days a week. Then, Jane Horvath was hired away from us to go to the Senate Finance Committee and I stepped in to take her place.

SMITH: We were talking to Bob Wardwell about some of the evolution of the Director's association during this period. And he was, among other things, discussing the kind of relationship with the Governor's association and how the [Medicaid] Director's association would begin to feel a bit separate and how professional attitudes and commonalities of feeling would begin to develop. I wonder if you could—

MOORE: That was Larry Bartlett we were talking to.

SMITH: Oh, Larry Bartlett. That's right. Well, I wonder if you could comment on the development of the director's association during this period, how you saw it.

PARTRIDGE: Well, actually, the Director's association developed considerable independence and resources. After Larry left, beginning in the middle eighties, CMS (or HCFA) contracted with them to provide a certain amount of technical assistance to the states under something called the Medicaid Information and Assistance Project (MIAP).

The primary task under that contract—was to provide staff support for the state members of the Medicaid technical advisory groups.

SMITH: Uh-huh.

PARTRIDGE: When Larry Bartlett was at APHSA (and he was just leaving when I became D.C. [Medicaid] Director in 1983) he was, I think, spending half time on Medicaid and the other half on other health issues at APHSA. I had a health responsibility, too. But there was more public health emphasis under Larry. By the time I came along we had concluded that ASTHO, the association of state and territorial health officers, had a lot of the rest of the health issues kind of in hand.

And to some degree the Directors' association took advantage of the MIAP role to expand their reach. They began to get a little more money under the same contract with the feds to facilitate more information exchange with the

states. And then in the late ‘80s with Jane joining them to work on nursing home and other long term care issues they attracted some additional outside funding.

SMITH: That was the HRSA contract?

PARTRIDGE: No, HRSA was a later contract to work with the Medicaid agencies and the HRSA major grantees, the community health centers, Ryan White, adolescent health—to try to help these different programs work together at the state level. The regular meetings with HCFA start in 1979 between the—leadership of NASMD (an executive board) and federal officials.

MOORE: Okay. So it goes back pretty much to the beginning [of HCFA].

PARTRIDGE: The big change I think came in 1993 when HCFA gave up to APHSA the sponsoring of the annual meeting.

MOORE: ...wasn't written. It was put into other places or—

PARTRIDGE: No, it's under the (MIAP) project. It was all considered part of—a major part, in fact, of the information exchange.

MOORE: Uh-huh.

PARTRIDGE: And Richard Chambers and I did the agendas. It was always a joint agenda and we made sure that both state and federal concerns were addressed.

MOORE: Uh-huh.

PARTRIDGE: A top DHHS official was on the program— Secretary usually.

SMITH: We hear a great deal of talk over the years about the importance of waivers and the governors saying they need more in the way of waivers, et cetera, et cetera.

And yet here you are representing the state Medicaid Directors, and looking back at your experience in the District of Columbia. It sounds to me that in your view they were really making more of an issue out of this than was justified, that is, of the need for waivers.

PARTRIDGE: No, I—no. I think that the waivers were important, as I said, especially for purposes of expanding your eligibility, as happened with the rash of "health reform" waivers that began in '93.

There was a new initiative called health reform waivers. Some states wished very strongly to be able to do some of the kinds of things that Oregon was testing. And they felt their hands were tied under the statute.

And so they looked at waivers. Some of those Medicaid waivers were quite small in the sense they waived only one or two Medicaid provisions, but very important. Freedom of choice waivers, for example, with the growth of managed care, were big at this point. And HCFA was not expert in this area...it lacked experience.

MOORE: We forget it was a big—

SMITH: —things in a rural area.

MOORE: And we forget it was a bigger deal 10 or 15 years ago than.

PARTRIDGE: And we were also experimenting. One of the other things I did in the District was create the first managed care program despite a lot of local opposition.

SMITH: Uh-huh.

PARTRIDGE: And the statute as it existed then had the 75-25 rule. The contracts had to be approved by HCFA. We didn't have any models or templates.

MOORE: Over the range of these years, how would you characterize the relationship between Medicaid directors and HCFA and then CMS? Did it change dramatically? Did it have its up and downs? Was it back and forth?

PARTRIDGE: When I became Medicaid director in 1983 there was a very strong sense that the federal government was in charge.

MOORE: Among the states?

PARTRIDGE: Among the states. It was a very, very, very much an "us and them" environment. They met with us primarily to inform us what they were going to require of us. I think I have told Judy this story before. One of my

favorites is back—oh, it must have been early on, '84, '85. There was federal interest in requiring a second opinion on elective surgery for Medicaid, because people saw it as a cost containment issue.

There was a meeting at which this was being discussed and of course there was a lot of grumbling and people felt that it was adding complexity and unnecessary costs and because doctors were uncomfortable "second guessing" their peers. Then Mabel Chen, who was director for Guam said, "But we only have two doctors on the entire island." That was the absolute end of that discussion and of the proposed regulation.

SMITH: You are scarcely speaking to each other now, right?

PARTRIDGE: It never moved to that point.
There was also a lot of tension in those days around rising pharmacy costs—and a strong feeling that the federal government should be more helpful to the states in trying to curb those costs.

At the end of the decade of course we had Senator Pryor. His Aging committee held a series of hearings that ultimately resulted in legislation. Faye Baggiano was the Medicaid director from Alabama.

And Faye, in particular, hated the pharmaceutical manufacturers. And I can remember some very heated discussions between CMS staff and Faye.
I should say, coming back to your question, that over time the relationship between NASMD and CMS changed and became more and more cordial. I think the TAGs probably had a lot to do with it in part because people used them as a forum to think through issues and get state input.

And Gail Wilensky, to her eternal credit, pushed for a Medicaid Bureau, and insisted that it be headed by a Medicaid Director. That was a final turning point. The tension still to some degree played out in some of the regional offices. There was more of an adversarial relationship in some regions than in others. But at the national level that really pretty well subsided.

SMITH: I had the sense, too—and again, this was from talking with Larry Bartlett, that often it seemed that the Medicaid directors and HCFA or CMS would get along pretty well on many of these things.

And as you said, the TAGs helped a lot. But many of the issues would be whipped up on a partisan basis by the NGA.

PARTRIDGE: Oh, yes. I think that probably as a group they must be much more protective of states' rights—than perhaps people who are down the chain. Of course there was the huge fight over DSH—as the economy went south and the caseloads rose dramatically in the late '80s, Court decisions against a state with regard to reimbursement also increased state fiscal pressures. These, plus passage of the bill mandating coverage of infants and pregnant women up to poverty level, pushed many of the states to pay for benefits they could no longer fund, and seek out various funding strategies to help.

In Missouri, for example, the Medicaid eligibility ceiling was about 35% of poverty, which isn't that unusual, but if you look now at adult levels of eligibility which are still at 30, 40, 50 percent of poverty, you can see that without the enactment of the Waxman legislation you would probably still be back there with those levels, though it's hard—it's always hard to generalize.

SMITH: I have heard Medicaid directors say that as much as they complained about the mandates to cover the kids especially, it was the best thing that ever happened to them, that is, as a state Medicaid Director to have this mandate, so that you can say to your Governor, "The Feds are making us do this."

Do you think that's accurate and do you think that forced the kind of DSH creative financing or that it would have happened anyway?

PARTRIDGE: No, I think that creative financing would have happened anyway because the Waxman requirement wasn't the only thing affecting the program. The number of people who were qualifying for long-term care beds, the growing cost of medicine in general. The same kind of things that are driving costs today.

SMITH: Did '89 seem like a really big year? Because you remember you had the catastrophic repeal and then you were left with these dual eligible—

PARTRIDGE: Yes. '89 was the year in which the swap was negated.

SMITH: Uh-huh.

MOORE: Uh-huh. Did that also provide some of the interest for OBRA 90, the fact that the drugs had been taken over under catastrophic by Medicare. We would have had some fiscal relief for the states if it was not repealed.

I mean, the drug benefit was going to be and then it wasn't. So then the next year based on the hearings that Pryor and others had had we saw the enactment of a drug rebate program. Was that kind of a federal sop to the states? Did you...

PARTRIDGE: I don't think of it that way.
If I went back and looked at some of those old hearings after passage of the rebate law we were still testifying to our concerns about the rising cost of drugs. That has just gone up 200 percent.

Another issue, of course, was improving the quality of nursing home care. Which Bruce Vladeck had a lot to do with and culminated in the '87 Medicaid amendments. These also generated state financial pressures that would have been relieved somewhat by the Medicare Catastrophic [Coverage] Act. Because the other thing the Medicare Catastrophic Bill did was pick up a larger share of nursing home coverage.

That was how we got the QMBs because they—Congress didn't want Medicaid—they didn't want the states to have a windfall from expanding Medicare coverage of nursing home care.

SMITH: Were states beginning to complain about unfunded mandates? It was about this time, I think.

PARTRIDGE: Oh, yes. Throughout the middle ‘80’s, Henry Waxman had been doing a lot of expansions.

SMITH: Sort of the Waxman two-step?

PARTRIDGE: Some of them were state options.

SMITH: It was almost like, “We’re so sorry that some of the states haven’t taken advantage of these wonderful opportunities—many states have, it seems only appropriate that others should.”

PARTRIDGE: And there was a fierce fight over the DSH legislation.

SMITH: And Henry fought it tooth and nail.

PARTRIDGE: Henry never fought it.

SMITH: No, no. He was fighting the cut-back on DSH.

PARTRIDGE: Yes.

SMITH: You have seen a lot of this from both sides. I wonder what your feelings are about the HIFA waivers—this kind of development.

PARTRIDGE: I don't think these HIFA waivers are a big deal. It's an interesting change. It's saying that the Administration will approve a waiver that under a strict interpretation of the statute it might not—but as a practical matter I don't think it has turned out to be that important.

SMITH: I had an interesting chat with Howard Cohen who was reflecting on differences between now and when he was on the Commerce Committee back in 1994-1995. He said that back then the Governors were eager to give up the entitlement in exchange for more freedom, while now they seem to be scratching their heads and saying they really need to think about where they want to be in the long term—eight years down the road.

PARTRIDGE: I think there's a lot of thought that the program has become proportionally so rich in terms of benefits—there is a benefit structure that is broader than that offered to most commercially insured people and that's a little bit out of line. They really don't think Medicaid recipients should get a better deal than the working poor—especially some of the more conservative Governors and legislators. At the same time, I don't think that any of the Governors want to cut back on eligibility. Yes, cut back on some of the benefits, but I think in this last year we've seen Governors say, "We're going to do it," and then ride right up to the brink and then not do it. May be the "Perils of Pauline," and may not. Now, this year, some of it happened. They complain about EPSDT. But if you were going to cut it, what would it be? And they say, "You know, all those kids with special needs..." It's tough when it gets down to the personal level.

SMITH: It sounds as though there might be room for some kinds of compromise. I mean, if you looked back at 1995, that was more like war and a fight for victory; but now there seems to be something more like convergence. Do you think there might be room for some deals?

PARTRIDGE: Oh, I think so. If you look back to their resolution of eighteen months ago—they were saying, "We are willing to live with the traditional benefits if you give us more flexibility under the optional ones. And by that we don't mean optional under the waiver, we mean optional under the statute itself."

SMITH: That sounds like a good place to end. Do you have any further thoughts?

PARTRIDGE: I think too many people are ignoring the challenge of increased longevity; also the handicapped who are 20, 30 years of age.

MOORE: Do you actually see any opportunity to change with regard to the dual eligibles? more Medicare and Medicaid integration?

PARTRIDGE: Of course more cooperation would be good—but I don't see any leadership within CMS, the Administration, or the Congress in that direction.

SMITH: Is there any good way that the Federal government could take up more of the financial burden? What are some of the ways you could do that? Have a block grant? a counter-cyclical adjuster?

PARTRIDGE: I think you might do something about the QI(1s) and QI(2s)—and that seems to me substantial since you are now up to $60 for the Part B [premium].

SMITH: Judy and I were much impressed with Bruce Vladeck's recent piece in *Health Affairs* about the big challenge being how to work with the dual eligibles and chronic and severely ill. Do you have thoughts about that?

PARTRIDGE: Just getting them [states and federal government] to work together would be a huge step forward. And one of the things I learned is that it is a Federal-state-local program—with more than twenty states, such as California, New York, and New Jersey, having counties as a substantial part of the program. So that's a big order.

MOORE: That's maybe a good place to stop. We want to thank you very much for spending time with us. It's been a real pleasure.

PARTRIDGE: Thank you. I have enjoyed it, too. Let me know if I can help you any more.

SMITH: Thanks very much. This should be a real contribution. Good to see you again.

INTERVIEW WITH GERALD RADKE
JUDY MOORE AND DAVID SMITH JUNE 17, 2003

SMITH: This is an interview of Gerald Radke by Judy Moore and David Smith and it is June 17, 2003. We thought to begin that you could summarize some of the major stages of your career.

RADKE: I am a social worker by training. I went to University of Pittsburgh and as I told you earlier, I married a Pittsburgh girl.

That's the Pittsburgh connection. I was working for the United Way in Allegheny County consulting for the social service agencies on how to get 75 percent federal money for them putting up their in-kind 25 percent. This was predating Title 20. Back then it was Title 4A and there was no maximum in terms of federal reimbursement. I did that for the United Way and then Norm Lourie, who was the godfather of the Pennsylvania Department of Public Welfare at the time, invited me to do it representing the state. I went to Harrisburg to organize and head a research and evaluation program for the Department.

SMITH: This would have been about what date?

RADKE: This would have been in 1975. In 1976 Frank Beal was Secretary of Welfare. Frank got upset with his deputy for social services one afternoon, and the following Monday I became the Pennsylvania Deputy Secretary for Social Services. This was all under Governor Milt Shapp.

MOORE: And this was in the mid-'70s.

RADKE: This would have been 1975 to about 1979.

SMITH: And Shapp was very strong on social services.

RADKE: Mrs. Shapp was a geriatric social worker. Gov. Shapp proposed a Department of Aging in Pennsylvania and brought in Jerome Miller to help with children and youth. We had a very active social service program. When Dick Thornburgh ran against the Shapp administration, his message was basically to throw the cronies out, and Dick Thornburgh won. I thought

I would be leaving state government, along with the other appointed officials, and in fact interviewed for a job in Massachusetts to run a child protective service agency for Massachusetts.

When Dick Thornburgh got elected, he hired as his Secretary for the Department of Public Welfare, Helen O'Bannon, who was very bright and an excellent manager, and to my surprise Helen asked me to stay and run Medicaid for her.

I said, "Well, you know, I'm a social worker and I don't know anything about Medicaid."

And she said, "Jerry, it's politics and providers."

And I said, "Oh, I think I can do that." And so for Dick Thornburgh in '79 I became the Medicaid Director. I will come back to that later.

Jumping ahead, I was Dick's Medicaid director for his two terms. Then when Bob Casey got elected Governor, I did leave the government. I went to work for Virginia Blue in a private profit-making subsidiary called TCC, which is now First Health.

For Virginia Blue, I handled all of their TCC pharmacy activities, and in fact put together a little pharmacy benefit management division for Virginia Blue. I did that for about two or three years and then Virginia Blue, at the direction of the legislature, had to divest its private profit-making activities.

They sold this little subsidiary to some Atlanta bankers and it wasn't as much fun working for Atlanta bankers as it was for Virginia Blue. Then one day I got a call from Governor Bob Casey's budget director, who called to tell me that the hospitals in Pennsylvania—Temple Hospital was the lead hospital—had sued the state.

And I said, "Yes, I knew that."

And he said, "Well, do you know the hospitals won?"

And I said, "Yes, I knew that."

And he said, "Well, do you know the judge is holding the governor and me in contempt."

And I said, "No, I didn't know that. Why would they do that?"

And he said, "Well, the governor won't pay them."

And I said, "You know, you have to pay them if the judge says so."

SMITH: Which judge was this? This wasn't Broderick?

RADKE: No, I don't think Broderick handled that case. Broderick handled a lot, but I'm not sure who handled that one. I was told that the Governor and the head of the hospital association had a dinner meeting and both of them thought I was the right person, to go back into the state government to settle this litigation.

I quit TCC and Virginia Blue and went back to do my second tour of duty as Medicaid director.

SMITH: Do you remember the dates on that?

RADKE: Yes, I went back into state government around July of 1990. I first left state government at the beginning of Governor Bob Casey's term, which was around 1987.

My second tour as Medicaid director was primarily to deal with the litigation. We did a provider donation scheme and “stole” money hand over fist from the federal government using the justification that it was a federal law, a federal judge, and the feds were nowhere in sight to solve this. We thought the feds should pay for it.

Then—this is a wee bit embarrassing, but I guess I will tell you. When I went back into state government, I took a 50-percent pay cut, gave up my stock options, and the state wouldn't pay to relocate me.

I said to the Budget secretary, "Just as long as you pay me as much as you can pay me, I'll be happy." At the beginning of Governor Casey's second term, all of the cabinet officers got a bump in pay. You know, they do that prospectively.

They raised the salaries for the deputy secretaries that worked in the Governor's office, but not the deputy secretaries in the various state agencies. It was like a five-dollar-a-pay-period difference, but I was angry that they had reneged on the deal.

About that time a fellow from the Philadelphia Pharmacy School—in fact, he had been the dean there—Bob Abrams—was working for PCS Health Systems in Scottsdale.

Bob was trying to find someone to teach PCS about government, particularly Medicaid. You remember all of the discussion about the pharmacy benefit under Catastrophic [Coverage Act in] Medicare. PCS Health Systems had the premier technology for pharmacy benefit management, but they didn't understand government contracting and government business.

So, I left state government and joined PCS Health Systems in Scottsdale, Arizona. That would have been about October of '91. That was the good life, living in the desert. It was a great place to live and work.

Then, out of the blue, Eli Lilly and Company purchased PCS Health Systems from McKesson. I got transferred to Indianapolis—a nice town, but Indianapolis is not Scottsdale. They asked me to teach their sales offices Medicaid managed care. Eli Lilly was a very conservative company and had never been involved with managed care. I spent about a year teaching their sales offices.

Then, one day at the Lilly headquarters I ran across a fellow who was going to a meeting and I asked to tag along. The meeting was for all of the clinical investigators for a new drug called Olanzapine or Zyprexa. They were in Indianapolis for two days of, “Here's what the clinical investigators found and here's what the Lilly researchers were reporting back.”

I got so excited about that new medication that I actually joined the launch team and handled all of the public reimbursement issues for Zyprexa when it went to market in the US.

When that was over, I started to get bored with Lilly, and I never wanted on my tombstone something that said pharmaceutical company executive. While I was getting ready to leave, I was at a meeting here in Washington. This attractive woman came up and said, "Hi, Jerry. It's been a long time."

I could not place her for the world. It was Laurie Flynn. Laurie at the time was the executive director of the National Alliance for the Mentally Ill. Laurie and I had worked together when I was running Pennsylvania social services and Laurie was the child foster care advocate for Pennsylvania. Laurie and I chatted and she wanted to know what I was doing and I told her I was getting ready to leave Lilly because I was bored.

She told me that she was having a recurring battle with her board because they thought she didn't spend enough time on internal management issues.

As you know, NAMI is both an organization and a movement. Laurie was a great leader for the movement and not a very good manager for the organization. Laurie and one of her board members said, "Why don't you come to work for us. We'll ask Lilly to loan you to NAMI."
I said, "Well, I'm not going to ask Lilly that."

They said, "We'll ask. If they agree, will you do it?"
I said yes. So I became Laurie Flynn's chief of staff or Mr. Inside while Laurie was doing the outside. I did that for a year or two and then Lilly wanted me to go back to Indianapolis to do traditional pharmaceutical company management.

I told Lilly I didn't want to go back. Laurie said, "Well, why don't you quit Lilly and go to work for NAMI."
So, I quit Lilly and became a regular NAMI employee doing the same thing for Laurie as chief of staff. I started doing that on a Friday. The NAMI board had a meeting scheduled for that weekend.
Laurie and the board got into a fight and she quit that weekend. I'm thinking, you know, this is great timing. I just started here and she's quitting. The board asked me to take the job as interim executive director.

I told them I would do it on an interim basis, but I would not be a candidate for executive director because I strongly felt that somebody with a family connection to mental illness had to lead that movement.

I stayed with NAMI and helped them do their search, and then the orientation for the new executive director. While I was doing that at NAMI I knew that Charlie Curie the Pennsylvania Mental Health Commissioner was about to become the SAMHSA administrator.

At NAMI we spent a lot of time promoting Charlie because Pennsylvania was doing some very good work on seclusion and restraint restrictions.
I called Feather Houstoun, who was the Secretary of Welfare at the time and said, "Feather, you're going to need a mental health commissioner for about 17 months. I'm willing to do that for you."

She made arrangements for me to meet with the Governor's staff and I found myself back in government. I thought it was going to be 17 months, but the new administration took longer to get settled than anybody thought.

It turned out to be about 20 months. And, so here I am. I finished with that and now I am looking for my next assignment. [Mr. Radke is currently the director of the Bureau of Facility Licensure and Certification for the Pennsylvania Department of Health.]

SMITH: Well, going back a little bit in history, in Pennsylvania, Medicaid was under the Department of Welfare and in some places it is under the Health Department. Did you see advantages and disadvantages to it being under welfare? I mean, Pennsylvania government must have presented some rather interesting problems for you just in general.

RADKE: In the early days there was the big fight over whether Medicaid should be a public health program or a social welfare program. Pennsylvania clearly made the decision it was going to be a social welfare program. The Pennsylvania Welfare Department is and has been an umbrella agency model in terms of delivering services. All the human services are in one agency with the exception of the Department of Aging which, for political reasons, got spun off.

We're in the Welfare Department when I—before I got there Medicaid was a division within the office of mental health.

MOORE: Really?

RADKE: In the early days that was quite common.

MOORE: Was it?

RADKE: The Mental Health Commissioner had to be a psychiatrist. Usually that was the only doctor in the agency. They put Medicaid in with mental health so a doctor would be overseeing it. And it stayed that way for a while. The fights with the hospitals were just starting. Soon the battles with the providers became constant.

At that time in Pennsylvania, all of the claims were processed by the comptroller. When I became Medicaid Director I sat down with the comptroller's staff and reviewed their claims processing method.

They would check to see if the letterhead looked like a legitimate provider. They then tried to identify a covered medical service. Since they paid a percentage of charges, they just took the charges right off of the letter and processed it by hand.

They had no way of knowing if it was a duplicate bill or not. Since the claims processing was so erratic many providers would send the bill in every week. They would send the same bill in until they got a check. They would get a check for every bill they sent in even if it was a duplicate.

I took over Medicaid in 1979. The very first assignment was to switch from manual claims processing to computerized claims processing. That was a huge undertaking.

SMITH: This was much of the reason, it seems to me, there was such a push in the federal government to get Medicaid managed information systems in place.

RADKE: Yes.

SMITH: And data collection and things like that. About then people talked a lot about fraud and abuse. Yet the suggestion I get from the tale you are telling about Pennsylvania is that there wasn't so much fraud and abuse in Pennsylvania, as just the way they normally did things, which wasn't capturing the abuse that was out there.

RADKE: It depends on what part of Pennsylvania you were in. Pennsylvania has got its urban centers on each side and rural in the middle.

In some rural parts of the state if a provider got three checks for the same service they would send two checks back. That's part of the Pennsylvania culture. But in some Philadelphia neighborhoods the system was being ripped off like crazy. When I took the job they handed me a stack of news clippings showing that Medicaid was funding all of these Medicaid mills down in Philadelphia. People were going to pharmacies to get cigarettes and the Medicaid claims would be billed as—

SMITH: Therapeutic?

RADKE: Therapeutic. Vans were going through the neighborhoods to pick people up, give them box lunches, and then take them to these Medicaid mills where they would be processed through all of these exams and end up with prescriptions.

There was a lot of fraud. One of the things that I did early on in Pennsylvania was to make a conscious decision that no one would ever get to the right of us on the issue of fraud and abuse.

I set up a unit to deal with that, put a guy in charge of it who was pretty strict. His first request to me was could he have guns? I told him, “You're not going to get guns. You're not going to get badges. You need to go out and find the bad providers.” Early on, the big issues in Medicaid were getting your claims processing under control and dealing with your fraud and abuse issues, especially in terms of all of the bad publicity the states were getting on that issue. For claims processing there was EDS, TCC, CSC.

There were just a handful of companies that had the software to process these systems. These were gigantic workhorse-type claims processing systems. Back then these were big mainframe systems.

SMITH: What about the contracting relationships with these people? It’s easy to get taken in that game.

RADKE: Well, like you said, here we were, a bunch of social workers and state bureaucrats. We would get one part-time lawyer out of the attorney general's office to help us. They would come in, not only with the business knowledge but a bank of lawyers. The claims processing companies, the Medicaid fiscal agents, in the early days made fairly good profits.

That was a good business to be in. It wasn't until EDS decided to drive all the competition out that the bottom fell out of claims processing.
Then, later what killed the claims processing business was pharmaceutical rebates because companies would process your claims for nothing just to get access to your pharmacy data to do rebates. How do you make any money when companies are giving away your business for free?

SMITH: That's interesting. I never heard that in particular. Now, you mentioned also having on your staff Jerome Miller.

RADKE: That's when I was running social services.

MOORE: You might say a few words about who Jerome Miller is.

RADKE: Jerome Miller was an advocate for getting juveniles out of institutions. He started in Massachusetts closing the youth social service facilities. Then, I think the unions chased him out of Massachusetts. He went to Illinois to do the same thing and ran into the same resistance. There was in Pennsylvania a fellow named Terry Delmuth.

SMITH: Yes.

RADKE: He was working in Milt Shapp's office at the time. Terry hired Jerome Miller to come to Pennsylvania to do the same thing. Jerome Miller was then assigned to me as my Commissioner of Children and Youth.

And, I had a very aggressive young man named Bob Benedict who was in charge of my aging social service programs. Bob later became the Federal Commissioner.

MOORE: Of aging, right?

RADKE: I was earning my pay trying to keep these two guys under control. But, Pennsylvania got juveniles out of its jails. Jerome Miller was a true missionary. As someone that had bureaucratic responsibility for him, it was difficult. But he was highly successful in getting kids out of corrections facilities.

SMITH: So this didn't have any effect on mental health though?

RADKE: No.

SMITH: Not part of the mental health deinstitutionalization or anything of the sort.

RADKE: No, they were putting kids in county jails and doing all kinds of things like that.

SMITH: When you arrived what was the situation with mental health and with the mentally retarded? Were you beginning to deinstitutionalize? Was that over? What was the situation at that point?

RADKE: I went to Harrisburg in 1975 to put together a research and evaluation office and then in 1976 took over social services. At that time Pennsylvania was already in the midst of deinstitutionalization for both mental retardation and mental illness.

Deinstitionalization started when the first generation anti-psychotics came out in the mid-'60s and the Kennedy legislation providing for community mental health programs. Deinstitutionalization started in the late '60s in Pennsylvania. It was under way by the time I got to Harrisburg.
Just a little side step. In the umbrella agency in Pennsylvania we had Medicaid, mental health and mental retardation. The guy that ran mental retardation, Steve Eidelman, is now the head of the ARC. Steve understood

that Medicaid was a good funding stream for folks with mental retardation. Steve and I made a deal that as long as he was responsible for getting the non-federal matching funds and if any federal audits came along, he would be responsible for the audit, we would put as much Medicaid money into mental retardation as he could spend.

We started with small ICF-MRs. The Pennsylvania mental retardation system went fully Medicaid back in the late '70s. And we just spent everything we could spend there.

On the other hand, on the mental health side, the mental health commissioner would not accept responsibility for Medicaid. He expected me to get the non-federal share and to assume responsibility for any audit exceptions.

Mental health didn't get a lot of Medicaid money until the early '90s when Medicaid managed care was being rolled out and Pennsylvania carved mental health out of its Medicaid managed care plans. Right now, the office of mental health in Pennsylvania runs a billion-dollar Medicaid program just for folks with mental health problems and mental illness.

SMITH: That's interesting. Now, how much does that development depend on the fact you didn't have an equivalent of the ICF-MR.
Was that significant for Pennsylvania?

RADKE: I think so. When I got to Harrisburg, Norm Lourie would share with me some of the history of the Department. Norm was part of the national negotiations over creating Medicaid. Pennsylvania adopted Medicaid in 1966 right after the legislation passed. Pennsylvania was one of the five or six states that implemented on January 1 of the year following passage of the legislation to get an early start.

Norm told me the states, especially Pennsylvania, tried as best they could to get federal reimbursement for the state mental hospitals because Pennsylvania had a large state mental hospital system in the '60s. The Feds were saying no, we'll pick up what used to be Kerr-Mills, but we're not going to pay for your state mental hospitals.

So, the IMD exclusion was there from the beginning. The MR folks used ICF-MR to get around the IMD exclusion. I think it was in the early '70s that the MR advocates got federal legislation that ICF-MRs would not be considered IMDs.

Even today folks are concerned about the IMD exclusion. In Pennsylvania, we covered all of the kids in state mental hospitals under early childhood screening. Today, we have no kids in our state mental hospitals. For the aging, we created nursing home units within the state mental hospitals to receive Medicaid reimbursement.

For those two populations we got Medicaid. For the middle age group, 21 to 64, we were not getting Medicaid until Congress made the mistake of trying to provide Medicaid to the New York hospitals with a disproportionate share of charity care.

As of last fiscal year, Pennsylvania's state mental hospitals were a profit center. Under disproportionate share payments, we received cost-plus to run our hospitals, which is interesting when advocates say that as an economy measure we should close the hospitals.

SMITH: When and how did you actually maneuver into the DSH—use of the DSH money for the mental hospitals? Because that comes right down to present day.

RADKE: DSH payments are capped right now. As of last year they were a profit center; for the fiscal year coming up, we will exceed the cap. Pennsylvania's hospitals will be about $40 million short because the cap will start to cut into some of the cost.

I came back to Pennsylvania to run Medicaid the second time in July of 1990. In Pennsylvania, to generate additional federal funding, we decided to use a provider pooling arrangement. A bright young man down in Tennessee, named Manny Martins, was using provider taxes. He had the same idea of trying to put some non-federal money on the table in order to claim additional federal reimbursement.

Bob Casey was governor at the time. He was a very straight-laced Irishman who had been the auditor general of the state.

When I got back in the government this provider pooling scheme was the only way we're going to settle the hospital litigation. So, we convinced the Governor that we could do it. He asked was it legal? Yes, it's legal. Then, he was worried about the perception of it.

In fact, I came down here to DC to speak to one of your groups, to talk about provider contribution schemes. Governor Bob Casey wanted to make sure everybody in Washington knew exactly what we were doing and this was a good forum to tell people up front what we were doing.

The Pennsylvania House appropriations committee was staffed by a Pennsylvania Dutch guy who kept saying, "It's legal, but is it right?" I had to keep saying, "This is the only way we're going to solve this litigation. We need the money and they have the money." So, we did a large pooling scheme for the hospitals in order to settle the hospital litigation.

The way the pooling arrangement worked is the hospital association created a foundation and each hospital pledged money to the foundation. Then, the foundation borrowed money based on those pledges and gave that money to the Commonwealth.

We made disproportionate share payments to the hospitals and simultaneously claimed a federal share. We did all of that in one day using one federal reserve bank. So, the money never went anywhere. It was just bookkeeping. But, the bankers charged us two million dollars in fees just to get the deal done.

But, at the end of the day we had a couple of hundred million dollars that we didn't have at the beginning of the day.

MOORE: Did you give money back to the foundation—

RADKE: No. We paid the hospitals a disproportionate share payment. Then the hospitals honored their pledge by giving the money to the foundation. It was the hospitals giving it to the foundation, the foundation giving it to the state and the state paying the hospitals. We went into the discussions on pooling thinking about doing $20 or $30 million. When it was determined to be legal, and the Feds weren't going to stop us, we kept upping the ante. We not only covered what we needed to settle the litigation, but we were able to deal with some other Medicaid budget issues.

We were always very careful to spend the money within Medicaid. We were not one of those states that spent it somewhere else. We kept it within Medicaid. Then, since it worked for hospitals, we did pooling arrangements for nursing homes and for ICF-MRs.

Then, a young fellow named Tom Orr, who was a fiscal person working in the part of the Department's budget office that handled the state mental hospitals, one day said, "Well, how come those hospitals are getting all this money and we're not getting any?"

So, we started making disproportionate share payments to our state mental hospitals. That was even easier to do than this other scheme. So our hospitals suddenly became a profit center because we would just do a Medicare cost report and use the cost report to claim the federal share.

SMITH: Well, one thing that strikes me about Pennsylvania is that there is no great presence of safety net institutions, with the exception, I guess, of the medical schools.

You remember Philadelphia General Hospital, and other places like that shutting down. I have wondered why DSH money wasn't used for that? But you didn't get into DSH like that. You came into it a very different way.

RADKE: No, the Philadelphia hospitals closed for a different reason. When Dick Thornburgh came in as Governor, he had as his budget secretary Bob Wilburn. (In fact, Bob is now in charge of the foundation that raises money for the Gettysburg park.)

He is very, very bright. Bob Wilburn looked at the Medicaid budget and saw that there were structural problems in the budget and wanted to take $100 million out of Medicaid. I'm looking at him like, you know, we can't take $100 million out of Medicaid.

He said, "Well, you don't have to do it today. But, I want you to come up with a plan on how do deal with Medicaid's structural problems."
We put together a staff group and decided that we wanted to do recipient cost sharing. We wanted to use some bulk purchasing, where possible. We wanted to do managed care and we wanted to do prospective payments for hospitals.

We went back to him and said, "Here's our plan." Then, Mr. Wilburn put together a Governor's blue ribbon task force that studied this for a year and came out with a report that said we were going to do those four things. The Feds were going to do Medicare DRGs for hospitals and Pennsylvania decided to convert all of the Pennsylvania hospitals to Medicaid DRGs at the same time that Feds went to Medicare DRGs.

The hospital association agreed to that because they were concerned about trying to manage under two different systems. They thought it would be helpful. Little did they realize that it would change the nature of hospitals. It used to be that accountants became hospital administrators. Now, you have to be a manager.

That was one thing. We were going to do DRGs. The Feds were very helpful to us. They loaned us their expertise. As they did Medicare, we did Medicaid at the same time.

We then did a Medicaid mandated managed care program in Philadelphia using what was called a health insuring organization model.
For one-third of the City of Philadelphia we said, "You are in mandatory managed care."

SMITH: Was this the famous Health Pass?

RADKE: This was Health Pass.

We also did recipient co-payments. I thought it was kind of funny to listen to this morning's discussion because when we did co-payments it was a philosophical statement that we wanted recipients to be involved with the cost of their health care. But, we excluded the kids, we excluded the elderly, we excluded people in nursing homes. Then, we excluded certain classes of the drugs because for anything that would not give you an immediate benefit, we did not want to provide an incentive to keep people from using it. Like all of the medications for hypertension—

MOORE: What did you have left?

RADKE: Almost nothing. Finally, we put a cap on how much each recipient would pay a month in co-payments and we raised their public assistance cash grants a percentage to get them up to that level. So, it really was a philosophical statement. We were not doing this to save money. We're doing this to involve recipients in decision-making. Every quarter, if anybody spent more than a cap, we would process a check and mail the excess back to them. The income maintenance folks decided that our check was not revenue. So, the recipients would actually get a little bonus if they spent over the cap.

Then, on bulk purchasing—we do bulk purchasing for drugs in hospitals—but bulk purchasing for drugs in a community just doesn't work because we

never take possession of the product. So, wheelchairs and eyeglasses were the only things that we could bulk purchase. I was all ready to do eyeglasses when one of the poverty lawyers said, "You know, you don't want to be able to look around the room and tell who is on welfare by looking at their eye glass frames." So, we decided we wouldn't do frames, we would just do lenses. We bought all of our lenses from this company down in Texas. But, the savings is in the frames, the money is not in the lenses.

We developed those four strategies that Bob Wilburn could use. This was his Medicaid reform package. As it turned out the DRGs and Health Pass were the two biggies. But, the other two rounded out the package. We did this around 1984. That's when the governor's report came out.

SMITH: Health Pass got an awful lot of negative publicity.

RADKE: You mean accusing us of genocide?

MOORE: There was that, yes.

SMITH: —yes, there was that. And I knew from personal experience how some of those storms could get whipped up, especially coming out of Philadelphia. Do you have any comment on that?

RADKE: We knew we had to do Philadelphia because 40 percent of our recipients were in Philadelphia. We were only going to do one-third of the city so we could use the other two-thirds as our baseline.

And, gee, I'm not sure I can remember the fellow's name but the guy that started Health America. Breslin, I think his name was. Phil Breslin. He later became mayor of the City of Nashville or Memphis, Tennessee. I remember when he was a young man. He was a true missionary for managed care. He came to the Welfare Department and you could tell his suit was more expensive than all the clothes that the state workers were wearing.

But, he convinced us that managed care was the way to go. When we actually put together an RFP, Health America won the RFP. It was going great guns because he was not only a believer in managed care but he had good public concern and made it work. But, the politics of it, just to sidetrack for a little bit. Congressman Gray was head of the appropriations committee at the time. The understanding was that we would not deal with his Philadelphia constituent staff. We would have all of our conversations

with his Washington, D.C. staff. Congressman Gray, not by supporting it, but by not opposing it, helped us a lot with the politics.
As I said earlier, Bob Wilburn had put together this governor's blue ribbon task force. Henry Nichols, the head of the health care workers' union in Philadelphia, was a member. The union was having trouble paying its own employee health care costs. He was interested in managed care for his own office staff, so he did not oppose our recommendation for Medicaid managed care.

The rest of it was just dealing with the welfare rights organization and its advocates. We went out of our way to show that we would be able to improve access and we felt we would have a positive impact on quality. Remember at the time under the Medicaid fee for service program we were wasting a ton of money and not providing very good service. We had to do something different. So, we put Health Pass into place.

And without realizing the unintended consequences, we changed the Philadelphia health care marketplace. At the time, we said to Medicaid recipients, "You can either join our mandatory managed care program or you can join a voluntary commercial HMO." And there were only 4,000 voluntary HMO slots available to Medicaid recipients in the city.

Creating that strong incentive, the national managed care companies came to Philadelphia knowing that they could easily get the 10,000 recipients that you need in order to spread your risk.

Medicaid became the driver that brought commercial HMOs in the Philadelphia marketplace, which gets back to the comment that we were making on hospitals. It was managed care that took that excess capacity out of the hospital system, not Medicaid.

But, it was Medicaid that brought managed care into the marketplace. And still today, if you look at Pittsburgh versus Philadelphia, Philadelphia is managed care and Pittsburgh is fee for service.

Health Pass was going great guns, then Maxi Care bought Health America, which is the problem that you have in government when you privatize these systems. You have no control over what happens in the private marketplace. Maxi Care was a West Coast company using a cookie cutter in that every HMO was going to look like every other HMO. Health America was an East Coast company and it was “let 1,000 flowers bloom.”

We loved the Health America attitude and approach to Medicaid. We couldn't stand the Maxi Care folks. They would just pretend Health Pass wasn't Medicaid. They would pretend it was a West Coast commercial HMO. We kept saying no, it's not.

One day Eileen Schoen, who was the bureau director overseeing this area came in with a stack of computer printouts. This is when they were on the big paper with the holes on the edges. She looked at those and said, "You won't believe this, but Maxi Care is losing money hand over fist."

I said, "No, that can't be right, Eileen. I mean, these are sophisticated West Coast management types."

She said, "We have looked at this and they are losing their shirt."
And I said, "Well, you know, Health America was doing great. They were giving good service and then they combined." So she and I flew out to Los Angeles and met with Pam Anderson—there was a husband-wife team that ran Maxi Care at the time.

Eileen and I met with them, showed them all of our spreadsheets. They thought we were these stupid state employees from Pennsylvania, didn't know what we were talking about, and pretty much kicked us out of the office.

We went back to Pennsylvania and six months later Maxi Care went into bankruptcy.

We then went into round three of Health Pass. A community based company won the bid. A bright young man named Tony Welters who, even though he was African-American was very Republican, very entrepreneurial. He just put together a company and won the bid. Then he used that to do a lot of managed care on the East Coast.

I think he had some New York City contracts and has been very successful. A bright young man. Once an African-American started running Health Pass, all of the criticism that we were receiving disappeared.

Tony was smart enough that he funded a lot of community programs. He reinvested profits back into the neighborhoods. He did the kinds of things that a commercial company would never think about doing and he made

Health Pass a much more acceptable program.

If it wouldn't have been for that Health Pass experience, Pennsylvania would never have gotten Health Choices off the ground.

It's Health Choices now, but Health Pass was the springboard that got us here.

SMITH: Well, on that general subject, it seems to me that Pennsylvania got quite a bit into managed care and managed care carve-outs in mental health. What is your view about how well that has succeeded?

RADKE: Oh, that's been a big success. Pennsylvania decided to do the entire state with Medicaid managed care back in the early 1990s. The implementation coincided with a change of administration. It's when the Ridge people came in. Feather Houstoun was the Secretary of Welfare for Governor Tom Ridge. She called for re-looking at the whole Medicaid managed care statewide approach.

Part of that re-evaluation gave the mental health advocates a chance to argue in favor of a carve-out of mental health services because the original plan was to leave them in and let the managed care organizations subcontract them out. But two decisions were made.

One was to carve out the mental health services and the second decision was to give the counties the right of first opportunity. Pennsylvania is a state-supervised, county-administered program for mental health. But it's a state-administrated program for Medicaid. So, counties never had any financial responsibility for Medicaid.

Suddenly, we're saying to the counties, "Here is an opportunity for you to take over Medicaid for mental health but you have to assume financial risk." The decision was made to do the five southeastern counties first, then do the southwestern counties, and then fill in the balance of the state. Again, since Health Pass had been successful in Philadelphia, the decision was made that instead of turning this over to a contractor, Philadelphia created a non-profit organization within city government to run the behavioral health part of Health Choices.

Estelle Richman, who is now the current Secretary of Welfare, was the city health commissioner at the time. Estelle had the vision that this could change how mental health services were delivered.

I think she also realized that there was so much fat in the fee for service system there was no way that they could lose money. So, she and Mayor Rendell, who is now Governor Rendell, moved forward with the City of Philadelphia picking up the behavioral health part of Health Choices. The four bedroom counties also agreed to take responsibility for Health Choices but they subcontracted to commercial organizations to run them. When you look at that part of the state, the Philadelphia program is much more of a social service model.

The suburban programs are much more of a health model. I think it's just because of the people that were put in charge of running it.

MOORE: To what extent did the counties or the city get a lot or a little more money from Medicaid? They had not really been drawing down any Medicaid money before this, before the managed care carve-out?

RADKE: You have to step back and go back to the 1960s. When the Kennedy legislation passed in '63, it assumed a planning model for mental health under which you would have catchment areas, you would have unified intake, you would have a rational allocation method to make the money available. In essence, you would have a provider network. That was the mental health model being presented by the Feds in the early '60s.

MOORE: So really, a network all over the country of community mental health centers.

RADKE: Yes. Then in '65, along comes Medicaid. Medicaid is a provider model, a fee-for-service model. The providers decide where they will locate, what services they'll provide, what fees they will charge, who they will serve, and who they won't serve.

What happened is that Medicaid undercut the public mental health system from day one. In Pennsylvania a lot of Medicaid money went into mental health but it went directly to the providers. It bypassed the counties. It bypassed any central mental health planning structure. So you have these two different forces, a planning model and an unmanaged model going on at the same time.

When Pennsylvania in the early '90s decided to create Health Choices and to carve out behavioral health and give it to the counties, it took all of that Medicaid mental health money that was throughout the system and put it in

the hands of the counties. We put a billion dollars into the hands of the county mental health programs that they didn't have before.

We did it on an at-risk basis, but knowing that there was no real risk. The counties not only had control over the money that was being spent, but suddenly they had all of the profits. And, we controlled how they would spend their profits.

They had to give us a reinvestment plan. All of the profits stayed within the mental health system. And, we then used what is traditional in managed care, which is to use cost-effective substitute care. We allowed the counties to create cost-effective substitute care.

In the mental health system, a lot of the services are not covered by Medicaid. So, we started funding a lot of services with Medicaid dollars that had never been funded before. It revitalized the mental health system.

SMITH: It really kind of took the place of the vacuum that was left when the old service units collapsed.

RADKE: That's right.

SMITH: And they collapsed I think largely because, what, they didn't want to pay for them?

RADKE: Well, they were part of a system that assumed management from the top. They could get their money straight from Medicaid and tell the county mental health administrator to go to hell.

No one had control over the providers; no one could make them to do anything. We went through that period where every community mental health agency was saying they needed to diversify their revenue. They were all out trying to serve the middle class and find new revenue streams. I think to a large extent they lost focus on their mission, which was to treat persons with mental illnesses in the community.

You know, the thought was that when they deinstitutionalized that system would provide equivalent care in the community.

We took people from institutions where you have integrated administration for services and put the people in the community where you had all of these

decentralized social service programs. Our people could never manage the system. They got lost.

Pennsylvania is keeping the rates high for its county Health Choices programs. Every state dollar that we spend on mental health we draw down a federal dollar through the managed care system.

SMITH: What do you think remains to be done in the mental health field in Pennsylvania? I mean—what do you see as the big task? We were just talking about how optimistic a picture it is but we don't know why.

RADKE: You have to separate children from adults. Let's talk about the adult system first. On the adult side, the system needs to decide is it there to provide mental health services or is it there to provide treatment for mental illness? The system still hasn't made up its mind which of those two it wants to be.

Philadelphia I think runs the best metropolitan mental health system in the country. Philadelphia identifies people with mental illness as its targeted population, provides a broad range of services for those folks, and has a fully functional crisis intervention system.

If you go into the balance of the state, again talking about adult services, you will find in most of the counties there is no psychiatrist on staff. They get about 10 hours of psychiatric consultation a month. What psychiatric time they do buy is doing med checks.

Here you've got mental illness, and psychiatrists are excluded from the system of treatment. So, on the adult side the big thing we have to do is decide are we in the business of treating mental illness, and if we are, we need to bring the treatment professionals back into the system.

On the children's side, Pennsylvania made an early mistake and it has still not recovered from it. The decision was made to use EPSDT to provide anything and everything to kids. I mean, we went far beyond providing mental health services in the home to providing dance therapy and therapy with horseback riding.

About a third of the mental health payments Pennsylvania makes for children goes into nothing more than one-on-one child care. The problem with that is most of the children we serve have ADHD. There is a standard of care for treating kids with ADHD.

But instead of providing them with a good clinical workup, access to ongoing clinical care, and access to appropriate medication, we provide them with a full-time baby sitter to make sure that they don't get in trouble or to provide respite care to the parents. Easily a third of what we spend in the state for mental health for children is no more than just one-on-one child care. In Philadelphia every day that school opens 1,100 Medicaid-paid workers called TSS workers—therapeutic staff support—go into the Philadelphia school system to sit in the back of the classrooms to watch their charges and to make sure the kids don't misbehave in school.

And then they follow the kids home. Since these 1,100 folks are not part of the school system, the school system can't use them to do appropriate teaching assistance roles. They are not trained clinicians. They are college kids that can make more money being a TSS worker than flipping hamburgers. The kid's system is in terrible trouble because of this early mistake. You now have a TSS industry. Providers can make more money providing TSS than they can make hiring psychiatrists.

MOORE: Yes.

RADKE: The whole system is being driven with the wrong incentives.

MOORE: Is it your experience that this kind of situation exists in other places or is this unique?

RADKE: It is probably in other places, but nowhere to the extent that it is in Pennsylvania. And it's in Pennsylvania because we had staff early on who decided that they were going to use EPSDT to put a ton of money into kid's programs.

The irony of it was that because they knew managed care was coming, they were going to try to drive up the fee for service expenditure so that when managed care came you would have a better capitation. What they discovered is once you start offering somebody state-paid free baby sitting there is no way to take it away. So even though managed care comes in, there is no way to take it away.

On the other hand, if you go to Pittsburgh, Pittsburgh has a terrible adult mental health program. It's probably 15 years behind. But, on the kid's side they have a mental health program that is probably as good as anything you will find in the country.

SMITH: It seems to me as I look at Philadelphia, one reason why the mental health program is so good is the presence of all those medical schools.

RADKE: The medical schools played very little role in the mental health side. When the state closed one of the state mental hospitals in Philadelphia it did a very bad job of closing it. People went into the community and there were suicides and people disappeared. I mean, it was a disaster.

There is no other thing to call it. So, the next time the state closed a facility in Philadelphia there was so much pressure on the state that the state gave Philadelphia about sixty million dollars.

To close an institution costs the state about 110 percent of the cost of operating the institution. Putting all of that additional money into the community is what built the infrastructure in Philadelphia. We wouldn't let anybody out unless they had case managers.
So we created and funded the infrastructure that stood in place.

MOORE: What year was that, this second closing, which would have built this adult mental health system?

RADKE: That would have happened in the early '90s.

SMITH: And why is the Pittsburgh child care program so good, child mental health?

RADKE: Because of Western Pennsylvania Psychiatric Institute. Unlike Philadelphia, it's the only recognized psychiatric school in the Western part of the state—so all of the psychiatrists trained at the same school. They not only trained there, but they were involved early in wraparound services for kids.

In Pittsburgh they understood what wraparound services were. If one of the docs made a request that was inappropriate—all the people he went to school with would look at him and say, "You can't do that."

It's not the bureaucracy bringing discipline to the system, it's all the clinicians. If you go into southwestern Pennsylvania, all the docs were trained at WPIC. When I went to school in Western Pennsylvania, WPIC was truly the old boys' club. I mean, there couldn't have been a more old boys' club than that was.

When I came back to Pennsylvania two years ago I was introduced to this bright woman who is the president of WPIC.

And I said, "How did you get this job? How did you break through this?" She has a vision for the university. They are a teaching facility, for a good while they have been a provider, and they created their own managed care company. They are the contractor for Health Choices in Allegheny County for behavioral health.

She sees a system of vertical integration including being the health insurer, the provider, and the teaching facility. It's all part of one system. When you look at statistics in the state, for TSS as an example, they use on a per-capita basis about one-third of the TSS that is used in Philadelphia.

But, if you look at when the behavioral health plans deny a TSS authorization, Philadelphia and the surrounding counties have very high rates of denial, while in Pittsburgh there were almost no denials.

How can you never say “no” and still have such low utilization? And it all goes back to a good clinician wouldn't dare ask for something that is inappropriate because you are asking your colleagues.

SMITH: Well, they used to say Philadelphia was a city cursed with five medical schools. And maybe Pittsburgh is blessed with only one.

RADKE: Yes.

MOORE: Say a few words, Jerry, before we close here about federal-state relationships over the years because I think you were fairly involved in the Association of Medicaid Directors and expansions that were passed in the '80s when you were Medicaid director, and how you approached that.

RADKE: When I took over Medicaid in '79, the Medicaid director at the time was a mid level position within state government and a fellow named Glenn Johnson was the Pennsylvania Medicaid director. Glenn had been active in organizing the state Medicaid Directors into a national organization. In fact, Glenn was the president.

Glenn was a good guy and taught me a lot about Medicaid. At that time the Feds didn't pay any attention to Medicaid. They were spending their time on Medicare. It was sort of like the neglected step-child.

The issues at the time were fraud and abuse and claims processing. There was a technical advisory group on claims processing that I got involved in, since that was a big chore for me. There were also technical advisory groups on the fraud and abuse issues.

For the most part, state and federal relations would just deal with are we going to get our state plan amendments approved, the fact that the regional offices were not consistent in their decisions, and the states were always trying to get 75 percent reimbursement and the feds were always trying to say no, it's at 50 percent.

Those were the kind of battles going on at the time. It changed when Len Schaefer came in. Len thought Medicare and Medicaid should be the same. That's when a lot of the real tension got into the system because he was trying to Medicare-ize the Medicaid program.

I would say tensions were at their peak during those years. After Len left, it calmed down again and that's when the states started to move beyond claims processing. When I took over in '79 our job was to pay the claims.

Then, we started to view our job as prudent purchasers. We started to try to use state leverage more. We moved into changing the systems. Fee for service doesn't work. Cost-based reimbursement doesn't work.

We started challenging some of the basic underpinnings of how the thing was put together. For me to drive down to meetings in D.C., I would always drive by the Gettysburg Battle Field.

And I recall I was the states' rights advocate coming from Pennsylvania. The federal people are probably a little smarter now, but some of the folks we used to deal with back then were pretty pathetic.

SMITH: On the federal-state relations, when you were engaged in that DSH adventure you must have felt that you were just taking back what was yours.

RADKE: Tom Scully at the time was working at OMB. I can remember he called us to D.C. for a meeting and shook his finger at us, lectured us, and told us not to do it.

MOORE: Are you involved in the negotiations to put the lid on donation and tax stuff with Wilensky and all of those folks who were in—

RADKE: I was out of the government by that time. I was part of the big compromise program in 1990, regarding the pharmaceutical rebates and—

MOORE: Uh-huh.

RADKE: —you know, open access versus rebates. When I started in Medicaid, claims processing was my first chore, 30 percent of my claims were pharmacy claims. So pharmacy got my attention early on.

MOORE: Right away.

RADKE: I spent a lot of time there. Then it was later with DRGs that hospitals came into play.

MOORE: We could go on and on forever.

SMITH: I think we could probably go on and on. It's been such fun, really, and we enjoyed it enormously.

RADKE: Well, thank you.

SMITH: And it certainly makes me happy to feel that you were in charge of this Philadelphia program—Pennsylvania program for so long. So, thanks so much.

RADKE: Thank you.

INTERVIEW WITH MARK REYNOLDS
DAVID SMITH – AUGUST 21, 2003

SMITH: It is August 21st, 2003. This is David Smith interviewing Mark Reynolds. And, Mark, maybe you could tell me about your life after you left college and how you wound up involved in the Massachusetts Medicaid program.

REYNOLDS: My start was a fairly random one, as I believe it is for most people who ended up involved in Medicaid. I started working for the state in the late '80s.

SMITH: This is Massachusetts.

REYNOLDS: This is the State of Massachusetts in the late '80s. I had been working on a Ph.D. and the topic that I was looking at at the time had to do with fiscal forecasting at the state level. And so I took a position as an intern with the state budget office.

At that time they needed an assistant looking for new federal funds. So the position worked for me and worked for them. And they asked me to spend some time looking for new sources of federal funds.

SMITH: This was DSH kind of stuff?

REYNOLDS: Well, Title 19 in general. And Title 19, of course, is generally the major federal funding in the states. In practice most of the work ended up focusing on Title 19, as it normally does if you are really trying to bring in federal funding. So that was my first introduction to Medicaid.

After being there a short period of time and having decided to step away from my dissertation for a period of time I was about to take another consulting position. The state offered me a full-time job to become the Medicaid analyst and, given the work that I had done on federal funding, I had the background to be able to take on that position.

So I became the state's Medicaid analyst at the budget office and after a few years moved on to become one of the assistant directors there. So I ended up overseeing Medicaid and a number of the other state programs.

Eventually I moved on from the Governor's budget office to be the budget director for the Secretary of Health and Human Services, the executive office that oversees a number of individual state agencies.

I started under the Dukakis Administration but when I moved to become assistant state budget director, that was under the Weld Administration.

After moving to Health and Human Services where I had responsibilities for Medicaid and a number of the other Health and Human Service agencies, I ended up moving down to the state's newly formed Medicaid agency in 1996 as deputy commissioner.

SMITH: And this was after Weld had taken over as Governor and this was really a transformation of the program.

REYNOLDS: Well, Weld took over—the Weld election was in '90 so he took over in January of '91. So this was fairly well into his second term. And then I stayed there through Governor Cellucci. And after Bruce Bullen left, I took over as acting commissioner. I then moved to Tennessee in 2000.

SMITH: We talked with Bruce Bullen and he gave kind of a picture of the Medicaid program under the latter part of the Dukakis Administration as—well, I guess you wouldn't be exaggerating to say he pictured it as the death throes of a single payer, rate regulation approach.

And that salvation of the program came in large measure through heroic efforts to slim it and transform it into a program that depended heavily on managed care, maybe also primary care case management, but managed care in one form or another. Would that be an overstatement, simplification, or more or less on target?

REYNOLDS: Largely on target. I think it's fairly simplified. Certainly in the late Dukakis period there were a lot of things that were coming together and one was simply a strong focus on health policy from the Governor's office. During '98 there had been a whole effort for universal health care.

Really a health care package that Governor Dukakis brought to the federal level but prior to that had moved at the local level. And so there had been a bill which was designed to provide comprehensive health care coverage for the citizens of Massachusetts.

It was basically a pay-or-play model for businesses. Businesses would either provide health care coverage or they would end up paying into a state system. A bill was passed—but delayed by the state legislature a year later and then delayed for a series of years until it was finally repealed in the mid '90s.

Elements of that bill, however, did go into place fairly immediately, including some smaller health care expansions, for instance, a requirement that all students enrolled in college in Massachusetts above—I believe it's three-quarters time, it might have been two-thirds time—must be offered a health care package by that college or university—filling an important gap in Massachusetts.

Likewise, another provision provided health care coverage for people who were receiving unemployment insurance—again, filling an important gap in both federal rules and also what was provided at the state level. So there were a number of specific elements of that universal health care package.

SMITH: That were really kind of a moving or staged implementation.

REYNOLDS: Right, exactly. They were small moves, they weren't big ones, but they were incremental moves and filling holes in the safety net. A new agency was created to focus on some of those issues, to run those procedures, and also to focus a lot on issues surrounding a lack of health care coverage.

That agency was later—basically, its primary mission was abandoned and it was integrated into another agency. So that was one thing that was happening at that time in the late Dukakis administration.

At the same time, cost escalation was substantial in the Medicaid program. And the state's financial condition was in perilous shape just like a number of other states, a period similar to the one we are currently experiencing. So this is really the next round of that same periodic process that happens in state governments and therefore is an important feature of the Medicaid program. It is something that can't be ignored.

SMITH: Would you go as far as Jim Tallon does, and call this a kind of a binge-and-bust cycle?

REYNOLDS: Absolutely. I think that's absolutely true. I think that is true, but again, has to be put in the context of state government. It is not true

for Medicaid alone. It is true for state governments at large. State governments, because they cannot deficit spend in large part end up in fiscal crisis due to having political pressures to either expand or give tax relief during good times. It's not simply expansion. You have to view tax relief as a form of expansion.

SMITH: Yeah.

REYNOLDS: When you are spending your money somehow, you are either giving it back—

SMITH: Alan Weil was making the point that often in these bust cycles you are sticking it to the providers. And so these guys come back and say, "Geez, you know, we stayed with you when times were hard. How about a little raise?"

REYNOLDS: Exactly. And that's certainly part of what happens on the Medicaid side, there are constraining pressures during the bust cycle and those do have to be satisfied at some level during the expansion cycle and...

SMITH: That's just fairness and keeping your promises and stuff like that.

REYNOLDS: That's right. So that's true also for coverage expansions. So, back to the late '80s. That fiscal pressure created a lot of focus on controlling the cost of Medicaid. Once, the head of the Senate Ways and

Means Committee declared Medicaid to be a budget buster and created a list of something like seven programs that had been growing substantially faster than average revenues. And Medicaid was one of the programs.

The Governor himself took a lot of personal interest in the program and had early Saturday morning meetings on Medicaid every week as part of trying to control costs. We are still talking the late Dukakis period. The Dukakis governorship ended in the middle of the crisis, really only, 40 percent through the crisis. Weld came in office in large part because of the fiscal crisis.

He was able to successfully argue that the state's financial condition was miserable and a new path needed to be followed in order to be able to change the direction of the state.

SMITH: Now, this is what date?

REYNOLDS: This is would be January '91.

SMITH: January '91, uh-huh. So we are not into the Clinton Administration yet.

REYNOLDS: Not yet.

SMITH: Or the failure of health care reform.

REYNOLDS: Exactly. So we haven't reached that at all. In Massachusetts we have gone through our own failure of health reform. In other words, the bill had passed, the health reform statute. We can talk more of that if you want. Some of the specific elements had actually been put in place. Alan Weil was at that time general counsel to that new agency that was established, the division of medical security. And that was one thing that had happened in terms of that bill, but that bill had otherwise been postponed. So Massachusetts was having its own pre-national universal health care bill experience.

SMITH: That was really going to the crash before Clinton did.

REYNOLDS: Exactly. There are other parallels in Massachusetts and the federal level that would come up later in the decade. But the Weld transition happened amidst this large change. Bruce Bullen had come in as the director of the Medicaid program, fairly recently. He had come on, I believe, in the summer of '90 so that it was really about half a year before the change in administration. He had been in the House Ways and Means Committee as the budget director and was fairly on top of the fiscal pressures. Bruce had started a process. He brought a different focus in a variety of ways to what should be happening in the Medicaid program. The first challenges were again mostly fiscal challenges, to climb out of what were great holes. And that's where the discussion about the state's highly regulated approach first occurred. Bruce brought a different perspective on how to approach some of the issues. Some of those perspectives were really being more aggressive in terms of pricing, in this case meaning—

SMITH: Taking advantage of your Medicaid monopsonistic position?

REYNOLDS: Exactly, particularly in nursing homes where Medicaid dominates the market--in Massachusetts about 75-80 percent of the market. And uniquely, as in a lot of regulatory areas, regulation provides both the

ability of the state entity to be able to control prices but also as with regulatory capture leads into other patterns that are not necessarily economically efficient.

SMITH: So you have a real sense at the state level that if you are into rate regulation you are constantly fighting this problem of capture.

REYNOLDS: Absolutely. As a separate discussion, it is interesting to look at whether or not regulatory approach or a market approach actually drives down aggregate costs. But it's certainly true at the micro level, you end up with patterns of regulation that discourage efficiencies, even if you are able to constrain aggregate costs through regulation to a level that might be lower than the market might allow for.

I believe it is often true in health care, that the market will often allow for higher aggregate costs than a regulated approach. You end up with odd characteristics in terms of pricing.

In the nursing homes in Massachusetts, the general theory had been coverage of provider's cost. You hear that every day in conversations with providers today that, of course “you should cover my costs.” And it sounds like the most rational thing in the world. And of course the problem with covering cost is that it is inherently inflationary. It builds in an ability to have any cost accounted for and reimbursed with no economic pressures on those costs. No market pressures to really try to force the question of which costs are appropriate and which ones aren't to make the program efficient.

So one of the big things Bruce brought to the table during that time was really rethinking the question of—if providers should be reimbursed at a full cost basis. So his first energies were really put to establishing pricing policies which were no longer cost-based, to move from full cost to something less than that and then really to move off a cost-based system entirely.

So that's probably the big change that Bruce introduced to the program during that period. That program was very well supported by the Weld Administration when the Weld Administration began. Bruce hadn't come in during the Weld Administration but was kept on by the Weld Administration because his approach to things worked well for them. The Weld

Administration brought in Charlie Baker, who had been at a place called the Pioneer Institute, a fairly conservative think tank. He came in as Under

Secretary of Health and Human Services. And that overall policy worked well with Charlie. Charlie became the administration's health care policy guy as well as Human Services' policy guy. And Bruce and Charlie struck up a very strong working relationship, given that their views of the world matched rather well.

Moving off a cost basis was a big change. Another big change had to do with a shift from a regulatory approach to a non-regulatory approach. And the big example there is hospitals. The state had, like a number of states, a regulated hospital payment system where all hospitals were regulated in terms of their rates. That provided coverage for people who were uninsured and everything else, but it was a structured rate system.

SMITH: Was it a retrospective or PPS system?

REYNOLDS: Retrospective system. So again, a rate-based retrospective system. That was upturned through legislation that Charlie Baker spearheaded. And I believe the language was passed in late '91. The regulated rate system moved to a market-based hospital system, a competitive system.

SMITH: Was it a DRG or related to a DRG? What did you do about risk adjustment?

REYNOLDS: I didn't spend a lot of time on the system at that time. It was cost-based. It was not DRG-based, nor was there a real risk adjuster. It went fairly quickly from a cost-based reimbursement system to a market-based system, given that the bill got passed in '91.

So in Massachusetts we have the overall health care system going through a number of changes, including those expansions in the late '80s and then a big change in term of the hospital payment system. Also, on the Medicaid side we had a push for a re-visioning of pricing.

We at the same time had great success for the state in the very first months of the Weld years in bringing in a lot of new federal monies through the DSH process.

SMITH: Yes.

REYNOLDS: Massachusetts, in fact, was never a particularly aggressive state and is still considered a low DSH state. But it was actually a fairly big

single swoop, I believe; $415 million brought in at one moment in time, big enough that Dick Darman actually sent a SWAT team to investigate what was going on in Massachusetts at the time, Dick Darman being the head of OMB.

SMITH: How big a factor was DSH in actually bailing them out?

REYNOLDS: Substantial. The Dukakis Administration had argued that the budget was basically balanced. We are talking right now the cusp of '90-'91. The Weld Administration argued that there was a $700 million budget deficit. The truth is probably somewhere in between. Seven hundred was inflated—sort of a quick number reached at the beginning and then held to because it had been used publicly. $415 million in DSH was used to solve the problem.

SMITH: That's a big deal.

REYNOLDS: Exactly. The project had already been initiated the summer before in the Medicaid bureau. But it wasn't ready for prime time before Dukakis walked out the door. So Weld got the credit for it when he came in the door.

SMITH: Beginning about then you have a long period of relative prosperity, so it's really hard to say what bails Massachusetts out, isn't it?

REYNOLDS: Well, yeah. In that fiscal year it was a combination of the new DSH revenues, the $415 million roughly—I think that's the figure. It's been a long time now—and substantial cuts that started under the Dukakis Administration.

There were cuts in fiscal year '89. There were substantial cuts made in September of '90 with Wall Street creditors breathing down the throat of the administration saying, "We are going to drop your bond rating unless you do more." So there were a whole series of cuts that happened. And then there were further cuts in the fiscal year '91 and '92 budgets that were put out. So there was a lot of fiscal management happening during that time, management in other areas of state government. The state closed a number of facilities—public health, mental health and MR facilities.

SMITH: Now, Dukakis goes out in—

REYNOLDS: January '91.

SMITH: Okay, okay.

REYNOLDS: And this move was...Weld...

SMITH: But a lot of these cuts are started really under Dukakis.

REYNOLDS: Oh, sure a number of cuts happened under Dukakis. But the Weld Administration then came in and was even more aggressive with cuts. Which also makes sense, given their philosophy and the fact that the fiscal situation hadn't been resolved with the more incremental cuts that happened during late Dukakis. More substantial action needed to happen in order to resolve the fiscal pressures.

There's also a big tax increase that was passed as well just prior to Weld. So Weld also benefited from having new tax revenues. You know, as usual, these stories get mushy.

SMITH: But it's an interesting story when you start looking at these big trends in Medicaid. It's very hard to attribute them to one thing rather than another. Most people, Republican or Democratic, are striving in some measure to take account of or adjust for what the economy is doing. But it is many ways independent of the party.

REYNOLDS: Oh, absolutely. For instance, this DSH revenue would have happened regardless of who was Governor at the time. But of course the new Governor got credit for it because of the workings of the staff going on behind the scenes.

SMITH: Do you have a sense that in Medicaid there was a really substantial shifting toward managed care?

REYNOLDS: Well, there was but that's sort of the next play in the act.

SMITH: Oh, okay.

REYNOLDS: The work that was done in Medicaid during that period of time—and again, during this period of time I was in the Governor's budget office both under Dukakis and under Weld, as opposed to down in the Medicaid agency itself. Bruce was down in the agency at that time.

But the primary workings had focused on the rate issues, rethinking how rates were structured so that they were no longer based on retrospective

cost-based procedures. That was both true for hospitals and nursing homes and then applied more generally to other rate categories.

That was the primary activity. During the discussions a number of other reductions in Medicaid were considered over and over again by both the governor's office and the legislature, including significant reductions in eligibility. Only one of those reductions in eligibility ever ended up passing and that was a reduction of coverage for individuals who were between age 18 and 21.

That was the only reduction that occurred during that period despite at every budget cycle having—

SMITH: That's interesting, yes.

REYNOLDS: There were minor reductions made in benefits, the number of benefits covered, but they were fairly minor reductions. But of course in every budget cycle new proposals to cut benefits or eligibility were put on the table but rejected during that period.

The growth in the program was controlled by rate modifications. The economy started to improve toward the mid-'90s and two big changes happened in the Medicaid program during that period. You might even say three big changes. One, efforts to secure federal reimbursement had expanded.

Some of that was consistent with the deinstitutionalization policy that was directed under Charlie Baker's leadership. For people in the community it made even more sense to try to pursue federal reimbursement to support the services for those individuals.

And it wasn't only Medicaid. I mean, there was effort to bring in new federal housing money, for instance. There was an effort to try to provide more services. There is an interesting editorial in the Boston Globe today that talks just about that from the person who is now Bush's housing/homeless person, that used to be an advocate for homelessness in Massachusetts during that period, who worked closely with Charlie Baker to establish new housing supports for the mentally ill.

There was a lot of effort on bringing new federal dollars to support people in the community and there were more people in the community due to the deinstitutionalization that had happened. There was also—

SMITH: So they are kind of moving ahead of the curve.

REYNOLDS: Generally, I think, at that time. The other effort was toward managed care, and I will get to that next. And the third effort was toward the creation of an independent Medicaid agency, which is, I think, a fairly important part of what happened in Massachusetts. Massachusetts, like many states, ran its Medicaid program as part of the welfare agency for most of the Medicaid program's history.

By the late '80s in Massachusetts, and in other states, Medicaid had suddenly become a big deal. The value of the program was so large that people were starting to take notice.

That had obviously happened gradually over time, but because of the high health inflation rate of the late '80s, Medicaid programs suddenly became obvious to state legislators and governors. Before they had often just been run as sideshows to welfare programs, in large part.

SMITH: There have been a lot of studies that show a very big part of the increase in Medicaid costs have been increases in enrollment. But it seems to me that during much of this period when you get to increases in enrollment that's obvious and visible and you know you're doing that. On the other hand, when you get this kind of whammy of the increased medical costs, the medical inflation, that's kind of a sneaker. It's always bigger than you expect.

REYNOLDS: That's true. I mean, enrollment occasionally sneaks up on you but less so than it used to in many ways. Actually, because of expansions enrollment is less directly tied to the number of people who are indigent than it had been in the past, but it has been escalation in price per unit and utilization that has been more shocking to programs and more difficult to manage than the eligibility...

SMITH: Right. You were going to say something about managed care.

REYNOLDS: Well, let me finish this thing about creating a separate agency, which is an important part of the Medicaid history: the shift from Medicaid being a sideshow in most states up until the late '80s to Medicaid becoming a major issue for states starting in the late '80s and continuing through today.

In a number of states, including Massachusetts, Medicaid programs became independent agencies. But it is less important whether or not they are independent agencies than the shift from having been considered a sub-part of a larger welfare policy to being viewed in the 1990's as programs that were viewed independently. That independence in Massachusetts was originally to give the agency more control over its fate, to de-link it from welfare. But if you are starting a new agency, you have to create a new mission.

In the '80s what Medicaid did was live with the eligibility that Welfare decided. Then you managed your costs based by controlling your pricing as best you could.

In the '90s, now that Medicaid programs were being treated independently, more options were considered. Part of that had to do with there being extra revenues available. But Medicaid in Massachusetts became a separate agency and really created a new mission, a mission that focused not just on cost control and paying providers, a provider-based mindset, as it had been in the '80s.

Everything shifted to a mindset that said we are serving a group of people. We should care about more than just what happens to providers. We should care about health care quality, for instance. We should try to drive changes in quality, not simply pay providers. And we should look at how we interact with our customers and we should improve our customer service.

SMITH: It's about this time that you got the same kind of emphasis in HCFA because Bruce Vladeck was saying, "We are not just a bill payer. We're looking at customers out here and at prudent purchasing and all that kind of stuff."

REYNOLDS: Well, I think a lot of that was driven by states, actually. A lot of the emphasis on customers was driven by states. You really have them both, although from different angles, which we could get to later. I think there were differences in the mid '90s in the approach toward customers taken by states and the federal government.

SMITH: One reason that it is good to get the outside-the-Beltway perspective, because the states are in this a lot more than people realize.

REYNOLDS: Yeah, on Medicaid, states are the driving force, which is a very interesting part about the Medicaid program. Because the Medicaid program

is not managed at the federal level, it is managed at the state level. The feds create a structure with certain rules that matter significantly, but no one at the federal level is involved in the daily operations of Medicaid. Which is good and bad.

SMITH: Many of them have never served in the states.

REYNOLDS: That's true, too. It's a unique program in that it is really managed by states even though the federal government provides most of the money. So it just makes it a very different program. And it also means there is a great deal of variance, state by state.

But I do think that the change from Medicaid programs being on the sidelights to being major programs, sometimes managed independently, has mattered a lot. It mattered internally to Medicaid programs because they started to focus on customer issues, not just on provider issues.

It also has meant that the NGA is always looking at Medicaid because the money is just so big. It's such a dominant feature of state budgets. It is, generally speaking, the second-largest line item for a state budget after education/local aid, however states organize themselves. It is just a major issue in a way that it hadn't been in past years.

And I think it is finally happening at the federal level. HCFA/CMS has always treated Medicaid as a sidelight, second fiddle to the Medicare program. Always. The agency is structured that way. The history of the oral history project suggests as well that Medicare is what mattered to the federal agency and Medicaid was seen as the sidelight that states managed but you had to deal with somehow.

That is changing. Medicaid is now spending as much money as Medicare, even at the federal level. That will mean, I believe, in coming years that CMS will focus heavily on Medicaid issues in a way they never did before. At least, its institutional focus will start to be more accurately split between the programs than it had in the past.

SMITH: Now, the date you organized the independent agency was...?

REYNOLDS: The independent agency started, I believe, in the summer of '94.

SMITH: So and it wasn't very long after that that the federal government formally separated welfare. Again, you are ahead of the curve.

REYNOLDS: That's right. The welfare reform act was then passed in the summer of '96. Back to managed care. Managed care is the other big thing that happened in Massachusetts during that period of time, the managed care/1115 waiver.

During that period of time, in the late Bush Administration and then the early Clinton Administration, there was a real interest both at the federal level and at the state level in states pursuing the different paths. And there was a real tension, as there still remains, over managed care in particular.

But part of the effort at waivers had to do with simply giving states flexibility to manage their own resources and part of it had to do with the concept of managed care, which under standard Medicaid rules was not permissible because of freedom of choice, primarily, although statewideness and other issues mattered as well.

So the move toward waivers during the mid '90s is directly linked to the concept of managed care and managed care became the rationale for waiver expansion. One thing a lot of people externally don't really understand about a lot of the expansions that occurred in the '90s is that the argument for receiving a federal waiver, an 1115 waiver, was that you could cover more people but only if you could do it within the amount of money you would otherwise spend under a regular Medicaid program. So implicitly the argument was: we are going to save money by employing managed care and that saving will be used to support covering additional people. That was the implicit argument being made by all of the waiver states during the mid-'90s. Tennessee was one of the first waiver states, January '94, with Massachusetts implementing their expansion in mid-'96, the summer of '96.

The Massachusetts waiver had been submitted—originally created in '93, and approved, I believe in '95. It took quite a while to get through the federal process, and then actually there was an odd battle that happened at the state level.

The administration—or really the Medicaid agency, working with Health and Human Services, had created the waiver but it was originally rejected by the legislature. Then the following year it was brought back up and a very odd twist happened with it.

The waiver was then supported by the legislature but with a different funding mechanism, a new funding mechanism which relied on the cigarette tax.

SMITH: Oh.

REYNOLDS: John McDonough, who was the chair of the health care committee, pushed that legislation and expanded coverage for a greater number of children than the original administration proposal.

SMITH: Was this strictly a cigarette tax or was it part of the state fund damages, distribution damages?

REYNOLDS: No, this is all before that activity happened. In fact, I don't believe the Attorney Generals were even onto that at that date. It was mid-'90s. So some legislation expanded coverage a bit but its primary change was a change in financing from the original administration bill. The Governor, who had originally submitted the legislation the year before ended up vetoing it because he was opposed to any new tax, including a tax on cigarettes.

The Governor that had proposed it in effect got no credit for it because he then vetoed it. His veto was overridden.

It must have passed during spring of '95, spring/summer of '95. The state had had 12 months to implement it. And so the new program was implemented in the summer of '96. Shortly after that, of course, SCHIP also happened at the federal level, which is another interesting story. John McDonough had created the CMSP program at Massachusetts. The state program was called the Children's Medical Security Plan in Massachusetts. And then the federal legislation was the State Children's Health Insurance Program.

SMITH: Now, were they taking the Medicaid option for this or were they—

REYNOLDS: No, this is non-Medicaid. In Massachusetts, the program provided primary care for children who were not Medicaid-eligible. Their hospital care was then provided under the state's uncompensated care pool system, which covers indigent hospital care along with bad debt.

The Children's Medical Security Plan program provided primary care for those children. It was then used as a model by Kennedy in the creation of the federal SCHIP program.

SMITH: I didn't know that history.

REYNOLDS: It was one way, in the end, SCHIP ends up being like Medicaid, but not Medicaid. Now, it's comprehensive. It's not only primary care but it's comprehensive.

Anyway, managed care was always a big fight in every state. But it provided a mechanism to cover more people. And Massachusetts also had a rising managed care market, unlike Tennessee, on the commercial side.

SMITH: Now, one item that is interesting about Massachusetts is that a large part of your managed care was not-for-profit.

REYNOLDS: Absolutely. It still is.

SMITH: Now, can you have a for-profit HMO in Massachusetts?

REYNOLDS: Yes. Although many people in the industry believe it is impossible, there is no regulation against it. But there is a general worry by the industry that the Massachusetts market is not friendly to for-profit health care. There is very limited penetration of for-profit hospitals and managed care in Massachusetts.

SMITH: Which makes Massachusetts pretty much unique in this regard.

REYNOLDS: But it is not prohibited by statute or regulation.

SMITH: One characteristic that strikes you about Massachusetts, for instance, when you look at Bob Masters, and that remarkable program of his, that Massachusetts has a different attitude toward health care.

REYNOLDS: There is a lot of communication in the health care community here that I'm not sure is true in all communities. There is a lot more talk about quality improvement that goes across participants in the industry.

And part of this is arguably due to the not-for-profit nature of the industry. It is much easier to get the HMOs and hospitals at the same table in Massachusetts than in some other states, in part because people don't have

the same competitive pressures. It's a little unfair. There's still some fairly cutthroat competition. There is a big struggle, as you said, because of oversupply in certain areas, there is some real competition that occurs. On the other hand, people don't—

SMITH: They don't come to it with a money-making mentality.

REYNOLDS: I think that's a little unfair. They are always looking at the bottom line. But it's still different than having to produce quarterly earnings reports—and have your stock price rise quarterly. You are still trying to make money. Don't be fooled. But it's different and it leads to more cooperation sitting around the table because people are less worried about giving up trade secrets than in other environments.

And managed care, interestingly enough, grew rather rapidly in Massachusetts, just as it did in California. In fact, the last time I saw the statistics Massachusetts had the highest managed care penetration rate in the nation at 60 percent...

SMITH: Yeah, yeah.

REYNOLDS: Tennessee, for instance, where I also was, had a very low managed care penetration in its commercial marketplace. It was, in fact, only about five percent.

SMITH: You can look at managed care and the various purposes it has. One would be to save money. Another would be to provide access. Another would be to give you a handle on accountability and to get certain kinds of data and things of that sort.

It sounds to me as though surely one of the reasons it spread so rapidly in Massachusetts is that you were seeing the benign face of managed care, by and large.

REYNOLDS: I think so. I think it's probably a combination of things. Its spread coincided with hard fiscal times for, among other people or groups, the major insurer of the state, Blue Cross/Blue Shield, which is now, once again, the healthiest insurer in the state.

But around 1990, the insurer was having difficulties. So new competition was able to grab some market share. It had to do I think as well with it being a fairly benign form of managed care. People were still able to get

access to all the teaching hospitals that they desired. Everyone has Mass General in their network. Everyone has Brigham and Women's in their network. Everyone has Children's Hospital in their network. And in fact, everyone has all the other hospitals, too. I mean, we have a form of managed care that does not really have exclusive networks here.

SMITH: It's more like a gigantic PPO.

REYNOLDS: Well, now it has become that. And that's another story about the changes. Even today, in fact, it is just a gigantic PPO. And, in fact, that means that managed care has lost a lot of its ability to control costs. Which is a problem in the current industry. A decade ago that wasn't quite true. You still had players such as Harvard Health Plan, which had a closed network. So you had to go to Harvard docs at Harvard clinics. But you still ended up having access to the same Harvard hospitals.

Even though Harvard Health Plan clinics were technically separated from Harvard University teaching hospitals. But you still had access to those hospitals. And if you were in Tufts Health Plan, the competing health plan that didn't have a closed network, you still had access to the same hospitals.

So you might have had different delivery systems in part. But everyone was using the same hospitals and in that sense things were not nearly as exclusive as they were in other marketplaces, even a decade ago. Like California, I think the oversupply or the substantial supply of health care providers, particularly physicians, has led to the expansion of managed care. And managed care partially relies upon having competition amongst physicians for networks and participating in networks.

In places like Tennessee it is difficult because in certain environments there is no competition between physicians. So for you to have a network that works, you have to have that physician in your network or you can't operate as a comprehensive network. You need to have that hospital in Jackson, Tennessee, or you're stuck. So in that sort of marketplace you don't have any real competition. It is the providers that rule the roost, not the health plans.

Health plans can only really be effective when there is so much competition between providers that the health plans can in fact gain the upper hand.

SMITH: Can we shift a bit to Tennessee? Or is there more on Massachusetts?

REYNOLDS: Well, probably just that for Massachusetts—back on that third point—managed care was a big part of the eligibility expansion, the waiver which provided a substantial expansion for coverage in Massachusetts. And I'd also argue that the unique thing, in some ways, about the Massachusetts waiver is that it was one of the limited number of waivers that tried to cover adults who were childless.

I don't know if you have gotten to this in the history of Medicaid but the big gap in Medicaid and the big flaw in public perception for Medicaid is that Medicaid is not for all of the poor. It is strictly a categorical program. And Lord help you if you are an adult who doesn't have kids and are not disabled or elderly. Because you can't get anything. And that is a real travesty in the health care system.

Massachusetts, at least, made an effort along with a few other states. But only a limited number of states, even waiver states, are trying to cover poor adults. It's interesting because it's exactly that program that was repealed last year by the state's legislature. It has now been reinstituted or will be. Technically it will start on October 1st but there has now been half a year where those people were kicked off the program.

SMITH: Okay. Tennessee, I was talking with Ginger Parra and I got the sense about Tennessee that it was like the Clinton health plan in its theory that if you could move comprehensively, capture health care funds wherever they were, and also expand the program so that you were drawing down a lot of federal match, you could make a go of it. Incidentally, what was your match in Tennessee?

REYNOLDS: Seventy-two percent, though it varies year to year. Let me just say—starting to talk about Tennessee, it would be worthwhile for you to talk to some others such as Manny Martins who was there at the time. I wasn't there during that period, so everything I have to say about the initiation of the waiver is second-hand.

But as I understand it, Tennessee came about because of a unique set of circumstances. Part of it had to do with the failure of the Clinton health plan. So at the federal level there was a desire to pursue expansions at the state level, given the inability of the federal government to move forward.

At the same time there had been a change in federal policy on disproportionate share. A substantial tightening, an effort to tighten disproportionate share. Let's put it that way. Tennessee had been running

a fairly expensive hospital payment system that brought in about $400 million in payments to Tennessee that were soon to be disallowed under the new federal rules. So Tennessee had a looming fiscal crisis in terms of federal revenue stream.

SMITH: One of the purposes under this waiver was to save your DSH money.

REYNOLDS: Exactly. There is a third element in the story—that again is all second-hand—that has to do with the passage of NAFTA, and the state's ability to contribute one more Senate vote to support NAFTA. Then again, this is second-hand, so I don't know how valid that is.

From the state perspective they needed to protect this revenue stream that they were otherwise going to lose. And from the federal perspective there were reasons to pursue an expansion of health care coverage. So a deal was struck in the form of the waiver whereby the federal government would basically allow the state to continue receiving those monies and use those monies to cover new individuals.

Now, one way for the state to be able to cover more individuals was to make sure their cost per individual dropped. And that's where managed care came in. It happened in a fairly aggressive form in Tennessee. The waiver agreement was concluded about three months prior to implementation in January '94.

I think many of the people who were there in the program at the time would have said that they had to do it quickly. If it didn't happen quickly it would have never happened at all. There would have been too much opposition. But of course the providers in Tennessee would say we woke up one day and it was here and it was implemented horribly.

And indeed, when the program started the so-called HMOs, managed care or MCOs (managed care organizations) weren't even managed care organizations. Some of them were created out of the ether almost.

I mean, there were a few of them that had been operating before and a few others that were created for the sole purpose of TennCare. Now, in Tennessee you had very low managed care penetration, unlike Massachusetts. So doctors were not used to managed care at all. They had heard about managed care and it didn't sound good. And then one day, literally, this thing happens because it happened very rapidly. The federal

approval happened and the legislature gave a blank ticket for Governor McWhorter to implement it.

The legislature gave him an opportunity to implement this without asking for a lot of detail. And so in the end they felt snookered by it, too. They felt they didn't know the whole story. So that created tensions later on. It happened very rapidly. State approval happened rapidly. Federal approval happened fairly rapidly, and then it was implemented exceptionally fast. So literally about three months after it was approved it was implemented.

SMITH: What about the role of now Senator Bill Frist? Is he the genius behind this scheme?

REYNOLDS: No, no, he wasn't involved at all at the time. Al Gore moved over in '92 and then there was an interim Senate member. And so I believe in November of '93 was the special election that put Bill Frist in office to take Al Gore's Senate spot. So Bill Frist wasn't involved in any of this at the time.

His role comes in much, much later.So the program in Tennessee started with a bang, a bang which providers hated, because they hated managed care but also because there were a thousand things that were—you know, any implementation that happens that fast there would be a thousand problems that occur in procedures and the fact that the health plans weren't really existing MCOs, health plans, managed care organizations.

And it took them a while to even act like managed care organizations, to do all the things health plans do. So, it was a difficult start—

SMITH: It's not easy. Just because you are in the health care business doesn't mean you know how to run an MCO.

REYNOLDS: Exactly. It really is a different experience for everyone involved. So I think the transition period in TennCare took a long time and a lot of the effects still aren't over. The provider community remains so angry about the implementation of the program today that it is hard sometimes for them to sit down and talk about anything else.

I am overstating a bit but that feeling of "we were left out" remains strong in the program and a constant worry that they are continually left out and can be left out tomorrow.

SMITH: Sort of like Hamlet. "What ceremony else?"

REYNOLDS: So—yeah, quite true. But, you know, truer for them because providers have had more of a role in the past and generally are much more at the table in changes that are made in Medicaid programs than occurred in that change.

SMITH: But you would expect that in a relatively small state.

REYNOLDS: Well, Tennessee isn't really a small state. I mean, it's a fairly mid-sized state, a little less than mid-point in terms of population, but not by much: 5.2 million. Geographically it's a fairly large state. It still takes nine hours to drive from Memphis to the tri-cities area in the northeast.

There are four decent-sized cities, although there's a lot of rural area as well. So, most of the rural areas have an urban core as an anchor. It's not that small of a state.

And there are a lot of differences politically. A large breadth of political opinion. You have the very, very historically conservative northeast Tennessee. In fact, most of the people there were pro-Union during the Civil War, and were small freeholders. And then the exact opposite is Memphis, where you have a lot of issues that are historic, again based on issues such as race. And it was a large plantation area before the war. So you have portions of the state that are very liberal and portions of the state that are very conservative.

And then you have everything in between. So you have a much broader breadth of the political opinion in debate in some ways there than, say, in Massachusetts where I think really the scope of political debate is narrower because the state is more uniform than it is in Tennessee. It also makes TennCare remarkable for having ever started or having ever been sustained, because there are many forces in Tennessee that would love to get rid of TennCare. A lot of the providers hate it, for a combination of reasons. Some of it is how it started and their lack of participation. A second reason is the very low rates of payment, substantially below market rates.

Of course, that's true for Medicaid programs everywhere, although the Tennessee Medicaid program is something like the second lowest in the nation in terms of its cost per person served. Part of that is utilization but part of it is that provider rates are relatively low compared to other states. And providers don't like managed care in Tennessee.

Without TennCare they could reasonably believe there will be no managed care in Tennessee. They would have effectively stamped out the beast. I mean, only about five percent of the commercial marketplace is managed care in Tennessee. About 27 percent of the population of Tennessee is on TennCare. And so together managed care represents a third of the marketplace in Tennessee. However, if you got rid of TennCare you would have practically nothing.

SMITH: When McWhorter goes out, and Sundquist comes in as Governor, I have the impression that there is an attempt to roll back TennCare or various kinds of assaults on TennCare, such as carve-outs and people, as Ginger Parra put it, people finding special protection for every kind of body part and things of that sort. What about the picture under Sundquist?

REYNOLDS: Well, again I am speaking second-hand. So I offer that as a caution. Sundquist had, I think, a very interesting relationship with TennCare in that from what I can tell, for a long period of time he was never particularly friendly to the program. He didn't like the program at root in many ways. At various times he thought of substantially modifying the program so that it wouldn't—it wouldn't have some of the characteristics that it does have.

But in the end, in his last years, he ended up deciding that fixing TennCare was going to be one of his primary objectives. In his last administration that was one of his primary objectives.

And so he really invested a lot of time and energy in trying to make sure that its management was improved; and he wanted a new waiver to be constructed that would relieve some of the tensions in the program. So I think he had a very complex relationship with the program.

SMITH: So it wasn't a clear, straightforward thing. It was more mended, not ended.

REYNOLDS: I think so, and something that evolved over time, too. Certainly there were TennCare directors that were almost opposed to the program during its history.

And those people were appointed by Sundquist, people who came in with a desire to basically ramp down the program and cover fewer people, to make some fairly substantial changes which were against the core notion of the program, which was to cover a broader group of people.

SMITH: They did cut back substantially. I mean, they did stop trying to just cover all the unemployed, did they not?

REYNOLDS: Yes, that change happened with a new waiver that was put in place in July of 2002 and was implemented just as I left.

SMITH: What was your experience when you were there? I mean, were there serious attempts to dismantle it or was it more just an attempt to amend it?

REYNOLDS: I think in the background there was that a lot of people always said, "We hate TennCare. We hate TennCare. It should be totally revamped." And some of those arguments were expressed very openly. Right-wing talk show hosts would openly say, "Just dismantle the program." The Republican gubernatorial candidate effectively said the same thing during the election.

In practice, the reason TennCare has survived is that the state doesn't know how to live without it. None of the critics on the right, at least, have figured out how to replace the funding stream that TennCare secures. Without TennCare, if the state would go back to the regular financial arrangements and it would lose some of the special arrangements that originally secured that $400 million.

SMITH: For example, the DSH. They would lose a lot of DSH money, I assume.

REYNOLDS: Well, it's not technically DSH money any longer. But, yes, that money which once was DSH money would be lost if—

SMITH: You say it is not technically DSH money anymore?

REYNOLDS: Under the waiver, the waiver re-based everything. I mean, it's no longer contingent on DSH characteristics. It is not specifically money for special hospitals. It is simply part of an overall agreement under the 1115 waiver for Tennessee to live within a certain budgetary restriction.

SMITH: Does it come about in this kind of odd budget-neutral sort of way? I mean, that money is there because it's still budget-neutral.

REYNOLDS: Absolutely.

SMITH: That's the deal?

REYNOLDS: That's the deal. Now, Tennessee is a different waiver from other states; it's unique in a lot of ways. Part of it is it was the first major 1115 waiver.

Most other states have a waiver in which the budget-neutrality calculations are not based on the population served. In other words, if your population increases within the eligibility parameters the state isn't held liable for that increase in population. The state is held liable if the cost per member increases or sometimes if your mix of population changes and your average cost increases.

Tennessee has what is called a global cap, unlike the other states, so that there really is an aggregate of money that Tennessee is allowed to spend. So population growth is a problem under Tennessee's waiver in a way that it isn't under other states' waivers. And that was not a problem at all in the early years of TennCare because spending was substantially below that cap. But it has become a problem in recent years, with Tennessee's combination of continuing eligibility growth and cost inflation.

They are also burdened by having non-waiver expenses accounted for under that waiver ceiling calculation. For instance, nursing home care is not one of the waiver services. It's not under the waiver package. If you are enrolled you can still get nursing home care but the benefit is not modified somehow by the waiver.

In Massachusetts, the service side works the same way. In Massachusetts you will still get nursing home care if you are in the waiver but the service itself—long-term care is not part of the waiver. The difference between the two states is the financing side.

SMITH: So does that mean that it's simply funded as ordinary Medicaid?

REYNOLDS: Yes. In Massachusetts the long-term care component is funded as ordinary Medicaid. It is not part of the 1115 waiver. In fact there are also other waivers, the 1915 waivers, that are in place.

In Tennessee, although long-term care is managed separately, spending on the long-term care side counts toward the waiver ceiling even though it is not part of the waiver. It's very different from other states and is rather painful for Tennessee at this point in time.

Early in the program it actually helped Tennessee's financial calculations because long-term care costs, which in Tennessee are almost strictly nursing home, were substantially below the overall growth expectations in the program. But...the inverse has happened, so now because of costs, population and such. But for a long time that was actually a benefit to the program. It's odd because those services aren't actually part of the waiver and yet they count toward the waiver ceiling. So any spending that happens in Title 19 in Tennessee gets counted toward the waiver ceiling.

SMITH: So this, at this point, must put terrific pressure on TennCare.

REYNOLDS: Yeah, it definitely creates terrific pressure on the program. And it has some advantages for the federal government. Tennessee has been much less aggressive about revenue maximization for just that reason, where all other states have put a lot of effort into school-based health programs, et cetera, in an effort to find more things that are federally reimbursable, which is another big part of the history of Medicaid. A lot of what states have done has been—have been over time to find more things that are federally reimbursable. A whole industry has been created to do that. And that's a big part of the growth of Medicaid. Which is good in a lot of ways, but also bad from a federal perspective. Tennessee hasn't had an incentive to do that because in fact all spending for Title 19 goes toward the ceiling. So you are stealing, if you give money to one thing that should be available for something else.

SMITH: Well, what kind of update is there for that ceiling?

REYNOLDS: It's a calculated ceiling.

SMITH: It's a calculated ceiling. And what is the inflator? Is it medical inflation or CPI or what?

REYNOLDS: There had been one ceiling which was a negotiated ceiling. And there is a new ceiling under the new waiver which is also a negotiated ceiling. The federal government at the time—this is in the spring of 2002—was using the estimates of aggregate nationwide Medicaid growth that OMB created which I believe weren't very generous or very realistic, given OMB had under-predicted Medicaid growth consistently for the prior years. But anyway, that I believe is what is now in the current Medicaid waiver, I believe that will be continuing pressure for the Tennessee program. They are not based to an independent figure that moves like the CPI.

SMITH: What would you see as the successes of the Tennessee program and why? How did they come about? It seems to me they got a lot of coverage for people in a pretty desperate situation and that they did get something resembling a viable managed care system in place and they did it rapidly in circumstances in which you might have thought it was impossible.

REYNOLDS: Exactly.

SMITH: But nevertheless there are some ways in which you simply can't escape the hard realities of life.

REYNOLDS: Right. And that's, I think, the current situation. The great thing about Tennessee is Tennessee decided to use... They were going to lose the federal money if they didn't do something, but still took on the challenge of trying to cover people who would otherwise not be covered with health care.

And they have provided coverage in a substantial way which is argued about strongly in Tennessee. I mean, there's an argument that says these people don't deserve this kind of assistance. But I would argue those people do deserve that kind of assistance, and that Tennessee has a fairly fragile health care net in a lot of the state, certainly in the rural areas and such, that needs help to survive.

There are a lot of people that didn't really have appropriate health care. Tennessee through TennCare was able to cover a number of people who weren't covered under the previous Medicaid program, who couldn't be covered under a normal Medicaid program expansion, and now have health care that otherwise they would not have, which makes their lives better. It really has improved part of what Tennessee can do for people, unlike a lot of surrounding states in the South. People are able to get better medical treatment in Tennessee than in some of the neighboring states. So in that sense it is a success story.

Where TennCare has problems is with the inherent tensions built into maintaining that. Nothing comes for free. So there is continuing tension over how to realize enough efficiencies to be able to afford to do all that in a state that has also become more conservative over time politically. It was a state that had a much more competitive two-party system in the early '90s. Now—maybe I'm overstating the fact—but certainly for a while all the major statewide elected officials had become Republicans. That said, a Democrat

did win the gubernatorial race last time. And the state legislature is still primarily Democratic. So it still is a two-party state, although I think

Tennessee has become more conservative over that period of time. And so it is still interesting that a program that is as generous, as liberal as TennCare, survives in Tennessee, given the political characteristics of the state.

SMITH: It must have gotten a lot of political support that was latent. I mean, people must have thought, well, we really depend on this and we like it. I have had the sense that there was almost a kind of a populistic undercurrent here where people say, "Don't take our health care away."

REYNOLDS: Oh, I think that's definitely true. I mean, once you get to the hard question of—are they going to take TennCare away—there's suddenly a lot of losers. Twenty-seven percent of the state is served by the program.

That is twice everyone else's program. And Massachusetts is pretty big and there are 16, 17 percent in the state covered by the program. Most states have about 10 percent of the state covered by the Medicaid program. And they are, of course, the most disenfranchised individuals. TennCare may have a lot of disenfranchised individuals as part of its program, but it still has more than one out of every four people in the state who are seeking benefits. So you have a pretty strong political base for support of the program.

SMITH: Is this support spread all across the state? Does it reach effectively into the relatively rural regions and small towns?

REYNOLDS: Absolutely. And in fact, rural areas are more likely to have high TennCare percentages than urban areas. The counties that have the most TennCare coverage as a percentage are generally in rural areas.

SMITH: Under the constitution, is there a big county responsibility?

REYNOLDS: Well, there is and there isn't. I mean, counties play a much bigger role than in some states like Massachusetts and there is certainly the organizing principle out there, but the county government itself isn't involved in the Medicaid process and in funding, such as in New York or California. It's somewhere in the middle if you look across the states.

SMITH: In contrasting Tennessee and Massachusetts, of course one of the items that strikes you is that Massachusetts is a provider-rich community. There are all sorts of providers and all sorts of networks. And Tennessee is somewhat the other extreme. Does this make a big difference in how things operate in the two states?

REYNOLDS: Absolutely. On the provider side of the fence in general there is much more conflict in Tennessee than there is Massachusetts for probably a host of reasons. One is again that the startup of the TennCare program was viewed as a real shock by providers. Part of it is, relatively speaking, Tennessee's cost per individual is fairly low. So that creates more tension with the providers, although Massachusetts hospitals are among the lowest paid nationwide, compared to what their actual costs are. But the relationship with the providers there is very different, and the practice of medicine is different. There is a lot different about the provider community here. It may have to do with the competition and the overlap. There certainly are more providers here. There has just been less tension between providers and the program in Massachusetts.

SMITH: In Massachusetts there are a lot of doctors that are still largely oriented toward academic institutions and a philosophy of giving care.

REYNOLDS: Yes. In Tennessee, you definitely have providers that are willing to deny care if push comes to shove. Not everyone. Not most of them. But enough of them, and they are vocal. They are the individual providers, if they are the only physician that is treating that sort of condition or doing that sort of surgery in an area they will use that to say, "I'm not going to serve TennCare patients." And make a big stink about it. Culturally, that would not be considered appropriate in the provider community in Massachusetts.

SMITH: Right, right. And you may be in a monopsonistic position in Tennessee—as the sole purchaser here, but a lot of these other guys locally are in a—

REYNOLDS: A monopolistic position. Exactly.

SMITH: And you find yourself butting heads and it doesn't work very well.

REYNOLDS: And that is just less true in Massachusetts. There is more competition. It's not entirely true because certain health care institutions are viewed as necessary here, particularly some of the big hospitals. Every

health plan has some of those hospitals at work. And so they have a very strong, almost monopolistic role. So it's a combination of the market place and also the culture, I think. Culturally a provider would have a hard time standing up and saying, “I'm just not going to treat that patient -–“ in Massachusetts in a way that it can happen in Tennessee.

SMITH: Do you think they made any big mistakes? It seems to me that many of the hardships with TennCare were almost inescapable under the circumstances and you probably had to move fast or not move at all. It seems to me that was probably an appropriate judgment. Do you think they made any big mistakes along the way?

REYNOLDS: Well, they certainly moved fast. That probably had to happen. But probably more planning would have helped. Apologizing more probably would have helped in terms of gestures and finding common ground. But I think a lot of the tensions are inherent in the way the program works.

And other tensions might have arisen anyway. There is a lot of political pressure on the program toward the left, not just the right. The advocacy organizations in Tennessee have been very aggressive, particularly in the courts. And Tennessee state government is not regarded very well by the federal courts in a way that, for instance, isn't true in Massachusetts. There is often an assumption, from what I can tell, in the federal courts there that Tennessee can't do anything right. So it's a lot easier for advocates to win in federal court than it is in, say Massachusetts. So the left has been fairly aggressive with Tennessee in trying to hold the state accountable for standards of operation for eligibility procedures in particular. And I think Tennessee is held to higher standards than some other states in terms of those procedures because of that process.

More care should have probably been exercised by everyone involved in the program at the administration's level over the years, trying to work harder with a variety of constituencies. We have talked about the providers. They are one group. Another group is the advocates, at least when I left a year ago the tensions were fairly high...

It felt that, on the one hand, there was huge pressure on the part of the talk show hosts and the public to pare down TennCare: the worry that there are all these people in the program who shouldn't be, that you hear about regularly on the street in Tennessee. Conversely there is the advocacy view that says we are not going to let the state move very fast to remedy any of this.

SMITH: Is there an individualistic hill country sort of mentality about some of these things? People should take care of their own problems, take care of themselves—

REYNOLDS: I think that's true. If anyone wants to talk about issues of the universal health care...Tennessee would be an interesting place for people to focus on. Because I think it reflects a lot of the tensions inherent in that debate nationwide.

SMITH: Before concluding, one of the topics I wanted to ask about is how Massachusetts deals with relations with the safety-net providers and the tension between them and managed care.

I remember Stuart Altman got together a book talking about the plight of the safety net providers. And this often would include medical schools and federally qualified health centers, and public hospitals. And he stressed especially the threat created by the health plans.

REYNOLDS: That tension...is prevalent in Massachusetts. Again, some of it is cultural, some of it is that the health plans didn't try to direct clients to different hospitals. But there has been some tension. There is increasing tension today in Massachusetts between the safety net hospitals and community hospitals with the teaching hospitals being somewhere sort of on the middle ground between the two.

There are two things that happened as part of the waiver. The federal government agreed to pay some bonus payments added onto to managed care rates for health plans established by the two safety net hospitals. So within the Medicaid program today, Boston Medical Center and Cambridge Health Alliance both have health plans. Those health plans, through the waiver, get additional payments for every person.

SMITH: That was transitional money, I take it, or something—

REYNOLDS: Well, in theory it was. Bruce Vladeck is the one that actually created that and was pushing for it because he was worried about the safety net facilities. It was designed to be transitional but in reality it's hard for those hospitals to survive without it. The second thing is, Massachusetts has supported the safety net hospitals through an uncompensated care pool established in the '80s. It is under the greatest strain ever today and the tension mostly is driven by the community hospitals who are facing financial

difficulties. The way the system is set up, most of the money goes to the safety net hospitals.

SMITH: So it's a tax on them for the benefit of these safety net hospitals.

REYNOLDS: Exactly. They have recently been able to tip the hospital association to support their position and that has led to a lot of controversy—a debate that has basically been postponed right now. A temporary resolution had been in the state legislature this year but one which is not fully resolved.

There will be significant pressure and it will probably be increasingly difficult for those safety net institutions to be able to get sufficient funding or funding that they are used to without significantly modifying their practices.

SMITH: For all the bad press, DSH took care of a lot of problems.

REYNOLDS: It certainly covered a lot of issues. Let's put it that way. Well, and that's the thing. I mean, if you step back and look at the past decade, DSH became a very big funding tool for safety net institutions at federal expense. But you will also notice that when Congress had the chance to roll those things back it never did. It might have capped them but it never repealed benefits. And I am not sure they would want to. Once they see what the cost of rolling them back is in terms of the impact, that's a very difficult situation.

SMITH: Well, anything else you think of, Mark?

REYNOLDS: I don't know, you were talking about the future, and where we were headed. It's certainly true that we are now in that next down period in the fiscal cycle which is something that Medicaid will always face as long as it is a program funded in a large part at the state level. That is just something that is inherent in the program's nature...that cycling, which causes problems because you have expansions, contractions. You have each of these cycles. It does mean the states have to think harder continually about maintaining a balance, cost control versus quality versus coverage issues. Those are constant challenges.

SMITH: Do you want to continue being part of the struggle? Do you think of yourself as a lifer in the Medicaid program?

REYNOLDS: I'm outside the Medicaid program right now. I'm not really doing much health care at all in this current work. But what I'm doing right now is temporary.

SMITH: Thank you so much for speaking to us today.

INTERVIEW WITH SARA ROSENBAUM
JUDY MOORE AND DAVID SMITH – MAY 6, 2003

SMITH: This is an interview by Judy Moore and David Smith of Sara Rosenbaum on the 6th of May, 2003.

To start out, we wanted to hear a little bit from you about some stages in your career.

ROSENBAUM: Sure.

SMITH: For example, after law school were you involved with the Health Law Project?

ROSENBAUM: Well, yes. I actually started life very briefly as a public defender.

SMITH: Which was where?

ROSENBAUM: In Boston. And I didn't like being a public defender. I felt as if I sort of came into the picture at—you know, what Stephen King calls the end of the road.

And it was all over by then. I had gone to law school and needed to do public interest work. And I was beginning about the time the Legal Services Corporation(LSC) was first established. We were now into the full-blown legal services movement. It had grown up from its MFY days.

And at the same time LSC was established, the Older Americans Act was passed and several other programs that pumped money into legal services. I interviewed for a job with Vermont Legal Aid. This was, of course, when VISTA also gave money to legal services programs.

A great wave of us who came into legal services came in with our first year as VISTA lawyers. There were two kinds of VISTA lawyers. There were national pool lawyers and there were lawyers hired by programs that got slots.

So I got hired by Vermont Legal Aid and six of us from VISTA started at the same time. Basically, we arrived at the first day of work and they said, "Well, you have got the upper tier of the state." And I just started riding

circuit and rode circuit across almost from the Champlain Islands down the valley and then over pretty far to the east.

All of my clients were, of course, exceedingly poor. And because they tended to be older they were quite ill or had lots of health problems. And without ever planning on it—I certainly knew nothing about it—I developed a health law specialty because I was dealing completely with Medicare, Medicaid, Hill Burton, and the University of Vermont.

A lot of the initial work, as with so many legal services lawyers, was collection actions, sort of defensive maneuvers. But if you learn anything at all, you learn that there are these services and benefits that your clients are supposed to be getting.

I went out on the American Legion circuit where they would serve the lunchtime meals. I would ride with the Older Americans Act people who would go out to do social services. And I would bring wills forms because I discovered everybody—it was like getting a door prize—everybody wanted a will.

So I went to the legal forms store, bought some wills forms and would write wills for people, and in the course of writing a will talk to them about, you know, what else they had. It was sort of a particular form of outreach. I didn't go through some outreach course, but it just seemed like the natural thing to do. And so I developed a health law specialty and over the course of that time met a lawyer from the National Health Law Program who was in Vermont working on one of our health law cases that was like a very early EPSDT case—one of the great early wave of cases. He encouraged me to apply for a job with the National Health Law Program (NHeLP) because he said, you know, there are a lot of us there who sort of came to NHeLP with some specialized knowledge, but we don't have any neighborhood lawyers at the moment and we really need someone with that kind of background. So that is when I went to NHeLP. And I spent a couple of years at NHeLP. And the big issue that I developed for them—and I was so excited—I went off as an insurance lawyer.

By then I was doing Medicare and Medicaid full-time. I was brought in as one of the two Medicare and Medicaid lawyers. Then, in 1977, Congress passed this strange thing, which I was given the assignment of writing about, called the Rural Health Clinic Services Act, which led me to uncover the supply side of health policy, but from this remarkable group of people attempting to build clinics and doctors working in underserved areas.

So I got into the business, for NHeLP, of working on what was the Carter Administration's big, southern, rural health expansion to try and reach out to the Texas-Mexico border and some of the poorest areas, to get community health services going. That was taking a huge conceptual leap. It was that, because while I would always define myself as an insurance lawyer first and foremost—that's my technical specialty, that's what I teach, that's what I know—what I love is the point at which the payment system meets delivery.

The other thing ironically that helped me in this life lesson is that one of the big bodies of litigation that I inherited when I came to the National Health Law Program was the huge mess with managed care, which was now in its winding-down phase in California but which was still going on. I was suddenly a lawyer on cases. And I saw the merger of payment and delivery in its worst light. So intellectually that was really my base. I also ended up doing a lot of work on what was at that point the Carter Administration's child health expansions.

After a couple years at NHeLP, I got a call one day from staff of the Children's Defense Fund, who said we need someone to head our health work. At that point my husband and I were thinking about moving back East. We both worked at NHeLP. And we couldn't both be in the East Coast office; it was too little.

So we agreed that the first one of us who got another job would go. So I said sure, I'll go. And that's how I came to do child health work. My specialty was Medicare, Medicaid, long-term care, aging, service delivery. I was the designated hitter for Legal Services on child health because I knew the Medicaid program.

But I didn't come to child health work because I had been steeped in it—in fact, my first reaction to the whole thing was children's health people are really rather weak. They didn't know anything about insurance. If I would ask them about child health policy in the U.S. they kept telling me about something called the Title V program. I finally sat down and flipped through the statutes and found this miserable—You know, it's a lovely little program but compared to the behemoths I was used to, this was nothing. And so I think I was one of the first children's advocates who came, ironically, from a strong insurance background.

The people who were at the Children's Defense Fund, Elizabeth Shore and Wendy Lazarus, Judy Weitz, were wonderful, really, maternal and child

health advocates. They weren't insurance lawyers, which is by then what I was.

I think at that point the whole discussion sort of changed because we were really in the course of reforming the insurance system. And luckily, the most important thing was that at that very moment in time—we are now up to about 1979—the magical commerce committee staff was being finally assembled.

And there you had the collective brainpower that understood that when you talked about children the issues were just as big and serious. It was about financing and insurance. And ironically, of course—and somebody once did a little story about this—it was the National Health Law Program populating offices everywhere.

There were people, of course, working for Karen Nelson. There were people working for Congressman Henry Waxman, advocates, and we all were very committed. Most of us were health lawyers or something like that. Many of us had been trained as insurance lawyers.

And so it was a different sensibility from what it was like when I spent time with Vince Hutchins or Jonathan Kotch or Woodie Kessel or other key figures in child health policy. It's a very different cut at the issue.

SMITH: Is another way of saying it that you came out of child health into the mainstream of Medicare and Medicaid?

ROSENBAUM: I was a Medicare/Medicaid lawyer who found child health.

SMITH: I mean when you joined up with Waxman and all.

ROSENBAUM: Right. Or up until then a lot of children's advocacy had been very conventional—from the vantage point of community health who arrived at insurance. Whereas I was an insurance lawyer, who came to child health. And I think that if you had to define Henry's committee, it was the same thing. They were a financing committee that tended to think about populations.

It took me a while to learn that you really had to be able to think both ways at the same time, that one side informed the other. What was good policy for children at the third and fourth order. I mean, everybody has to be

insured, but the design of insurance is very different for children from what it would be for adults, say. Their needs compel different types of financing. The other huge influence on my life, I have to say, happened to strike at the time that I went to the Children's Defense Fund, and that is when I had my daughter.

Suddenly, everything that I had been doing as a lawyer then took on a different meaning. Once you have a child you sense the great ethical drive, because they simply have no control over their environment. You know, you no longer have to read reports to understand how much the issue really matters.

And of course, indisputably the other was working for Marian Edelman. I mean, she is just an extraordinary person. Very complex. Of course her roots are like mine. I mean, that was one of the reasons I think that I so reverberated to her. Here is the civil rights lawyer who had essentially moved to a whole different level of thinking about issues, a place that I never went.

I mean, we are very different in the sense that I am not driven by religious beliefs or the kind of moral framework that drives her thinking. But a lot of what drove her, the urgency of her work I think had a great impact on me. And she remains in my professional existence, the most important influence I would say.

SMITH: But now in the Children's Defense Fund, how centered were they on health, and how much was it—everything that dealt with children?

ROSENBAUM: Well, the roots were education and Head Start. Everything else—I mean Marian is sort of like the Pied Piper. So, you know, she was very friendly with Lee Shorr. She picked up child health. She uncovered Mary Lee Allen when she was working in Mississippi on the recovery after Hurricane Camille and then picked up child welfare.

The story is of Marian knowing that she had to be concerned about the whole child and then finding ways to move there with staff whom she trusted. By the time I came to CDF, the notion of children's health was very much there. Of course, the very first study was “Doctors and Dollars Are Not Enough,” which is the funniest thing because when you read it, it is all about community health centers and maternal and child health clinics and real public health delivery stuff.

And then came “EPSDT: Does it Spell Health Care for Poor Children.” And I came just as “EPSDT” was being published and they were positioning to start the big push as part of the Carter Administration's initiatives around Medicaid reform, sort of the lesser initiatives accompanying national health reform issues they were waiting on at that point.

They were doing lots of stuff but I would say that they were—even far worse than Clinton. They just spun their wheels and spun their wheels and spun their wheels and then made the wrong choice and then the effort collapsed.

So this is where I entered.

She was very interesting. I would say Marian's original work did not center on child health, although that came to be her life. She tended—you know, like a lot of people in her position, very focused.

And so it was kind of hard, though we were quite close. If I would come to her and say there is an important issue, she would usually let me work on it.

In 1979 the Carter Administration published—redid all the Hill Burton regulations, a very important set of reforms. Comments were needed as this process was going on. I drafted a letter having to do with the importance of some change. And I brought it down for her to read and sign and she, of course—she had legendarily very horrible handwriting—she wrote this whole passage about when she had been an attorney in Mississippi and travelled with a man who was a victim of a gunshot wound, from hospital to hospital, and couldn't get him any care. So, I mean, when these things happened you would see that it drew back on her history.

MOORE: I associate you almost entirely with EPSDT in those years and in the early—

ROSENBAUM: From '78, really, to '92. These were the years of the big reforms in the program. Of all the things I did, this was the most important. When I retire, and am thinking back on my life, EPSDT is the thing that I feel the greatest about. These changes, in particular the 1989 amendments, really are hanging by a thread.

It was not so much the eligibility changes because once the changes began, it was all a cakewalk. We barely had to lift a finger to do anything.

Once Senator Dole, David Stockman and John Dingell, and Henry Waxman sat down and with—I'm sure with the support of Congressman Rostenkowski and Pete Stark—worked out the first deal that involved taking some of the Medicare savings and plowed them back into those initial teeny tiny expansions, then it was set—then suddenly every year there were more pieces.

SMITH: Well, this was the sort of Waxman two-step that was—

ROSENBAUM: Yes. Every year we would figure out some other way to bite off some other piece and then we could count on somebody else coming in and saying, "I'll see you one and raise you." And everybody got on the expansion bandwagon from '83 to about '88.

And then in '89, of course, the poverty level expansions were put on a mandatory phase-in, which was great. But the thing that to me is the deepest, most important change in Medicaid is the EPSDT amendments of '89 with that benefit design for children.

We can ration for other people but for the very poorest people in the society, which were poor children, care that was clinically appropriate should be paid for. It didn't matter if it was preventive, didn't matter if it was primary. It didn't matter if it was long-term.

SMITH: We actually got some Rawlsian ethics in medicine.

ROSENBAUM: That's right. And that to me is still the single greatest statement of child health policy the country has ever committed itself to. And one of the things I'm finding very painful at the moment. My gut instincts have always been at the side of children who—we call them children with special needs—children whose need for resource investment is way above the norm. If we do nothing else, we should make it possible for them to grow and develop.

And so to see people hauling out anecdotal factoids the way they did with SSI children in '95, to unravel the treatment available through the program. I find this very painful. Because it's so little money. It's not anything that anybody is going to miss.

MOORE: How do you think it's unraveling?

ROSENBAUM: Oh, I think that if any of the reform proposals that are on the table—well, I mean, there are sort of two visions of Medicaid reform. Our vision is that you would take the things that are best about Medicaid, which is its ability to go where the market won't go, the populations and services that simply cannot be covered by regular insurance—they will never be. It's not a matter of reinsuring people or anything. This is way outside the market.

Our vision would be to take that part of Medicaid and grow it to be able to do for any person with functional limitations who needs supplemental coverage, to have a program that does for all people what it can do for children. And I wouldn't even really think it was the end of the world if the defined benefit entitlement for normative needs were converted into premium support, so that we would buy everybody a standard benefit plan with Medicaid as a supplement.

Medicaid would provide supplemental coverage for these kinds of functional needs. I'm afraid though that such a model requires a fair amount of up-front investment, so that it is not going to be. I'm sure that if we have a Medicaid reform bill later this year, the model will push for eliminating the benefit design of the program for people with disabilities. That's where the money is. I am sure that the model will be premium support. Again, I don't think there will be a whole lot of argument. There certainly won't be an entitlement anymore. I must say, as a lawyer, the things that I feel most strongly about in Medicaid are its entitlement status and its benefit design.

And both of those I think are so unpopular at this point for reasons in all honesty, I don't think—it's not the cost. We fritter away way more money in this country on unnecessary things. If you look at the Administration's proposal, it was budget-neutral with savings achieved through elimination of the premium and benefit design.

It isn't the cost. It is just like what is going on with appointments to the bench right now. This is an ideological matter. We don't mind tax entitlements. We don't mind wildly expensive tax entitlements. We do mind, as a people right now, apparently, direct support, legal entitlements for lower-income people, whether it's EITC for one or—you know, direct spending.

And so I think this is all about entitlements. We are not even, despite all the rhetoric, for federalism other than the fact that the word is constantly

misused. The concept doesn't mean what it has come to mean. It is not simply about state autonomy.

We're simply abandoning certain populations and obligations. So somehow all of this depth of belief that drove the '60s and a lot of the '70s has been replaced by equally deeply-held beliefs. But the people who held those beliefs have been much better at expressing their beliefs in ways that sound good.

Those who believe in a social contract have never learned to do that. We have never learned how to express our beliefs. Those of us whose beliefs are shaped by the progressive time of the '60s and '70s—you have never learned how to shape those beliefs in ways that appealed to a large segment of the population.

And I remember when welfare reform happened. A very gifted legal finances lawyer who was mentor to many people named Ralph Abascal put his finger on the problem. Ralph died a few years ago, and had been a long time California Rural Legal Assistance lawyer.

Ralph was the person who got the short-handled hoe outlawed and really a lawyer's lawyer. Brilliant man. He said that one welfare reform law could be laid at the feet of those who advocated for welfare rather than jobs. People were so focused on immediate need that they never learned to talk compellingly about the deeper meaning of what was being advocated for.

It is the same with health care. Why haven't we ever learned how to talk about the value of comprehensive insurance coverage for people with disabilities in ways that anybody could reverberate to? The way people can understand, such as the way people understand why an entitlement to a home mortgage deduction is essential.

The 1989 child health reforms were really all about as a nation redefining what, at least in a health context, we mean when we say we are investing in the health of children.

SMITH: Now, the '89 reforms, would you say perhaps the biggest thing there was getting the T in the EPSDT?

ROSENBAUM: Oh, yes.

SMITH: And who, in your view, was responsible for getting it?

ROSENBAUM: Oh, it was maybe the most brilliant piece of legislative magic I have ever seen. We started with—I mean, we just knew that this had to get done, that there was such extensive untreated mental illness and developmental disabilities among children.

Much of my thinking about it was shaped by the experiences of my colleague, Mary Lee Allen, who was dealing with the unending child welfare crisis and the lack of treatment for poor children.

And so we went to Andy Schneider and Karen Nelson. They said, "Look, here's what we can do. We don't have any money. This is going to cost money. So we'll set up the whole statute for you." We'll set up the bill—everything you see in the law today. The E, and the P,and the S, and the D. They drafted the periodic screening, and all the right language on vision, dental, hearing, lead assessments, and developmental assessments. They got all that done.

We take the structure to the Senate side, where precise structure was harder to achieve. That structure got a zero score because all it did was codify the current EPSDT program. In the Senate Finance Committee, Marina Weiss of Chairman Bentsen's staff played the crucial role. She immediately saw this as her issue. And she said, "Oh, I'll do the T." And so they drafted a companion statute but this one included the T as well as the famous last sentence of the provision. It was a typical Finance committee mark-up —where there wasn't a lot of focus on legislative language. But Marina did circulate draft legislation. And CBO scored it at almost nothing. CBO somehow—I don't know even who would have been at CBO?

MOORE: Was Don Muse still there?

ROSENBAUM: It couldn't have been Don.

MOORE: It couldn't have been Don.

ROSENBAUM: He wouldn't have figured this—

MOORE: I mean, he got in—he sold them this much...doing catastrophic.

ROSENBAUM: Yeah. That was when Steve Long left. So I don't know. It's like nobody was home. It's like there was a vacuum. So they scored the bill as nominal.

SMITH: Amazing.

ROSENBAUM: And so in conference they just took Bentsen's version and Henry receded to Bentsen's version with the "T" and the magical "S" last sentence. Everybody was happy with the choice.

SMITH: Darn right.

ROSENBAUM: When the '89 amendments were drafted, you know how these reconciliation measures go. Nobody sees anything.

MOORE: Nobody sees anything for days.

ROSENBAUM: The language goes to the President. And, you know, the first Bush Administration presided over this. I don't know if you asked, I'm sure Gail would perhaps remember some of this. But if you talked to Don Johnson.

MOORE: The legislative drafter?

ROSENBAUM: No, the legislative analyst at HCFA, at CMS.

MOORE: Oh, Don Johnson.

ROSENBAUM: Yes. If you ask Don, Don must have been the person who read the bill through.

MOORE: Right.

ROSENBAUM: And it just went trotting off and it was signed. And people look at it and say, "Holy moley."

SMITH: What are we doing?

ROSENBAUM: And the states went bonkers. And Marina was very cool about the whole thing. She said, "Look, I showed you the language. Everybody was just asleep at the wheel."

As issues go, it's a teeny, tiny, thing, okay?

But it was like altering the entire insurance design for 25 million people, which is basically what the EPSDT amendments were. And people just couldn't believe it. And it was the only time I've been involved in anything other than FQHC where people thought we pulled a fast one.

SMITH: Uh-huh. Uh-huh.

ROSENBAUM: And there were literally two. There was a House version and a Senate version and the difference was as plain as day. People just didn't read it carefully. And that was all she wrote. And holding onto this change ever since has been hard.

And one of the things actually that I found—I say this because I was working there at the time—one of the things that I found most unforgivable about the Clinton Administration was the cavalier way with which so many people dealt with the Oregon waiver.

Because it was the first waiver under President Clinton, and from a liberal state, to unravel the benefit mandate. Even though they just played around the edges with a ranking system, the notion that the federal government would alter the benefit design that easily was, I found, very unacceptable.

But other than these 1115 demonstrations, and usually they have been limited to the demonstration populations, that is not happening anymore. But in some ways I find it remarkable that EPSDT has withstood the amount of pressure it has because, really, people don't like it. They don't like the fact that you have to cover clinically appropriate services, period.

SMITH: I think there's a number of local agencies that thrive on this.

ROSENBAUM: Oh, they do. And, I mean, local agencies, entire systems—the entire system of financing education-related benefits thrives on EPSDT. And that's been one of my arguments back over the years. If you look at education—if you look at the IDEA program—Individuals with Disabilities Education Act—if you look at the welfare statutes, they all contemplate a very comprehensive Medicaid program.

There is no money in those programs for medical treatment. They all are presumed to key off of a very, very broad medical assistance program, especially in recent years as Medicaid has, you know, proven to be such a big insurer of children.

A paper that Trish Riley and Christy Ferguson and I wrote was meant to express, that, when it comes to children—adults, too, but it is particularly true for children—if you view Medicaid for its policy related to special needs children, you see its strength. States think now they are hurting on their special ed programs. They are in for a world of hurt if this part of Medicaid

is repealed. So, I think that not enough actually has been written about what a major departure in design the '89 amendments caused Medicaid to be.

SMITH: There were the nursing home amendments then, too.

ROSENBAUM: Everything was happening at the same time.

SMITH: Catastrophic repealed, and the dual eligibles.

ROSENBAUM: Yes. It all was happening—at the same—there was so much noise in the system that I think this was just a remarkable change in benefit design.

MOORE: I doubt if there were very many people who really understood it other than the states. And you said states went wild because the Medicaid Directors did understand it.

ROSENBAUM: Oh, yeah. And it was all in the area of mental and developmental. This was because there weren't very many things that people would deny if it was a child with a heart condition. But growth and development issues were huge. And I must say we spent a lot of time after the '89 amendments making sure that there was no hamlet in the United States that wasn't aware of what had been enacted.

SMITH: That's interesting, particularly your mentioning here the importance of EPSDT as supporting, providing filler, wrap-around, all this sort of stuff. We have it for children but we don't have anything like it for adults, do we?

ROSENBAUM: No. And in Medicaid for adults, much is optional. You can use arbitrary limits actually on treatment. There is more cost-sharing. Now, if you ask somebody—if you ask a 40-year-old man with traumatic brain injury who has Medicaid he would tell you that Medicaid is indispensable. But in terms of benefit design, it is much less generous than it is for children, sure.

SMITH: One of the things we wanted to ask about particularly was reflections you might have on health care reform and another was the work that you did on the Medicaid contracts.

ROSENBAUM: Sure. The health reform, I take it what we are talking about now is President Clinton's health reform efforts?

SMITH: Yes.

ROSENBAUM: It's very interesting to me. I never would even begin to be as personally emotionally connected to the debacle that was health reform as I would were Medicaid to unravel.

I would say—I'm sure Karen Nelson would never remember this, ever, ever. But when I started working at the White House in the winter of '93, January of '93, after about a week or two Karen and I got together to have lunch. And, you know, always the optimist, she comes bounding in, says, "So how's it going?"

And I said, "We're doomed. It's all over. We're finished." And she looked at me and I'm sure she thought I had lost my mind, if she remembers this at all. And I will never forget it was Karen I was talking to, because I'm sitting here thinking that she and I had been through so much together and she is going to think that I just checked my brain at the gate or something.

SMITH: Right. Wimped out or something.

ROSENBAUM: But it was evident from the very first day—and I mean the first day that I started at the White House when I went to my very first meeting—that this effort was going to crash and burn in a major way. And the only thing I was amazed at was that we didn't crash and burn way before we did.

Now, I will tell you from my perspective why we didn't. And I don't think that the books have it very right. By May it was evident that there was no plan. There couldn't be a plan. Ira [Magaziner] was not capable of creating a plan.

Everything was in disarray, of course, at that point. The First Lady's personal and family situation, she just lost her father, so everything was kind of a mess at the White House. And Ed Grossman, Peter Budetti, Greg Lawler and I and a couple of other people essentially decided there would be a plan.

There would be a plan because there would be legislative language—we would take everything that these people had produced and we knew what

they wanted. I mean, it was very clear. And of course the two most important intellectual forces were Larry Levitt and Gary Claxton.

And we sat in a basement from May to November and all I did was sit in the basement 16 hours a day, every day. And we drafted 1,361 pages. We produced the plan for them. We produced the document they needed from which they then could write their pamphlet to show that they had a plan, and make their security card, and all that.

The most interesting moment came about a week—I mean, I can't tell you what a horrible time in my life this was. It was a horrible experience. This is the one time I ever went to work for the government, and it was truly a horrible experience.

And about a week before the bill was completed, we were all in the basement—this must have been 2 o'clock on a Saturday morning trying to write this bill, it was around that time that I would say Ira figured out that the real thing was happening down in the Cannon Building.

And he demanded to start meeting with us. But he couldn't get in, because he discovered that his White House pass was good for nothing down there, and in the middle of the night Ira was screaming into the phones, so we disconnected all the phones in the legislative counsel's office and all the fax machines so that he couldn't communicate with anybody.

Ira attempted basically to destroy me quite personally within about a month of my starting there because he suddenly realized that here I was leading the drafting group. Here he was with the plan. I didn't answer to him. And he finally had to back off and leave me alone for reasons I don't quite understand.

And it was through Larry and Gary's knowledge of managed competition, how to structure it, and Ed's genius, with everybody just sort of sitting in this basement writing hundreds and hundreds of pages, pulling in people as we needed them: when we needed the fraud and abuse people we would bring them into the basement; when we needed the graduate medical education people we would bring them into the basement. The tax people—the tax people sort of came into the basement when they wanted to come into the basement.

The defense department people never went to the basement. Actually, there was an emissary group dispatched to go to the Pentagon to pick up the

language. But that is basically what we did. I remember standing in a room—it was the only time in my whole life, in almost 30 years of practicing law, that I have cried.

I stood in the West Wing and cried and cried and said, "I can't." This was May. There was no plan. I was supposed to draft a bill. I knew in order to draft a bill I needed specifications. I stood there and cried. I said, "I can't do my job."

And Ed kept saying, "If you don't come back with specifications we can't do anything." And finally when he realized in his kindness that I wasn't going to come back with anything he said, "Well, let's just sit down and write it." And so we did.

And that's why the President had a plan. That's why there was the bill.
It was never spoken about that leg counsel had basically produced this whole thing for them. I'm sure if you ask Senator Clinton today, or the President, how they came to have a bill, I don't know that they would realize quite how this all happened. But this is what happened.

SMITH: Fascinating.

ROSENBAUM: And I am also convinced that had we not produced a bill, somebody finally would have prevailed upon the President to do the right thing and send a two-page letter with some statement of principles. And we might have had a shot.

It was by producing this 1,361-page bill that we gave everybody who opposed reform something to shoot at. This White House is bent on the same error. I have been reading with amusement these stories about Medicare. “Well, if the President hasn't produced his proposal for Medicare”—if he did produce a detailed proposal there would be no reform.
One of the best policy statements ever written is the Handbook of Public Administration, Supplement D.

SMITH: Oh, what is that?

ROSENBAUM: That's the original statement, the original implementation vision of the Medicaid program. And if you look at how Wilbur Cohen—it really was written under his direction, I am sure, how he imagined that this statute would work and what benefits people would get. A lot of it still lives that way—

In fact, it's so phenomenal that one of the first things—I don't know if you remember this—that the Reagan Administration did when it assumed office was to issue a statement of policy declaring that the Handbook of Public Administration was dead.

If my office were burning—this is what I would take, yes. And it's very interesting to read it through.

You can find things that haven't changed in 35, 37 years. I made a copy for Vern Smith who was writing Medicaid history. And he couldn't find—you can't find copies of this thing anymore. This is so interesting—like this is all there was.

MOORE: And you put in the new pieces within the column.

ROSENBAUM: Right, the transmittals—

SMITH: Now, who put this out?

MOORE: The Medical Services Administration.

ROSENBAUM: Yeah.

MOORE: And the Social and Rehabilitation Service.

ROSENBAUM: It's part of—it's the HCFA with no past, you know.
And to the extent some of these things did still exist, my guess is when they moved from Washington to Baltimore there was huge pressure on everyone to get rid of stuff. Throw away everything, throw away everything.
Another—oh, the contract study.

SMITH: The contracts—yes, somebody working through all those contracts blew my mind. I thought, there is a true lawyer for you.

ROSENBAUM: Health reform was a true learning experience for me. I went in as a public benefits lawyer and came out the other end of health reform as a private insurance lawyer.

That's basically what I teach and what I work on now. And you can't appreciate public benefits until you have had to learn private insurance. Ideally, you would first learn private insurance. Most people who first learn private insurance never bother to learn public benefits.

At any rate, here is private insurance and here is all the legal doctrine that governs private insurance, very different from the legal doctrine that governs entitlements, although they serve the same purpose. And we glibly say that a public entitlement has similarities to private insurance coverage.

But actually, at a deep level the two are like apples and oranges. So what first drove me to do this was simply the legal wonderment at how could you buy something that looked like commercial insurance coverage but was Medicaid, because the commercial product would be just a subset of the Medicaid program. And how a state would knit the edges of commercial coverage and Medicaid together, to keep itself from being robbed blind by companies that would consistently deny deeper coverage.

This was of great interest to me. But the other thing that propelled me to do the project was, as I mentioned to you before, my great love of the point at which financing hits service delivery. I mean, why else pay all this money if you're not going to get anything for it.

And I suddenly thought: Holy cow. This is my chance to see if Medicaid agencies really understand the complexities of service to their beneficiaries.

And—because I knew the managed care contract is a contract of service not a contract of insurance really. And by the time I started the project I had read a bunch of these contracts. I actually started writing about them in the '80s, but on a lark I wrote off to Carolyn Asbury, who was then at Pew, and she had this very good person working for her then named Harriet Dichter. Very lovely. She was a former legal services lawyer. And of course she immediately got what I was interested in.

I just hit them on a good day because they gave me nearly two million dollars. They gave me two million dollars on the strength of a letter about three pages long. They said, "That sounds good. Why don't you just keep asking us for more money." And so they gave us—and they gave us so much money that we were able to do this incredible project.

SMITH: Which foundation is this?

ROSENBAUM: Pew Charitable Trusts, where we literally were able to have enough staff to not merely read these contracts and tell you in sort of a trust-me way what they said, but we were able to literally build a database, and put it up for all to see, so that you can go still to our website and see the content of contracts.

And the Medicaid Directors were upset. We were threatened with all kinds of repercussions for this until the report came out. And what the report said was that agencies were doing a remarkable job, far more so than private purchasers.

And to this day I think the most remarkable thing about managed care, Medicaid managed care, is this tremendous effort on the part of agencies, that were really insurance agencies, to try and understand delivery and buy care for people. And it's a much more serious model than even those of us who were in a traditional HMO.

We middle class folk don't know from serious managed care, because this is really all these people have. And Medicaid agencies were extremely unbalanced, extremely cognizant of the seriousness of the undertaking.

There were only a couple of agencies where I felt that the agency, either it was just in outer space, or corrupt. I mean, there were a couple of states where clearly the contracts were a way to throw a lot of money at friends. But the vast majority of Medicaid agencies were about the business of attempting to buy an adequate level of health care for people.

And they struggled mightily with what this meant. If I had to pick a piece of research I did that probably altered the course of something it would be this. It was really I think news to people just how significant this purchasing effort was.

Now, we clearly touched a third rail. In other words, if you look back this was really the first study that seriously raised purchasing as a piece of research that should be studied and analyzed and aided. We were never part of any subsequent foundation-sponsored plan.

Pew was very happy—they were delighted. If they hadn't gotten out of the health business—I don't know if we drove them out of the health business—but if they hadn't gotten out of the health business they probably would still be funding us.

But other funders were very frank. For them our work was touching the third rail. It was touching the legal documents. It was like legislative language. It was touching the document that was all about—

MOORE: What happens in the real world.

ROSENBAUM: Yeah, exactly.
And so, you know, there would be these purchasing institutes and they would bring in people and they would say, oh, and then we were going to do this, and buy this, and that, and we would say, well, let's see it in writing.

And so this had been a wonderful project because it essentially pushed all the fluff aside and just got right down to the meat of buying and selling health care. And it was, I felt—I feel that of anything I have ever worked on, wearing now an academic hat, that this was really still the most seminal work I could have done.

SMITH: Did you use any body of theory that was helpful here? I mean insurance theory, I suppose, and HMOs and stuff, but there's various kind of material on the theory of contracting and purchasing.

ROSENBAUM: Well, as I say, a lot of my work came out of my roots in entitlement law and the intrigue I felt over how you could use entitlement funds to buy a contract of insurance and how you would essentially structure the agreement to not be legally exposed.

And of course the huge controversial finding in that first study, was the amount of legal exposure Medicaid agencies experienced because of the ambiguities of where their obligation started and the contractor's ended. And so I was really driven by the point at which insurance law meets entitlement law and doctrine. It was, you know, purely a—really a legal study.

The project was like tumblers falling into place in terms of how various sectors of the health economy might come together or do come together, the politics of it, the policy of it.

But it was really—it was a legal study. And of course what I have always loved about the law is that it is simply the most formal expression of social value, using words, instead of numbers.

So if you view it that way, it's just this elaborate word game. I love the contract study, because we would show people how wording could differ tremendously on the same topic.

And then the other thing that we did, which was great fun, and they are still up and in use today in one way or another are the sample specifications. Because people would immediately call and say, "Well, of all the state

entries, which one should we use?" And you really couldn't point to any one because some of them were good and some of them weren't so good. But, you know—and so then we just got all these millions of dollars to develop and post these purchasing specifications. It made HCFA crazy. It made HCFA absolutely bonkers.

I never could quite understand what they were so concerned about. Because, hey, this is just, you know, the way you would have a cost estimation tool or whatever.

If you are milling around looking for the right language to write down in an agreement, this is as good a place as any. Yet they were really bothered by it.

MOORE: I think they were concerned that it will all get codified and require all the little pieces.

ROSENBAUM: I guess. Oh, they were very concerned about it. And at some level I guess I can understand it, except as a lawyer, of course, I laugh so. Debbie Chang and I got into this discussion the other day about why not to write an Olmstead plan. “Well,” she said, “what if you wrote it down and then somebody made you write it into a law?” Making legally enforceable law is not that easy. I think lawyers actually are much—it's like non-doctors being fearful about medical stuff that doctors aren't fearful about, you know. So it's just kind of the shoemaker's shoes or the shoemaker's children or whatever.

SMITH: As you read these contracts you were favorably impressed by the quality of reasoning and struggling with problems that you saw going on in the state agencies. What does this experience do to your sense of comfort with waivers and things like—

ROSENBAUM: My problem with 1115, specifically 1115, is that it is an utter bastardization of a legislative process. I actually think that it borders on a constitutional violation of the separation of powers. You've got the federal agencies rewriting statutes.

I'm not sure that you could ever challenge it under a separation of powers theory. But I don't like—it's not the waivers themselves. Some waivers do good things and some of the things that the waivers do I would be very eager to codify in statute. If we could codify Mass Health overnight, that would be great. I think that they really tried very hard to modernize the

Medicaid program under the banner of Mass Health. But what has always bothered me about waivers is unilateral decisions by the Department to basically overturn a law.

And in the end I don't think you could win on a separation of powers argument because for reasons that only Wilbur Cohen and God know, in 1963 Congress wrote this crazy provision into the Social Security Act. They clearly put it there to let some good people do some good things. They had no sense, I am sure. I think everybody who would really know what 1115 was there for is probably dead. But I don't know. And I don't have—I don't have the problems with state administration of things.

I have problems when you just completely thumb your nose at a democratic process, and I have problems when you disentitle people from their coverage. I don't think you should use demonstration authority to do that.

It's a governance issue, much more than the merits.

There is something too, to the issue of when people do bad things and they cloak it in all this nonsensical rhetoric that they are really doing something good. No, you're not. You're really cutting back on a benefit, you know. So don't dress it all up like this. But that's a separate issue.

SMITH: One thing we must ask you about. You may pretty much have covered it, but any thoughts about what we should try to do about Medicaid now?

ROSENBAUM: I have never taken the time to stop and write it down in great detail. But I could sketch out for you what I would do with the program.

I would break it into two subtitles, one being a premium support program; an entitlement though. I mean, I think the worst thing that ever happened was the enactment of SCHIP. Because rather than fixing Medicaid, we sort of started down the second front and destabilized the Medicaid program in very serious ways.

And so I think policy-wise, that was a very bad move. I think we should have bitten the bullet, or whatever the expression is, bitten the bullet and fixed Medicaid. I would break Medicaid into two pieces, one being premium support with a contribution at a very high level for really poor people and a modified contribution for moderate income people. You and Lynn have a lot

of this. I would benchmark the benefit package. And then I would have Subtitle B which would do two things.

One is to act as the primary insurer for people who really can't get a market benefit plan for all kinds of reasons. And the second would be to act as a source of supplemental coverage for anybody who has functional limitations of the kind that push your resource consumption needs up over the norm, so that essentially Medicaid would be broken into two programs.

Of course, my views are very unpopular with advocates because I would replace the defined benefit package with premium support. And my views are unpopular with the other side because I would give everybody actually a conditional legal entitlement to additional coverage in the event that they have greater than normative needs.

As I have noted, Medicaid runs by its own rules. It runs by rules that are very different from insurance. And in order to keep the American health system going and keep a market going you have got to have one payer that doesn't run by market rules. And that is what Medicaid does for us.

And then the price—the price for having a multi-insurer market is that the government essentially agrees to bear uninsurable costs.

And nobody likes to hear that, you know. They want the government to off-load everything, except if it is the property and casualty industry and then it's okay. The government can bear the risk just fine.

SMITH: Right.

MOORE: Right.

ROSENBAUM: I know that my views on Medicaid—what we call Medicaid basic would be not popular, because I would be seen as blowing up defined benefits and EPSDT. I would just reconfigure the whole thing.

The reason I have felt this way comes right out of the contract study. What I have just described to you is exactly what the contracts do. They create Medicaid as concentric circles. The smallest circle is the commercial coverage package that the agency buys from a contractor and then the surrounding residual coverage, the residual coverage, is what the state remains directly responsible for that is not insurable. The actuaries won't take it on.

MOORE: ...or carve out or—

ROSENBAUM: Sure. They do it themselves.
They may have different modified payment systems for those services but they are basically the insurer.

MOORE: Uh-huh.

ROSENBAUM: And I think that makes great sense.

SMITH: Uh-huh.

ROSENBAUM: And I think that it allows poor people to move into markets where they—especially if they are working—would like to be.

And it encourages insurers because there is a stop-loss basically. There is a supplement for needs that are beyond the benchmark. They would have to agree to cover the benchmark, but then beyond that they would be off the hook. And I think it modernizes the program to let Medicaid agencies sometimes be purchasers and sometimes be direct insurers.

I think that that model has been staring at us since the first big comprehensive managed care agreement was drafted.

The Arizona Access Program was such a system. Although, they got off the hook with the residual benefit until they had to bring on their long-term care program. Actually, TennCare or any of the next generation was the model I have described.

MOORE: Right.

ROSENBAUM: The early '90s were really that model.

MOORE: Uh-huh. Uh-huh. Uh-huh.

ROSENBAUM: You guys didn't waive benefits other than Oregon except in certain limited ways for the demonstration population. For the traditional enrollees—the benefit plan is still the benefit package of Medicaid.

MOORE: Absolutely. It still is. Even as they have cut back and cut back and sliced off.

ROSENBAUM: Right, right.

MOORE: It's still there. The core is still there.

ROSENBAUM: Uh-huh. My proposal also, of course, preserves a legal entitlement on both sides, to a premium support and then to a residual benefit package. So it is clearly unacceptable to, you know, to the right; it's just unacceptable. But it may be to you because your article suggests that you guys clearly were thinking the way I'm thinking. And actually you had a very nice thing that I hadn't thought about, which was the juxtaposition with the tax credits. So—

MOORE: That's what everyone was talking about.

ROSENBAUM: But if you spend any time with this program you desperately want to save the things about it that are, you know, irreplaceable. We'll never have a legal entitlement again and we'll never have a financing program that pays for all the care that insurance won't.

MOORE: Uh-huh.

ROSENBAUM: And so the question is: How do you keep that—while making the program less horrible to use?

SMITH: That seems to be a very good point on which to conclude.

ROSENBAUM: Good. Well, thank you. This has been fun. Usually I don't get to do any fun things like this.

SMITH: Thank you so much.

MOORE: That's what people tell us. And it's great to see you.

INTERVIEW WITH DIANE ROWLAND
JUDY MOORE AND DAVID SMITH – SEPTEMBER 30, 2003

SMITH: This afternoon we are interviewing Diane Rowland, with Judy Moore and David Smith. It is September 30th and we are at the Kaiser Family Foundation. We would like to ask you to think back a little bit, not so much about your career as such, but about formative developments and experiences that helped shape your ideas about the Medicaid program, made you an addict like many of the rest of us.

ROWLAND: I first really became familiar with the Medicaid program while I was a graduate student at the University of California at Los Angeles working on my master's degree. There was a group based at UCLA at the time—the National Health Law Program (NHELP)—a back up center on health issues for the legal services programs around the country.

And it had a sign up one day for students to come over and look for part-time positions or write term papers on issues related to health care for the poor. I ended up working with an attorney named Patricia Butler and became familiar with Medicaid through the National Health Law Program's work on the implementation of the program. Medicaid was enacted in 1965, but in 1972 many states were just setting up their programs.

SMITH: That made you familiar with the program, but it didn't necessarily make you want to have a part of it, did it?

ROWLAND: Well, it made me familiar with the fact that this was a program that was enacted with the potential to provide health care and access to health care for millions of the lowest income Americans. Before I had gone to graduate school I had worked in Boston's Roxbury community at a multi-service center where I was assigned to work with a social worker.

I remember taking uninsured, low-income women to try and get access to care. And I particularly remember a woman who had very severe mental problems and had told us that she was going to commit suicide if she didn't get any help. We took her to a mental health center and they said, "Well, you know, you are uninsured and we can't admit you. Just come back and see us on an outpatient basis."

And the next time we went to pick her up she wasn't at her apartment anymore and her three children were alone in the apartment and she was

gone. She never got the outpatient care she needed, so she ended up taking her own life. And it made me as a very young person understand that health care and health coverage can make a difference and that some people in society have less access to adequate care than others.

When I got my master's degree, and began to work on health care policy issues, I remembered that case and it made me see Medicaid as a very important part of what we as a society can do to improve access to care. Before grad school, I'd also worked at a comprehensive drug addiction program in Boston and really learned about access to care and coverage issues for the heroin-addicted population at that time.

So coming out of college, I had a strong interest in health care, but it was really at UCLA that I began to understand that financing was as important a part of health care as treatment.

SMITH: Where did you go from this Boston experience? Was it just career moves? People would offer you jobs? Or were there particular things where you—

ROWLAND: I worked in Roxbury doing a student placement when I was a senior in college, and stayed in Boston for two years working afterward, which is when I worked with the drug addiction program, and then decided to go to graduate school. So that's when I moved to California.

MOORE: What did you do after you left? Did you go straight into the government when you left graduate school? Is that...

ROWLAND: No, I went from UCLA back to Boston to the Harvard Center for Community Health and Medical Care and worked there for two years—on a project on hospital rate setting with a researcher named Kate Bauer.

While I was working there I was working on a—Social Security Administration contract assessing hospital rate setting activity in the states as a model for Medicare. The people with overall responsibility for that contract were Clif Gaus and Jim Caple. When the contract came to an end Clif Gaus asked if I might be interested at some point in working in Washington with them at the Social Security Administration.

I moved to DC in 1976 to work for the Office of Research and Statistics of the Social Security Administration at the beginning of the Carter

Administration. However, early in the new administration our office was moved to the newly-formed Health Care Financing Administration.

SMITH: So your only love in life wasn't just Medicaid.

ROWLAND: I would have stayed and worked on Medicaid issues in California but it was a time when the legal services corporation and the backup centers like the National Health Law Program were being squeezed and in jeopardy of being phased out. So after I got my degree, I worked at the health law program for about six months while they tried to raise additional funds, but couldn't do so. Then I got this great offer to move back to Boston that worked out well for both personal and professional reasons. But, when I went to work for the Health Care Financing Administration, I returned to working on Medicaid. My first position with the Health Care Financing Administration was to be the Medicaid policy person in the Administrator's policy office.

SMITH: It must have been rather a difficult problem trying to work on Medicaid statistics back at that stage. Were you doing much work on Medicaid statistics as such?

ROWLAND: Well, we did have these great benefit charts of what benefits were offered by each of the states and what their limits were on amount, duration, scope. And we had the states report in their state data, as clumsy and as uneven as that might have been.

There was some attempt to collect state information on what they were covering and what the utilization was for the Medicaid population, trying to gather statistics on the form 2082.

But mostly I was working on policy issues. In 1978, we did a memo that was called the "Problems of Medicaid" which, interestingly enough, when we launched the Medicaid Commission in 1991, without telling them, we gave the Commission members the same memo. We just updated a few of the numbers in it, but we didn't change the issues. The issues were basically unchanged—it was all about low payment rates, gaps in coverage, uneven coverage across the states, fiscal concerns at the state level—many of the problems that are now totally familiar.

During the Carter administration, we worked on trying to at least improve the program. There was a big initiative during that time to improve Medicaid's coverage for children, and implement a minimum income

standard, and tie Medicaid income eligibility to the poverty level—things which have since happened.

SMITH: Over the years, we find people talking a lot about Medicaid as evolving from a categorical program for people on welfare, into a program which tried to reach out more broadly to the poor, into a program where you think about it as covering the uninsurable and to some extent the uninsured.

Can you recall how, in what ways maybe your conception or your vision of Medicaid might have changed over the years? Did you start back there thinking, well, if we could get a few of the children covered that would be just great? Or break down a few of these categorical restrictions? Was it a big thing when SSI came in, and so forth?

ROWLAND: Well, I was in graduate school when SSI came in. I remember being lectured about public law 92-603 and what it meant in graduate school. So, the federalized disabled welfare assistance and coverage through Medicaid was already in place. What I remember most about the early days at HCFA was the push to try and put in a minimum income standard as part of the CHAP legislation to extend Medicaid coverage for more low income children. The Administration proposed 55 percent of poverty as a standard and the Commerce Committee had a bill that went up to 66-2/3 percent of poverty. What I remember most about those days was looking at the AFDC payment levels that determined Medicaid eligibility being so arbitrarily low in many places that improving coverage for children took both raising the [federal] matching rate and trying to increase the minimum [income] standard—which is how the policy of relating the income standard to the poverty level developed.

That is one of the things I think that it's very hard for an analyst today—where we require all children up to at least 100 percent of poverty be covered—they don't know that there was a time in which children in some states weren't covered at 15 percent of poverty. But I remember the absolute low levels of eligibility in the southern states, and how restrictive the asset test was for populations.

The welfare reform initiative during the Carter administration raised the issue of whether Medicaid and welfare belonged together or should be separate. However, the separation was never quite achieved despite the discussion.

The child health legislation, CHAP or any of its other alternatives that came through the Congress, were the beginning point of saying that health insurance for kids can be different from those who receive welfare.

Welfare-based eligibility for Medicaid was tied to a single parent and their children but with AFDC-UP there was an opportunity to start to cover two-parent families.

I wouldn't categorize it as moving away totally from categories since childless adults were not really part of anybody's next step for Medicaid at that time. The goal was to broaden family coverage beyond single-parent families.

MOORE: When you left the department in the early '80s and went to Hopkins you became much more involved in long-term care and aging issues, did you not?

ROWLAND: Yes.

MOORE: Did you do that by choice because you wanted to learn more about those particular parts of the Medicaid program or low income programs? Or did it just kind of evolve.

ROWLAND: It evolved more because of where the funding came from—at Hopkins, research needed to be funded by external sources. And most of the funding at the time—I think that is a striking difference from today—most of the funding was exclusively around Medicare and the elderly. It was very difficult to identify funding sources for Medicaid research. What I looked at within Medicare was what happened to the low-income beneficiaries. That way I maintained my low-income focus, but with a Medicare focus for funding purposes. In that way, we continued to try and look at Medicaid and the interactions with Medicare.

MOORE: That's an interesting commentary on the policy world, too. As we have looked back at the history of Medicaid and at some of the research and statistics and policy studies, there was so little until around the end of the '70s. There was no money for it. There was no interest in it. Part of that was driven, I think, by lack of uniform national data.

ROWLAND: Medicare was very popular as a source of analysis because you had the data, it was a very strong database, and there was fairly substantial funding available through the federal government as well as a lot of interest,

in some of the foundations in aging and in Medicare. There was not very much interest in anything that was viewed as a state program.

I think what has helped Medicaid to become more saleable as a research topic is that what is going on at the state level has increased in priority. As Medicaid's role, beyond a welfare mothers' program, grew and its long-term care roles became more understood, interest in research on the program grew.

While we were at Hopkins, the Commonwealth Fund really wanted to look at reforming the way we pay for elder care—which then gave our research a direct link to Medicaid because that was the program really paying for long-term care.

SMITH: You wouldn't have had that much interest, you, in the elderly. But it is somewhat down the line before you begin to get much research that deals with the disabled generally, isn't it? Except maybe mental health?

ROWLAND: Even with the long-term care issues, I was thus able to continue my low income focus. There were several sources of funds for elderly—the Anders Foundation and the Robert Wood Johnson Foundation.

But also, there was kind of a skepticism in a lot of foundations about dealing with public sector programs. They felt that government should be doing that research and they weren't particularly interested in funding Medicaid—a federal/state program. Medicare seemed to get by because it covered all of the elderly, so it wasn't exactly like you were just looking at a public program.

Aging groups saw Medicare as a central part of understanding what was happening to the aged, but Medicaid was still viewed as a public program, largely organized around the welfare population.

MOORE: There was a huge evaluation done of Medicaid that started in ORD under Clif Gaus, although he doesn't remember it very well, that Mathematica did. You look back at it and there is this huge multi-volume set of documents that was done—in about 12 months. Marilyn Ellwood was very involved in it. And it's funny to me now, because any organization would spend three years on it now, but I wondered if you remembered it or if you were part of the process of developing that.

ROWLAND: The evaluation I recall was done just before the Carter Administration for the Social and Rehabilitation Services Administration. In fact, I recall one volume was on estimating Medicaid costs with David Ellwood as an author and an incredible cover design. It was in an appendix on how you do cost estimates for Medicaid.

MOORE: I had one for years but it slipped through my fingers somewhere along the line.

ROWLAND: Well, among the things that I have lost that I am sick about, are the Commerce committee prints from the 1970's and early 1980's with all the old Medicaid data. When the Commission moved from Hopkins down to Washington they were lost in transition.

MOORE: Gone.

ROWLAND: Gone.

MOORE: Okay. It's an interesting bunch of studies. We can't really put our fingers on what the impetus was and where it came from because nothing ever happened with it as best we can determine. Except Jerry Adler, if you remember him—has them in a file and has given us copies of all of them.

SMITH: There was a lot of pressure coming from ASPE, wasn't there to do a general evaluation of Medicaid?

MOORE: —you would have been in ASPE at that time because it would have been '79-'80, something like that. But in any event, I wondered if some of the impetus might have been related to reform or getting ready to think more about national health insurance, or something like that.

ROWLAND: When you think about what was going on in the Carter Administration, there was the initial work on cost containment followed by the effort to enact national health insurance. And there was also welfare reform and the CHAP proposal to extend Medicaid coverage for low-income children. With the national health insurance proposals, Medicaid is essentially replaced in terms of its health insurance role.

MOORE: One of my frustrations over the years of being in and out of Medicaid was always that no one would deal with trying to fix some basic pieces—we were always going to have national health insurance.

So when I tried to get people interested in eligibility reform in '76, '77, '78, it was like, "No, no, we don't need to deal with Medicaid. It's going to go away." And it never did. It kept evolving, which is—I mean, may be fine but it was always frustrating.

It was so complicated that people didn't want to have to learn all of those pieces.

SMITH: The easiest answer was to get rid of it, right?

ROWLAND: Well, it's interesting though because when it reemerges as an issue during the Clinton administration and the answer is, "Oh, well, we're going to have universal coverage and we don't need Medicaid," suddenly Medicaid is so much more than health insurance that you have got this huge issue of what is the residual and how do you handle it?

I think one of the issues with Medicaid is that the leading edge of the program has always been its role as an insurer of low-income families, while the leading dollar part of the program has always been its care for the elderly and the disabled. But that often gets forgotten in the public debate.

MOORE: One of the things that has changed most, I think, about Medicaid—and slowly but probably more in the last five years, it seems to me—if you look back over the program—is an increased awareness, knowledge about, and perception of the program as something that exists, at least in policy Washington circles, not that people really understand it in all its complexities.

You all, here at Kaiser and in the Commission, certainly ought to get a huge amount of credit for that. What is your perception of level of knowledge about the Medicaid program, both in Washington and across the board nationally?

ROWLAND: I guess we think that people have a much different view of Medicaid today than they did a decade ago. As the last round of budget cuts shows, many governors know that Medicaid is a big chunk of their budget and they might have to squeeze it, but they also know it's a program that they need and it is doing a lot in the state. So it has gone from being, I think, a program that any governor would like to get rid of to one that most governors understand is pretty fundamental to meeting some of the needs of their state. In part, Medicaid has become even more important because

states have moved so much, of what was previously state funded social services, into Medicaid financing.

But I also think there is a different feel about the program now. It is not just a wasteful welfare program, but a fundamental health care program. While its cost increases raise concerns, it's not viewed by most people anymore as a useless program. It may be breaking the bank, but it's not a broken program in terms of who it serves.

That is a fundamental difference from years ago when a lot of people thought, why don't we just get rid of this program. It's just another poverty social program that isn't very effective.

On the other hand, I think that there is still a lot of confusion about what Medicaid is versus what Medicare is. I still get people who call me up and I think they are asking me about Medicare and then I find out they are really asking me about Medicaid.

I think that every time we show our double bars, as I call them, the beneficiaries versus the dollars, we still have people who go, "Oh, I really didn't understand that so many of the dollars are for the elderly and disabled."

SMITH: Yeah, yeah.

ROWLAND: I think there is still a very, very poor understanding of Medicaid's role for people with disabilities. And of who constitutes Medicaid's disabled population and why they have high service [needs] and high costs.

When I hear how the Medicaid benefit package is too rich because it includes a full array of services, I think, well, but hopefully a healthy child doesn't use all those services. But a disabled child may need all of those services. So there is still, I think, a lack of understanding about how different Medicaid is from a private insurance policy, both in terms of the population it serves and in terms of the way it operates.

I don't know any private insurer that would do three months' retroactive eligibility like Medicaid. Medicaid takes on the sick when they are sick and goes backward to cover the prior three months of services unlike private insurance, which only covers future care and takes you after you have met a pre-[existing condition] exclusion or whatever. It is these kinds of basics of

the program that are maybe better understood today—but many still miss the point.

In our public opinion survey work, people do know that there is a Medicaid program and most of them encounter it if they are in the middle class when someone older needs long-term care. So the long-term care side is understood—though less so the disabled.

So, Medicaid has some broader public awareness; but I think still a lack of real understanding by both the public and a lot of policy-makers, of what really goes on under the umbrella called Medicaid.

SMITH: Now, this to me is a very fleshed-out, full view of what Medicaid is about. At what stage in your career would you say you really had that vision of it? Because certainly if you read Kaiser Foundation publications today and you look back 20 years, there is a great difference.

There is much more of a sense that this is a program not just for the poor, but for people who are uninsurable and for situations of very acute need that are not going to be otherwise met. So it fills some big chinks. As well as doing some things that are quite coherent and understandable such as covering people who are just uninsurable. And there is room for a kind of health care that no insurance will buy.

ROWLAND: You know, I would say that my early work with Medicaid was focused, by the government priorities—mostly about improving health insurance coverage and Medicaid's role as a health insurer, especially for children.

We did not spend very much time on long-term care. And in fact, even thinking about the way the HCFA policy office was organized: I was the person who did Medicaid; George Scheiber did Medicare, Judy Williams did long-term care, and Mark Chassin did quality. So quality and long-term care were not even underneath Medicare and Medicaid as policy issues in the Health Care Financing Administration's policy office—they were separate issues.

I think long-term care always suffered like national health insurance, from the problem that since reform was always on the horizon, it was hard to get anyone to focus on fixing the current program. And therefore, we stayed in a holding pattern waiting for long-term care reform.

The Pepper Commission crystallized that for me: fixing all these pieces—long-term care, health insurance, Medicaid and Medicare—was bigger than anything anyone had imagined. Working with the Pepper Commission and participating in those meetings was a kind of seminar and an education. I was studying and working at Hopkins and could pursue some of these items there. At Hopkins under Karen Davis, we had a substantial commitment from the Commonwealth Fund to look at elderly people living alone—a group that tended to be women and to be low-income.

In working with the Commonwealth Fund Commission on elderly people living alone, we had to look at income security issues, Medicare issues, and how Medicaid filled in the gaps. It had a lot of interesting Commission members: Peter Libassi, Jack Rowe, John Hope Franklin, Bruce Vladeck, and Bob Butler was the chairman of the Commission.

Medicaid became a major focus of the Commission as we increasingly recognized that Medicare had so many limits for low-income people that Medicaid had a really important role, not just for long-term care, but also for assisting with prescription drugs and other acute care services—the gaps in Medicare.

SMITH: So the elderly really was kind of a policy breakthrough, a conceptual and policy breakthrough because you're really looking—

ROWLAND: I think that the more you focused on doing research and work on the elderly the more you began to understand Medicaid is more than just a children's health insurance program. Work on the elderly brought us to see Medicaid from a broader perspective.

SMITH: The date of the Pepper Commission was when?

ROWLAND: The Pepper Commission issued its final report in 1990—met over most of the year.

MOORE: Uh-huh. And the Commonwealth Commission on the elderly living alone must have been about the same years?

ROWLAND: I'd say elderly living alone would have been from about 1985 to 1990. My book on Medicare with Karen Davis and that came out in 1986. The Elderly People Living Alone Commission was six years from 1984/5 through 1990.

SMITH: One of the things that struck me very much about the Pepper commission was that they were looking at what we have got with the various programs and what is their potential for expansion?

We are not going to get national health insurance but we might get pretty close to it. And it was kind of a last grand gasp of the grand old man in a way. But a noble effort.

But it raises the question of to what extent you at any point think, or do now think that Medicaid would be a vehicle for or maybe a template for a national health insurance? Because there is certainly one school of thought that would buy that and others that would not. Bruce Vladeck doesn't, for example.

ROWLAND: I guess I would have always thought that Medicare was more of the template than Medicaid. And it may have been that if you work on Medicaid you see such variation in state capacity and in state coverage that if you think of national health insurance as regardless of where you live you've got coverage and you are treated pretty similarly, then the Medicaid model falls short.

I think that one of the more interesting things about Medicaid is the tension between states, and state experimentation, and federal mandates such as covering all kids up to some income level to achieve uniform coverage across the country.

In our evaluation of Medicaid, we have so often written about state variation as bad because some states cover only people up to 100 percent of poverty and other states do it up to 300 percent or that some states offer comprehensive benefits and others have limits. To me, “national” means equal treatment regardless of residence. That's why I guess the Medicare model was always more the one that I thought was the building block.

But then what I learned in government was that anything that adds money to the federal budget is going to be difficult. And so I guess my later models all became more hybrid where the employer base was not bought out but was actually kept so that the incremental addition of people was not so overwhelming as it would have been to move all the money onto the federal budget under a single payer type approach.

SMITH: One of the things you mentioned was of particular interest to us. You said early on, partly because of the kind of data you had, that you were

very aware of interstate variation, variation of the various spend-down requirements and things of that sort.

Nowadays when people talk about possible reforms of Medicaid one of the things they say is that maybe we could get everybody up to the poverty level or something like that. What would be your view about the desirable or possible in this area of horizontal equity?

ROWLAND: I certainly think that the coverage of all children to poverty, even though it was done year by year, was an important floor to put into the Medicaid program.

And if I were building on that, I would like to see the parents of those children covered at similar income levels so that we are not splitting up families and are using the incentive of covering parents as a way to attract some of the additional children who are not yet enrolled.

I also have always thought that the welfare Elizabethan poor laws heritage of leaving childless adults out no matter how poor unless they are severely disabled is an inequity and that we should begin to phase in some kind of coverage of the poorest among childless adults.

If you really think about where Medicaid ought to go as a low-income people's program, I think removing the categorical distinctions and having a threshold floor for income eligibility that covers people equitably is important.

SMITH: What would you think about going farther than that? A lot of people say, well, maybe Medicaid should make a very real effort to include the uninsured. Maybe you should try to find more money, like the money for SCHIP and cover the working poor, just generally, where they are uninsured. How far up would you go with that? To the poverty line or stop there or—?

ROWLAND: Well, I think the key here is always financing. I think a priority for federal dollars ought to be filling in the gaps at the low-income end of the spectrum rather than broadening coverage to ever higher income levels for children. If there is adequate financing, my next group to bring into the program would be any adult under at least 75 percent of poverty, phased up to 100 percent of poverty. But when you look at the uninsured numbers, that is a large group of people. Two-thirds of our uninsured population is

under 200 percent of poverty. And philosophically, I think building on public coverage is a cost-effective way to go, but others prefer other approaches.

I think anyone who has analyzed and worked on Medicaid would always want to simplify the program, smooth out the rough edges and provide the coverage.

And of the stumbling blocks against doing that, the biggest one has always been finding the financial resources and the second one has always been that because the program is so uneven across the states there are some states that are always bigger winners if you are federalizing pieces and some states that aren't. The politics of the issue gets very clouded.

Probably the third thing is that, unlike Medicare, Medicaid has never had a defined constituency that has been able to push or advocate for it. And the main constituency for the program has either been the provider community, which tends to not like its low payment rates, or the states, which tend to love Medicaid in the good times but hate it when it is driving their budgets crazy.

MOORE: Another concern with the program over the sweep of time is the DSH.

ROWLAND: And UPL.
MOORE: And the UPL problem. Because if you looked at this in '75 or '85 and tried to deal with the inequities that had grown up over coverage levels or FMAP rates or whatever, it would have been one thing to deal with. Now, with the UPL and DSH, additional inequities on top of everything and the problems in communities with that money going to some facilities and no others and those kinds of issues...to me it just hideously compounds the problems.

ROWLAND: I think the financing schemes that resulted in provider taxes and donations and in DSH and now UPL have done nothing to help Medicaid, but only to hurt it. I know they have helped states get through some of their fiscal woes with the program by giving them some additional federal funds to fill some gaps at the state level...especially when the economy is poor and states are struggling with the required state matching fund.

But I think they have made the overall financing of the program less stable and created a lot of concern about how the program operates. While these

behaviors are apparently legal, they don't seem right and cast the program in a poor light.

I think anything that de-links the funding for the program from the individuals who are being served by it just makes it more difficult. When one looks at '90 to '91 period when costs increased by over 27 percent, it looked like Medicaid was out of control, when it was the financing schemes that were driving the double digit increases.

And I think much of the impetus behind discussions about capping the funding or limiting it have been this tension, and the gamesmanship between the federal government and the states, over the financing. I recognize that in some places the DSH money has been invaluable in keeping a public hospital or other community resources going, but I think that there ought to have been a better way to support those institutions, than to pull off funds from a program that should have been devoting more to the coverage of the populations that it was intended to serve.

When I worked in the Health Care Financing Administration in the Carter Administration, we had a financially troubled hospital initiative to address some of these concerns. However, when the Gramm-Rudman Legislation and all of the budget tightening happened, the appropriations process became less available. This made Medicaid, because it was an entitlement, and it was automatic, a more viable and attractive place to finance a lot of things.

Medicaid to me has proven to be one of our most flexible responses to health care crises, whether it's AIDS or anything else because it's there and can be expanded to meet these needs quite easily.

SMITH: A thousand places you could put in an increment.

ROWLAND: Right. So part of the patchwork that Medicaid has become is because it is so able, in a crisis, to fill that role. On top of that, these financing schemes make it seem more and more out of control when in fact, I think the program is still pretty lean in what it pays for and what it does.

The financing schemes set up the program to be scrutinized for reform and tend to overshadow its other achievements.

SMITH: We went to one of these conferences and Bruce Vladeck was in high form at the time, and talking about the great future for Medicaid in terms of program innovation and crises to be met, and the disabled, the elderly, and the institutionalized populations, and finding ways to deal with that and saying that the states that manage to discover good ways to deal with these populations are going to be the leaders in the future.

I would be interested in your comment on that, whether you think Bruce is right. We both struggled with the fact that you can find HRSA has developed interesting models. There have been things like centers of excellence and there's been things like the PACE program.

And targeted case management, all sorts of kind of nifty ideas like this for treating patients, service delivery innovations. But then you get the question of how do you go to scale with this? How do you make this work on a state-wide level?

You can find it working in the City of Boston. Can you make it work in rural Massachusetts, or can it be made to work across the nation? Have you given any thought to this issue of how you go to scale with these sophisticated service delivery models and still work well?

We have in mind Bob Master in Boston. Well, that's marvelous, but not everybody is in a position to create a hand-made Swiss watch.

ROWLAND: I think that it's not just a challenge in our social programs. It's even a challenge—we know medicine isn't applied equally across the country. How do you export excellence and adopt it on a wider scale?

I think most of the PACE programs have shown that they are really fine programs, but I don't know that we can have a PACE program in every community. I also think that it's people who make programs excellent and that the way we can export things better is if we spent more of our time and resources trying to develop the individuals who could run the programs.

From my years in government, in policy, and in education, I recognize that we really don't spend a lot of our resources on trying to develop the leaders who could take these projects and replicate them in different communities. We are lucky when we get a really talented team of people to put together a project in Boston but we don’t train people in the Boston program so they can replicate it in a hundred other places.

Some of the work the Foundation has done in South Africa was really all about training people, so that they could train other people, so that they could train other people to broaden the knowledge and broaden the expertise.

When I think about what we do to train people to run these complicated health programs, it's pretty minimal.

SMITH: One thing that certainly strikes you is that if you are making good investments in infrastructure they often pay off in the long run. And as we have looked at some of these different programs around the county, where they have had even minimum resources, but there is the will and there is intelligence and energetic people, they have been able to do remarkable things.

Maybe you don't need it—that sophisticated a service delivery system. Maybe what you need is some way to inspire the local will and have some of the people where they just said, “Well, we're going to do something with managed care.” And to do that, you've got to have a bunch of people trained in contracting with managed care and you have got to build infrastructure to do that.

MOORE: It was rocky starting out.

ROWLAND: I also think that when you look at even Medicaid Directors, their jobs are incredibly difficult. The Foundation has considered doing a survey on a day in the life of a Medicaid Director, to assess the turnover and the burnout. One of the crises that Medicaid faces is leadership turnover and lack of stability in leadership as well as limited resources at the state level.

Every time I talk to a Medicaid Director, their challenges are overwhelming and their resources to deal with the challenges are underwhelming. I just think that we have got to put some money into administration and money into developing the infrastructure of people as well as institutions.

MOORE: There are not many Medicaid Directors that have been there for more than a year. Yeah, and that's changing fast. It used to be a longer tenure than I believe there is now. It seems that way anyway.

SMITH: Someone like Bruce Bullen, someone in and out in the state sector, but in the private sector. Some of that I think has worked to the benefit of

the Medicaid program where people like that are still around, so to speak, still concerned with the issues even though they are not formally in the Medicaid program. But it doesn't give you these long-term Medicaid Directors, that's true.

MOORE: What are the Commission's primary priorities at this point?

ROWLAND: Certainly to continue to explain and help people to understand Medicaid, and how it is put together, and what it does, and why it is different than a private health insurance plan, is a critical activity. Also explaining the disabled population, and what kinds of services they use. So really, continuing to put out the basics to improve understanding.

Second, clearly to look at and monitor what is happening with regard to Medicaid coverage in the states given the fiscal situation and the crisis in funding that many states have...tracking eligibility levels, numbers enrolled, and what states are doing or not doing about their Medicaid budgets.

And, three, to really begin to figure out ways to both streamline or improve Medicaid, if it is here for the next 20 years, and ways to help provide a more stable financing base for the program, whether that is moving some of the services over to Medicare or increasing the federal match or looking at other ways. Really, seeing the program tottering on the edge, how do you put it on stable footing if there is no other vehicle out there to meet those needs for the low-income population?

MOORE: And how have those priorities changed in the 10 years you have been in business? It is 10? Ten or 11?

ROWLAND: Started in '91.

MOORE: Yes. So almost 12.

ROWLAND: Almost 12, right. The first one has been there all along, explaining Medicaid's role. I would say that monitoring what is happening in the states grew up over time, because we had much more of a national focus at the beginning, during Clinton health reform.

Since '94-'95 we worked to have more of an understanding of what was going on in different states with regard to coverage—and then increasingly in the last two years, looking at the budgetary issues, and the impact on coverage.

We spent a lot of time in the early days looking at why Medicaid costs were going up and the cost explosion, and that got us into the whole role of creative financing. We still track and look at what is behind Medicaid spending.

One of the newer initiatives, during the post-health reform period, has been looking at the implementation of SCHIP, and the implications for Medicaid of some of the eligibility and enrollment simplification Medicaid changes brought about by SCHIP.

And now we are really getting into looking at waivers and the potential of a block grant.

We are also beginning to do more around the disability and the long-term care issues. In the last two years the dual eligibles have also become a broader focus both because they account for such a large share of Medicaid spending, but also because of the Medicare drug legislation.

MOORE: Any more questions?

SMITH: Well, just one little small one. We were talking about the current fiscal crisis. Have you given any thought to whether there might be some kind of counter-cyclical mechanism that the feds could put in place or is that too much to hope? I mean, the Congress talked about it and then the question is whether—

ROWLAND: Obviously I think looking at the matching rate and the fact that the adjustments are so lagged from the reality of what is going on is important. Doing something that coordinates a state's FMAP more with the current fiscal reality, than with what happened two years ago in the economy, would make sense.

And obviously, one of the results we got out of our most recent budget survey from the states, when we asked them what the FMAP increase and fiscal relief meant in terms of their budgetary planning, was that many states moderated the changes planned for Medicaid because of fiscal relief. It came just in the nick of time when states were in the middle of the legislative sessions to cut Medicaid. Fiscal relief saved the parents' coverage in many states.

So clearly, I think looking at ways in which the financing formula could be more adjusted to the state revenue situation, and to the economy, would be one thing that the Commission can address.

But I think the bigger piece that we have tried to contribute to right now is, that it is not just the economy that is the problem in terms of Medicaid spending, it is really the overall state revenue picture. And most of the problem is revenues—not a Medicaid problem.

Medicaid is a drain on state budgets because it increases faster than most other parts of state budgets, but it is not the drain that is creating the revenue gaps. You have a revenue restructuring problem at the state level that is beyond the scope of the Commission.

SMITH: Just another small question I would like to ask which is: It's kind of a nice thing that there is an organization like the Kaiser Foundation but it is a bit unexpected that you would have the kind of resources they have devoted to this orphan program, Medicaid. How did that come about? Do you know the story, I mean?

ROWLAND: Well, when the foundation in 1990 had a change in leadership, and Drew Altman became the CEO of the foundation, he had a board that was very public-sector oriented. The chairman of the board at the time was Hale Champion and members of the board included Joe Califano and Barbara Jordan.

They wanted to do health care, but they were also a board that believed that understanding what public programs do, and focusing on disadvantaged populations, is a very important role for foundations. That commitment continues with our current board.

Kaiser set up the Commission in 1990-91, assuming that George Bush would be reelected, and that Medicaid would continue to be a program that very few people talked about or understood, and that the role of the Commission might be to really focus on increasing understanding of the program, being a resource, gathering some data.

They debated whether it should be a commission on low-income or a commission on the poor. And I think it might have been Phil Lee who was on the board at the time who said, "Well, you know, one of the problems is that people sort of dismiss groups that are focused on low-income people.

But if you build on Medicaid's role, it helps give the commission a hook. You can both look at how low-income people get their coverage and have a real program to hang your hat on."

And so the first name of the commission was the Commission on the Future of Medicaid. And that was set up and chaired by Jim Tallon and I was appointed Executive Director with a team as staff at Hopkins.

In '93, Drew invited me to come into the foundation as a senior vice president and we moved the staff of the Commission from being a grantee organization at Hopkins to being a part of the foundation.

But the Medicaid focus really came from interest on my part for years and on Drew's part, of wanting to have a focus on low-income people and wanting to really look at how to improve coverage for the low-income population. Medicaid was a good organizing umbrella for that.

SMITH: How did you assemble the board?

ROWLAND: The Commission members were selected in part by the Foundation staff and in part by us suggesting people. We tried to look at people who had some experience with either Medicaid or with government programs. But we made a decision early on not to have anyone who represented a vested interest. So we didn't want to put on an active Medicaid director. We didn't want to put on a member of the AMA or whatever. So we had Steve Schroeder from the Robert Wood Johnson Foundation and Karen Davis from Commonwealth. Then we had several members who were former elected officials: Governor Riley of South Carolina, Governor Bellmon of Oklahoma, and Senator Matthais of Maryland.

We really looked for people who had some interest in public programs, and who had some experience in government programs, or who had some real expertise—like Jennifer House, who was a former commissioner of mental retardation and had gone to the March of Dimes—in the programs that we were covering because our commission meetings are pretty wonky and really deal with issues like understanding how DSH works or UPL works.

But we also wanted commission members that could help ground the work of the Commission and be a reality test for whether it was balanced, whether it was meeting the goals of objective, good, solid research. And also commission members who, as Senator Matthias likes to say, could become ambassadors for the Commission's work.

In 1997, after the first commission had been around for six years, we gave people the option to phase themselves off. And a few did, but not many. And we reconstituted the Commission as the Kaiser Commission on Medicaid and the Uninsured, because over the Commission's life it had become clear that one of the other constituent groups among the low-income that we wanted to focus on was the low-income uninsured.

And whether they went into Medicaid or went into some other program, we thought that much of the work on the uninsured needed to focus on low-income people.

And I'd just say the other big decision, other than the naming of the commission, and the selection of the commission members, that was made very early on by the commission members themselves, along with the foundation, was that this was not going to be a blue ribbon panel that sat and met for a year or two years and issued a blueprint for how to reform Medicaid.

Instead, it was going to be a panel that didn't really make big recommendations, but instead provided information and analysis to let information and facts help shape the debates over Medicaid, rather than try to come up with some blueprint for what the program should look like or do.

SMITH: That's interesting, very interesting. It must have been, well, fun, really to work with a board like that.

Exciting people, interesting people.

ROWLAND: Oh, they're great.

MOORE: And you get to keep doing it. A good place to stop.

SMITH: Yes. Well, thank you so much. It has really been a privilege, and great fun.

INTERVIEW WITH ANDREAS SCHNEIDER
JUDY MOORE AND DAVID SMITH – MAY 22, 2003

SMITH: This is May 22, 2003, with Judy Moore and David Smith interviewing Andy Schneider, who is the principal of Medicaid Policy, LLC, and is also associated with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

Since DSH was something you didn't get very much into, maybe we could start with that. You would have come about the time they were getting more conscious of this problem, or at least some recognition of it back in 1975. You didn't have any DSH as such, some people were engaged in Medicaid maximizing strategies at that time.

Then in '81 there was the hospital addition to the Boren Amendment and there was a mention there of DSH but that seemed almost like it was for purposes of clarification, not particularly for establishing something. I don't know whether you know about that or not.

SCHNEIDER: I do know about that. I started working in the Congress in 1979, in the fall of that year. And I was and remained until 1994 a health counsel to the Subcommittee on Health and Environment which was then chaired by Henry Waxman from Los Angeles, who had first assumed the chairmanship of the subcommittee in 1979.
The subcommittee had legislative and oversight jurisdiction over Medicaid.

In 1981, of course, the Presidency had changed hands and the new Director of the Office of Management and Budget, David Stockman, who had been a member of the subcommittee when I first joined the staff in 1979-1980, had left the Congress to be Budget Director and had a very good sense of where he wanted to go from a policy standpoint.

One direction he wanted to go was to put an aggregate cap on federal financial contributions to the Medicaid program. And that's all detailed in his book, which I can't remember the name of right now. [The Triumph of Politics]

And he lays out his perspective on this. It wasn't one I shared or one that Mr. Waxman shared. So there was quite a little struggle in 1981 over that proposal. One of the many issues that came up during that legislative conversation was reimbursement for inpatient hospital services.

At the time, states under Medicaid were required to pay the same way that Medicare was paying for inpatient hospital services, which was on a retrospective reasonable cost basis.

The states sought and received greater flexibility within that payment methodology. As you pointed out in your question, we substituted the Boren Amendment language, which had been adopted in the previous year, in 1980, for purposes of nursing home reimbursement.

Because it was clear that a lot of states were going to take the flexibility and reduce payments rates vis a vis what Medicare was paying at the time, the question arose, well, what about the hospitals that serve large numbers of Medicaid patients? Is there a way to protect them in states that want to reduce inpatient reimbursement a great deal?

And there was a lot of concern at the time, although the role of these safety net providers wasn't as well understood then, as it is now. But it was still pretty clear that in some communities, the D.C. Generals were still around, and were really functioning for a lot of these communities as the source of access to basic health care services.

SMITH: And that would have been enormously important for California, wouldn't it?

SCHNEIDER: California was one of the states that had an extensive system of county-run facilities and of course there are still significant county-run infrastructures in place today, L.A. County among them, but not, by any means, the only one.

At the time, you know, this was really quite a concern, not just in California, but in other states as well. So the issue was how to give the states additional flexibility, allow them to move away from Medicare for prospective cost reimbursement for inpatient services, but at the same time, protect certain facilities that were doing a disproportionate amount of service for Medicaid patients and the uninsured.

And again, the numbers have changed since then and the penetration rates by Medicaid have changed because there has been a lot of water over the dam on eligibility rules and with all the poverty-related eligibility categories that people are now pretty comfortable with.

That was not on anybody's screen in 1981. Then there was still the direct link to cash assistance eligibility and those levels were far, far lower than the federal poverty level.

But that discussion really didn't start up in earnest until 1984. So at the time you didn't have all that much Medicaid penetration among the poverty population to start with and there were—I can't remember off the top of my head, but there were obviously significant amounts of uninsurance associated with the same population, which was largely being served by these public facilities, and in some cases private facilities as well. I mean, there were affiliated facilities and some children's hospitals. But our understanding at the time, as I remember it, was that this was largely a problem with the D.C. Generals and the L.A. Counties and the Jackson Memorials and the Gradys.

We wanted to be sure they didn't get taken down in the process. So...into the statute was placed a requirement that states make an adjustment in their payments for inpatient hospital services to facilities—and I can't quote this exactly off the top of my head but it's facilities that serve a disproportionate number of low income patients with special needs. And the Senate staff as I recall these discussions...didn't want this to be too broad and preferred to leave the contours of it somewhat ambiguous. There was no interest in crafting a specific methodology for what that adjustment would look like.

They were also quite nervous about the notion that this could be used as an indirect subsidy for people who were not eligible for Medicaid. That was not a concern from our point of view. We were interested in maintaining the facilities because we saw them as points of access to a range of basic health services.

SMITH: What staff—what Senate staff...? Do you remember?

SCHNEIDER: Bob Hoyer, you know, who was terrific about this. But we had a little difference of opinion on the appropriate policy. They were quite concerned about opening up Medicaid as a subsidy for uninsured people generally.

If you go back and look at some of the language in the statement of managers on the conference report and think about the statutory language a little bit, you can see that, in that gloss on it, that there's a little concern there.

A perfectly respectable concern—it's just that wasn't our primary one. We were more concerned about maintenance of the institutions and if there happened to be some cross-subsidization at some of these other—that was really not a major issue. Because again, we saw this as bounded by the types of institutions we were talking about. This wasn't a subsidy for every hospital in the country. But of course, the way this played out in some states was a little different.

That was the best I can recall. Again, in the context of these negotiations it was not a huge item. We spent some time on it but it wasn't the most important thing. There was a lot that happened in that bill, as you know. Then, for the next couple of years, essentially nothing happened. It wasn't high on the Administration's list of things to enforce and implement. And the states at the time were walking into a recession.

A lot of them were looking at reductions or shortfalls in their revenues. And so they weren't necessarily thinking about how to buffer these hospitals against the reimbursement cuts that they had to make, or wanted to make, in order to reduce their own expenditures or the rate of increase of their own expenditures.

I would have to go back and look at the dates, but generally around 1985-1986, there had been so much foot-dragging that Mr. Waxman was concerned and we started to explore language to basically enforce the 1981 provision. I would have to go look at exactly which enactment this was. But even over '86 or over '87, it's basically a three-year phase-in of implementation. And so a lot of what we see in the statute now in section 1923, in the early parts of section 1923, is the residue of that phase-in.

SMITH: 1985 is the first time you see in the regulations some discussion of provider contributions.

SCHNEIDER: Right. Now we are moving to a different—and related matter. I mean, these streams converged. But just on the pure question of enforcing the requirement that there be a payment adjustment of some kind, section 1923 now has some language in it which provides different options for what these payment adjustments could look like.

Again, not as precisely contoured as some would want, but with certainly more definition than there was in the original section 1902(a)(13) language, which still remains despite the repeal of Boren in 1997. The language that you see in there was the original 1981 language.

And when you look at the statute, you will see section 1923 basically says here is the way you enforce, here is the way a state complies with the 1981 Boren language. Take your choice among these different reimbursement options and at a minimum, to be a disproportionate share hospital, you have to have, et cetera, et cetera, et cetera.

Okay, so all that stuff started developing as a result of either the '86 or '87 amendments.

So there started to be some statutory pressure that the hospitals could use to enforce the DSH payment requirement. And of course, at the time there was federal court jurisdiction over the Boren Amendment and this piece of the Amendment.

And now you had a pathway for a three-year phase-in to enforcement, which was scored by CBO and which was paid for in offsets. So again, I don't know all that much about what was going on in the different states. There was plenty going on in the Congress, so I wasn't able to follow that closely.

But clearly, there was some fallout, and some pressure to start implementing the legislation. And around that same time, someone put two and two together and said, "Well, as long as we have to provide these subsidies to DSH hospitals, maybe we can use that to the advantage of state treasuries."

And so...provider donations and provider taxes started to appear.
And again it was, you know, as with most Medicaid issues, one which had several different aspects to it. To the extent that the real DSH hospitals were actually getting subsidies that allowed them to function as safety-net institutions and provide needed services in their communities, that, from my personal point of view, was a good thing.

To the extent that these arrangements were resulting in federal dollars substituting for state dollars, for some people that was a good thing. For others, it was not such a good thing.

For me personally, and really this was just me, I wasn't that upset about it as long as the subsidies were ending up with the providers for whom they were intended. Where I drew the line was when subsidies got diverted for purposes that had nothing to do with caring for low-income patients.

SMITH: I am curious about your thinking, I mean, I have looked at that and I said, "Well, it seems to be one of the immoralities in the way American health care is structured in that it does not take care of some of these really very hard cases." And that's in many cases what the safety net hospitals are doing.

So that, in a sense you can almost say that it's not just that it's going to take care of patients but it's going to take care of a fundamental flaw in the American system.

SCHNEIDER: I agree with that and I don't think anybody was under the illusion it was going to solve all these fundamental flaws.
But where it could help—because again, not all states were like California, which had a network of county hospitals and had a health system organized around that network and premised on that network being there.

So if you pulled the hospital out, or really contracted its capacity significantly, there were effects. There were definitely effects, whether on the trauma system or the satellite primary care clinic system networks.

There was enormous variation from state to state in the implementation of this and the distribution of subsidies and the intelligence with which they were used. I mean, ultimately, in a program in which the policy premise is state discretion, you have to accept a range of outcomes.

Now, I guess I viewed myself as somewhat tolerant in that regard, but I really did have a problem with the diversion of the federal dollars for purposes that had no relationship to health care for low-income populations.

Other people were more conservative about this and felt the states really should put in exactly their share as specified in the federal formula. And, that federal Medicaid dollars should simply not be used to pay for any services for persons who were not eligible for Medicaid.

That was not the job of Medicaid as a payer. Maybe other payers, private payers or Medicare partly are paying for services that their populations weren't getting that other populations were getting. But that was not the role of Medicaid. Plus there were deeper philosophical differences.

SMITH: We were talking with Tom Hoyer and one concern he mentioned was that the Medicaid statute, as a statute, has gradually eroded over time

so that it's hard anymore to say what is legitimate and what is not legitimate.

And you wonder if some of those people were just stingy-minded or whether they had a kind of longer view—the same way someone might say that judicial activism will rise up to bite you in the long run.

SCHNEIDER: Well, you know, Tom makes a good point—as always. I have to think about why that is. You know, ultimately a statute means what the executive branch agency that enforces it, wants it to mean.

It's the administering federal agency that makes the decisions day to day about how money can be spent, how it can't be spent, and what it is going to tolerate in different circumstances. And of course, you can't anticipate every issue in the statute.

So I think what has happened over time is that—and this is not a knock of any particular Administration—I think over the past 20 years there has been less of an interest in enforcing the statute. I say that acknowledging that some of the statutory provisions are ambiguous, either because they are not well drafted or because of the messy agreement that they reflect. And so it's hard for an administrative agency to enforce such provisions.

In other cases, the statute is clear but they just, for political reasons, didn't want to enforce it. You know, let's go back to the DSH issue. Had the administrative agency in the early '80s been interested in preserving the safety net institutions, they could have taken that language and issued a regulation in the old fashioned way with notice and comment and input from all the affected parties that said here is how you do this.

Because of course in the context of 1981 negotiations, we are not going to sit down and spell that out. For various reasons, that was not going to happen.

So that's an example of the statute is there, there is a policy statement, but what can we do with it? Particularly if the administrative agency looks the other way, and says to the states, you do with it what you want to do with it—but don't pay too much.

And again, they could have defined what is a hospital with a disproportionate number of low-income patients with special needs. If they wanted to, they could have gone out and said, we are going to enforce this, we are going to

bound everybody's liability here, this is not national health insurance, we are just going to try to protect some of these institutions.

SMITH: Some of these terms of art like “intermittent care”—that just don't get defined.

SCHNEIDER: Exactly. Exactly. So to me, you know, part of that is a problem of the statute. The statute is not specific enough, although as Judy will remember when we wrote a specific statute, when we took that Institute of Medicine Report on nursing homes and we basically codified it in 1987, the comments just went on and on about how prescriptive the statute was.

So there are always two sides to this. But I think Tom's general point is an accurate one. And to me, part of that is the fault of the statutory drafting and the inability to come to clear policy agreements and write these into the statute. And part of it is the administrative agencies that are just not interested in enforcing the statute, who are going to let people try to enforce it by themselves. And part of it was the Reagan Administration, because Dave Stockman did have a particular policy perspective. And part of it is bureaucratic culture. I mean, this is the way we deal with the states, this is the way we deal with the hospitals, this is the way we deal with the nursing homes.

And that eventually gets incorporated into the regulatory process, the administrative guidance process, the regional office oversight culture—the whole thing.

MOORE: Did you all have any oversight on public hospital problems or that sort of thing? I don't remember any.

SCHNEIDER: As public—just by themselves?

MOORE: Uh-huh.

SCHNEIDER: No. It was more diffuse. Public hospitals testified, as I remember, in hearings on subjects on which they had an expertise that was relevant. I don't remember any hearings specifically on how is DSH working.

Now, that was during the time that Mr. Waxman was the chairman. The DSH issue came up in the context of the provider tax and donations issue in

1991. But I didn't see those hearings as about DSH. To me those hearings were about provider taxes and donations and how to fix the problem. But that is easily checked from the record.

MOORE: The only hospital people that I ever was aware of who...I'm wondering if you remember...from a more mainstream, you know, public health...

SCHNEIDER: Early on I think maybe the public hospitals understood the potential here. My perception was that the others didn't really think about pursuing this—they were more interested in the Medicare side of this issue.

SMITH: Didn't you get this whole burst of activity which you might call loosely—Medicaid maximization with the late '80s. What triggers that? Is that recession or—

SCHNEIDER: Again, I'm probably not the best person to ask because those dynamics were at the state level. Jack Ebeler may have better information; I would certainly trust that. What I remember starting this was a problem at the end of the fiscal year in the late '80s in West Virginia. And what we were told was that the governor sat down with the hospitals and said, "You know, you are going to contribute to the state treasury so we can draw down federal funds or you're not going to get paid. And we don't care what the law says." Something—to that effect. So that was to me the political precipitating event. But what else was going on in other states at the same time, I don't know. I think once people saw how that transaction worked, you know, then the grapevine—

SMITH: And there were big questions, is this constitutional, and so forth?

SCHNEIDER: Well, there were a lot of questions about it. A lot of questions about it. It was perceived as problematic from a lot of different perspectives. But again, I'm sure there were other things going on that I didn't see from my particular vantage point. So I don't want to miswrite the political history. Jack actually had a chance to sift through all this stuff, so I would trust his analysis, more than my memory on a lot of this.

Tennessee was part of it. The high match states could definitely see the logic of this, probably because most of the high match states have real problems finding revenues to pay for public services. So they took the opportunity to bring in federal funds without spending their own. Maybe that dynamic was waiting to happen, maybe it wasn't. Why did it break out

then? I don't know. I just don't know enough about the state revenue circumstances at the time. But my guess is it had something to do with that.

SMITH: We talked a little bit another time about waivers. And I remember you said the 1115 waivers were one thing and HIFA is one thing, and that by and large you and Mr. Waxman were in favor of the 1915(c) kind of waivers. And felt that was a good way to go, particularly it would be very important for California, I would think; but were not so happy with some of the 1915(b) waivers and Mr. Waxman wasn't particularly negative about HMOs, but was just a bit cautious. Over time did you begin to get bit more jaundiced with waivers or—

SCHNEIDER: Well, this may be a long answer so we'll take this one piece at a time. Of course we have different kinds of waivers. The easiest one here is the 1915(c) waivers. They were also part of the OBRA 1981 deal. I don't really believe that waiver authority was about California. It was about Claude Pepper. Claude Pepper had, for a number of years, been very interested in reducing what he called the institutional bias—in the Medicaid program. Because a lot of money was going into not just skilled nursing facilities, as they were known at the time in Medicaid, but also into intermediate care facilities. And the quality of care was just not acceptable in a lot of cases.

To create an alternative, Mr. Pepper was very interested in allowing federal matching funds to be used for what came to be known as home and community-based services.

He wanted it to be a state plan option. I can't remember who objected to that. I just can't remember where the objection came from. But we were not able to enact a state plan option. So we said we'll try this with a waiver first. And because of cost concerns, we ended up constructing a waiver with a budget neutrality test. And here's another example where if you go back to Tom Hoyer's point, when the administration wants to make a statute live it can do so.

There was a long fight, as you know, over what that budget neutrality test should be, how restrictive it should be, and it went back and forth over the next decade basically between the Administration and the Congress. Because from the standpoint of Mr. Waxman and Mr. Pepper and others, it was not a bad thing for people who were at risk of institutional care to be served in the community even if it cost a little bit more.

The republic was not going to fall. But that was not the view of others, obviously, and particularly the people working in the Office of Management and Budget or at HCFA at the time, or both. Anyway, their view was this is a serious problem...and we want to be sure it is budget-neutral.

So that was just around the elderly. Then, of course, a separate set of politics was developing around home and community-based services for individuals with disabilities, particularly those in ICFs/MR. It's not like this was all triggered by 1915(c). I don't recall it being particularly thought through at time 1915(c) was enacted. But there was, you know, quite a movement on the part of some families of individuals with disabilities to move them out of state institutions into community placements, where that was appropriate.

And there were union issues. Pennsylvania was a state with this issue, when this came up in a major way. And there were fights over closing down particular ICF/MRs. There were quality issues on both sides, you know. There were quality issues on the deinstitutionalization side and there were quality issues on the institutional side. And the home and community-based waivers ended up playing a role in remedies for some of the litigation that was brought against some of the institutional settings.

I certainly didn't see that coming at the time. Maybe others were more farsighted. But again, in terms of making a statute live, either the Administration through a constraining budget-neutrality test, or the courts and advocacy groups picking up on the statutory mechanism and using it as part of the set of remedies, here are 2 examples. Very much alive—sometimes in ways not anticipated.

So that's one set of waivers. We have gained a lot of experience from the 1915(c) waivers. And a debate still continues: should there be a state plan option?

And now there is also quite a bit of interest in actually expanding the scope of home and community-based services to include direct payments to individuals with disabilities that they can then in turn use to purchase their own personal care and other services and supports.
So there is continuing exploration around this, all of which I think is very healthy.

Now, that's one set of waivers. You mentioned 1915(b) waivers. And that from my perspective and Mr. Waxman's perspective was about the mistakes made in California in the '70s. And so let's just go back there for a second. Ronald Reagan was governor and his notion of reforming the MediCal program included allowing private managed care plans, then known as prepaid health plans, to accept risk and take responsibility for providing covered services to low-income women and children.

This was not an issue about SSI beneficiaries at the time. This was about AFDC families. The record will bear me out on this: things went downhill very quickly. There were a lot of different reasons.

I don't want to go into the details here. But if you look at 1976 report of the Senate Select Committee on Investigations—it's all there.
And Mr. Waxman at the time was the chairman of the health committee in the California assembly and he co-authored something called the Waxman-Duffy Act, which as far as I could tell, was one of the first, if not the first, pieces of Medicaid managed care regulation...

SMITH: Do you remember when that passed?

SCHNEIDER: I want to say '72 because he came to the Hill in '74. So it was probably '72, '73, sometime in there. He understood what was going on, had some success at dealing with some of the abuses, but couldn't really stop it.

And so the Senate Investigations Committee came in and saw what was going on with the federal dollars and said, "We don't think so." This led to the enactment of the 50-50 rule, just a quick and crude solution.
You cannot use federal matching dollars to buy services on a risk basis from an organization that serves more than 50 percent Medicaid and Medicare patients. They have to have some commercial patients.

The analysis of the Senate Oversight Committee was that almost all of these prepaid health plans where there were problems were exclusively or almost exclusively MediCal. And so their solution was, well, if they can make it in the marketplace, fine: 50-50...

So fast forward to 1981. A lot of unhappiness about that 50-50 rule because people couldn't set up managed care plans just for poor people. And that was seen as a problem by entrepreneurs, that was seen as a problem by state agencies. There was a lot of discussion around that.

Now the other question was: Could you force people to enroll? And of course the premise of whether it is 50-50 or 75-25 or anything else, crude as it is, the premise is that people have a choice.

Which sounded sort of “market lite.” But that wasn't working for, again, the entrepreneurs, who wanted a captive market, and it wasn't working for the state agencies that wanted significant managed care penetration, one contract, et cetera, et cetera. So the compromise was, there is still freedom of choice but we are going to allow the Secretary to waive it: section 1915(b). And we want a check every two years.

This is an example of how staff and member perspectives are shaped. I was working in California with a legal services program in '75 and '76 and we had a lot of clients who were trying to disenroll from prepaid health plans. They couldn't get out. The plans liked the capitation payments. Of course the clients would go over to L.A. County Hospital or USC and get their services there but the plans weren't paying the hospitals for the services. So that really left an impression with me. I wasn't thinking about it as a federal staffer at the time—is this an appropriate use of federal dollars? I was thinking these clients need services and they are not getting it from the providers that are being paid to serve them. Mr. Waxman was not necessarily seeing it from that spot on the ground but he was seeing it from the range of perspectives that are presented to an assemblyman.
He learned from it, and I learned from it. And you bring that experience and the judgments you form into the legislative process. So that's the short story around 1915(b) waivers.

Over time, of course, the 75-25 rule was repealed. Now, you don't need a 1915(b) waiver to require enrollment. Most populations are in managed care. On the other hand, there are some additional protections in the statute, added in 1997, around what a managed care organization has to look like and how it has to behave.

And after some extended controversy, we finally, as of June a year ago, have a set of implementing regulations out. And we'll see what happens.
One final point. In 1981 as part of this discussion around managed care and the 75-25 rule, what showed up in the statute was a requirement that payments to managed care plans should be actuarially sound.
And going back to Tom Hoyer’s point about the statute not really living unless the agency wants it to, it was not until last June that that

requirement was spelled out in a regulation. That would be 20 years after its enactment.

SMITH: Who was responsible for putting it in? The actuarial soundness requirement.

SCHNEIDER: Again, there were discussions with Tom and the other Senate staff. And our point was part of the problem in California had been that the capitation rates had nothing to do with the health status of the populations that were being enrolled. And that's wrong under any circumstances. We didn't know exactly what the right methodology was. Of course, this is 20 years ago. I don't know if the word risk adjustment was even in the policy vocabulary at the time. But we did know there was different health status among these different populations.

So there was an effort in the statute to say, look, we are not talking about reasonable cost reimbursement but we want these rates to be actuarially sound so that the organizations delivering these services have enough resources to do it right, given who they are enrolling. And we don't want a situation where the private patients are constantly being called upon to cross- subsidize the Medicaid enrollees, because that is not going to work over time. I mean, that was clear. But no agency implementation, really, as far as I can ever tell—until the June 2002 regulation, and we are about to see how that plays out in this time of state fiscal distress.

The one thing that did get implemented quickly was an upper payment limit. On a contractor-specific basis. The agency had no problem with setting a cap on the payment and tying it to what would otherwise have been paid on a fee-for-service basis. Over time, as the fee-for-service rates deteriorated in a lot of states, that became a real problem, a real problem—again, depending on the state and depending on the contractor.

Well, as a result of this regulation that upper payment limit is now repealed. And to my way of thinking, good riddance. Instead we now have what I think was originally contemplated, which is that rates need to be actuarially sound. Particularly if states are going to require people to enroll and the plans can be all Medicaid.

If rates are not actuarially sound, you are basically talking about a situation where you are forcing people to enroll in an undercapitalized entity. You're just asking for trouble.

So you can see, a lot of these issues continue to percolate over a long period of time.

SMITH: The language stays though.

SCHNEIDER: And sometimes language doesn't change. Sometimes it just sits there and incubates. Actuarially sound basis. It has not changed. And now, after 20 years, we'll see what it means. We are about to see how it plays out...
SMITH: On this subject of waivers—
SCHNEIDER: Oh, yeah. 1115's?

SMITH: Well, I wasn't necessarily thinking of 1115's. Were you at all involved with the Katie Beckett waiver? We are actually going to talk to Katie Beckett today.

MOORE: Actually, I think we are having lunch with Katie Ann's mother.

SCHNEIDER: Well, give them my regards.
Tom Tauke, Republican Congressman from Iowa, was on the subcommittee at the time and that's how it got brought to Mr. Waxman's attention.

Your memory on this is going to be better than mine as to exactly how this started, but it does relate to the Pepper concerns. His primary concern was with the elderly and institutionalization of the elderly in nursing homes. But there was obviously a parallel problem for people with disabilities and kids with disabilities.

And what had happened, you are going to have to check the dates here, but around 1981 after the chaos of OBRA, in early '82 there were some highly publicized cases about kids being trapped in institutions. Under the eligibility rules at the time, which still apply, once an individual is institutionalized for 30 days or more, the income and resources of the parents are no longer attributed to the child for purposes of Medicaid eligibility.

And if the child doesn't have a trust fund, or any other income or resources, the child is pretty much eligible for Medicaid—as long as the child stays in an institution. This was an unhappy situation for families that felt like they could keep their children at home if they had a little bit of help, and that the state and the federal government were spending a lot of money on institutional services.

They could do it as cheaply, they felt, and provide better care and have their children at home with them. But they couldn't do it without some help. And the way the rules were at the time, there were no federal Medicaid dollars available because those children, if they were in the household of a middle class family, couldn't qualify. Again, they just had to be institutionalized. So what began to happen was the granting of individual waivers in highly publicized cases.

It was clear that what we were heading toward was a situation where someone in the executive branch would be contacted by either a member of Congress or a state official saying, “We know this family; they really need help; can you allow us to cover the service at home?”
And the answer would be, "Well, we'll think about it," and eventually, "Yes, that's okay as long as it's just this child. And where is the press conference?" And you know, that's just not the way to run a public program.

So there had to be a better solution. The states’ concerns were that they wanted to be protected from the woodwork effect because there might be a lot of people out there who were not putting their children in institutions, keeping them at home. But if Medicaid funding were available for the children at home they would ask for it and that would be an additional drain on the state treasury and the states couldn't exactly credit their financial exposure. So that was a concern.

At the time it was not clear that anybody had a clue how many children were in this situation and what it would cost. So Mr. Tauke’s provision was framed as a state option to allow coverage of children who were at risk for institutional care, would be eligible if placed in an institution, and could be maintained at home. The option was statewide because, again from Mr. Waxman's standpoint, it was important not to have either the governors or the executive branch at the federal level picking and choosing among worthy individuals.

That was just not heading in the right direction for a lot of different reasons. So that was the Congressional response. I believe that was enacted in 1982 in the TEFRA legislation that year.
Sometime around then, either shortly after that or simultaneously with it the Administration made a change in the 1915(c) regulations and allowed what were called model waivers. These allowed states to cover small numbers up to 50, up to 25, only in certain parts of the state. I don't remember exactly what the threshold was. But the basic notion was, it allowed the state not to

go statewide and to limit enrollment. I don't know how it played out: which states took the model waivers, which states took the Katie Beckett option, and how many children benefited. But that was the driving impulse.

SMITH: Was the Katie Beckett waiver different from the model waiver?

SCHNEIDER: Well, you know, it's called a waiver but it's not really. It's a state plan amendment.

MOORE: And if you ask people who were administering now, they don't really know. It's almost an accident of where the state was.

SCHNEIDER: It's just a question of whether you wanted to limit enrollment in it. From our perspective, that was a good result. The states could do it on a statewide basis, the states could do it on a more limited basis. And in either case it was better than picking and choosing among otherwise similarly situated individuals based on which politician they knew.

SMITH: But was there some strange wrinkle about having to give Katie Beckett a dollar income?

SCHNEIDER: If there was, I don't remember it.

The problem was—the problem was, she could not qualify for Medicaid assistance at home because her parents either had too much in the way of assets or too much in the way of income... But they will tell you about that.

I think they will know exactly what the situation was. The key point is that at the time, there was no eligibility category for home and community-based services that would accommodate this family.

SMITH: Was it pretty generally the case that OMB at that time was fighting almost any waiver during the '80's?

SCHNEIDER: There was, as I mentioned earlier, this fight over several years about what the budget-neutrality test would be for the 1915(c) waivers. That went on for a while. They would issue a reg. We would say that is not really quite consistent with our original statutory intent. So we would change the statute so as to say, here's what it means. So there was that, back and forth.

CBO was in a better position to answer your question because they would be in conversations with both the Administration and us. And of course there were times when the Administration wouldn't talk to us, for perfectly understandable tactical reasons, and vice versa. We both would talk to CBO because CBO was the scorekeeper. So CBO may be able to give you a better answer.

As you pointed out, the 1115 waiver far preceded my arrival on the Hill in 1979. The first time I became aware of it was in 1977 when a waiver was granted to the state of Georgia to test the imposition of cost-sharing. Georgia wanted to impose much higher cost sharing than the statute allowed, and they seized on the 1115 waiver mechanism as a way to do that, arguing that they were going to test what would happen. I was working in legal services at the time and of course legal services clients who were the subject of this experiment could not afford the higher cost sharing. In the court case that ensued, the argument was made this was impermissible experimentation on human subjects. There were regulations in place by that time and the agency's view was, well, these don't apply to Medicaid and poor people. And our view was, wait, they're human subjects, and this is a demonstration.

You will find in the current statute a provision that the Secretary does not have the authority to waive the current restraints on cost-sharing. States are allowed to impose nominal cost-sharing on certain populations for certain services. But the Secretary can't waive these, period, unless certain rigorous experimental standards are met. And that all flows directly from the experience around this Georgia waiver.

MOORE: Do you remember the 1115's on family planning...or eligibility expansions being used...

SCHNEIDER: Well, you know, I don't remember everything.

MOORE: You don't?

SCHNEIDER: I wish I did. I really wish I did. And I need to go back and figure out what did happen to waivers during the '80s. I was really distracted by a number of other...
SMITH: Yes.

SCHNEIDER: The big section 1115 waiver in the 1980's was Arizona. This was, I thought, a very creative but unintended use of the 1115 waiver

authority. Arizona absolutely positively had to have federal matching dollars coming in to avoid having its two largest counties crash, but for various reasons, including not wanting to have to contribute to the costs of care for their Native American population, they just did not want to have any part of Medicaid.

But without the federal Medicaid dollars, the counties could not handle their long-term care costs. So the state worked out an arrangement with the Reagan Administration where they had not Medicaid but AHCCCS. And it was going to be managed care, it was going to be new, it was going to contract out to a private vendor to manage the program, and so on. But it all came down to using section 1115 as political cover to bring federal Medicaid dollars into the state of Arizona.

You can draw your own conclusions. There were some hearings on the Arizona waiver. Again, sort of an unorthodox use of the waiver authority. Surely they were testing lots of things, but whether it was really to test them or just to bring the federal dollars in, is a matter of some debate. The next time section 1115 broke into my consciousness, through the other things going on, was Oregon. Now, that was a test of a radically different approach to structuring benefits. It merits a long discussion, but we can't do it justice in this interview. But there you can argue, that is the kind of thing that 1115 waiver authority is designed to do, provide a state with the opportunity to test a different way of structuring benefits... I personally had a lot of problems with the Oregon waiver, a lot of problems with it. So I don't want to be heard to endorse it, okay? But your question is, “What should a section 1115 waiver be used for?” And to my way of thinking Oregon is a much more comfortable fit than Arizona or than Georgia. The Oregon waiver has its own history and it continues to evolve as we speak.

It's worth pursuing.

Then we move to Tennessee. Tennessee is another executive branch to executive branch conversation. In this case, between a Democratic Governor and a Democratic President whose Vice President is from the same state. It's basically an effort to protect a large flow of federal funds into the state, that were otherwise going to go away because the political agreement at the state level, that had supported provider taxes, was unraveling. The way to save, to lock in the federal DSH baseline, was to issue a section 1115 waiver. Because most of the money ended up being used to provide coverage to a lot of poor people in Tennessee who otherwise would not have been covered on balance, I think it was a good thing. Was it what the 1115

waiver authority was designed to do, no. No hypothesis was really tested there. Not that we haven't learned from the Tennessee experiment but it's not like we went in to test and to learn. We didn't.

We went in to protect the federal flow of dollars to Tennessee and to expand coverage. Again, from my personal policy point of view, that is a great result. A lot of low-income people who otherwise wouldn't have been covered were covered.

SMITH: It starts with the Social Security Act and it seems like the logic of it is that you've got a powerful Administrator behind it who is going to focus on something they want to get done and get a waiver going and then use the results of that to spread it about.

And you almost wonder whether 1115 doesn't have misdesign...appropriate...for the Medicaid situation. But it seems that rarely does it function the way one would hope.

SCHNEIDER: Again, I wasn't around when 1115 was enacted. But I can't imagine they had some of these things in mind. It was clearly a limited grant of discretion to the Secretary to allow the use of federal dollars for pilot or demonstration projects.

It made sense, you know. We'll explore innovative delivery arrangements, or let's see what happens if we change the eligibility rules in a certain way. Does that change the work incentives? It was a more limited notion. But overtime, as political demands increased, the Executive Branch had this mechanism at its disposal to move its policy agenda without getting Congress to sign off.

In theory, the federal courts check abuses of discretion by the Executive Branch. When it really steps out of line, then reluctantly they will intervene. But the courts don't want to be running these programs. And the Executive Branch understands that. The Executive Branch also understands it is very hard for Congress to rein it in as well. If the waiver is something a Governor wants, the Governor can protect his waiver through his state's delegation in the House and the Senate.

We are in a situation now where section 1115 waivers involve a lot of federal dollars. You'll have to check the numbers, but probably a fourth of all federal Medicaid dollars are running through waivers.

Is that a good thing or a bad thing? My own point of view as a former legislative staffer is that's too much. Do you know where your federal dollars are? And if they are being spent in an appropriate way, why do you need a waiver for it? Let's change the statute. And if they're not, enough is enough. Of course, that is easily said in an abstract policy context.

I do want to commend to you an excellent paper by Jocelyn Guyer of the Kaiser Commission that was just released last week about the Pharmacy Plus waivers. This is a classic example, a classic example of the Executive Branch using the ability to give federal matching dollars for purposes that are not allowed under the statute, without the waiver, in order to extract a policy concession from the state—in this case, a cap on all federal Medicaid spending for the elderly. The benefit to the state is refinancing a state-financed pharmacy assistance program for near-poor elderly who are not eligible for Medicaid. The overall policy objective is limiting the federal financial exposure for all services.

SMITH: It does underscore Tom Hoyer's point about how the statute has gotten loosened and loosened with—

SCHNEIDER: Right.

SMITH: So at times of political upheaval it doesn't defend as well.

SCHNEIDER: It doesn't. If you look at the text of section 1115, it is to enable the Secretary to approve experimental, pilot, or demonstration projects. The Arizona Medicaid program was not a pilot or demonstration project in the original use of the term. The text of section 1115 also says the project, in the judgment of the Secretary, is likely to assist in promoting the objectives of the Medicaid statute. Well, how is it that an aggregate cap on federal matching funds for all services for the elderly will assist in promoting these objectives?

It's very elastic language and they are running with it as far as they can to advance their policy agendas.

SMITH: We are taking a lot of Andy's time. Do you want to get into children?

MOORE: Actually, there were just a couple of child health questions and they mostly have to do with...

SMITH: There was a question I wanted to ask you and it's not a trick question. It's not meant as a foolish question. But why, in your judgment, partly your personal opinion but also your ideal observer judgment, why is it important to keep Medicaid as an entitlement?

SCHNEIDER: There are two entitlements in Medicaid. One is the individual entitlement to a defined set of services for an eligible individual. The other is the entitlement of the state, that chooses to participate in the program, to receive federal matching funds at the specified rate, for allowable costs of services, provided to eligible individuals.

These work in tandem. You can't really have one without the other. Let's focus on the individual entitlement. I am talking about an entitlement to a defined package of services, not $500 and see what you can buy.

That's a different model. For a low-income population, an individual entitlement protects them against unexpected changes in cost. EPSDT is the classic example. That is on paper—the comprehensive package of services to which kids are entitled. And people are still continuing to try to enforce it, as you know.

There are lawsuits out there, some of them brought by pediatricians, some of them brought by community groups, to try to enforce specific aspects of EPSDT either on the fee-for-service side or in managed care.

Which is to say—it's not necessarily working well. But there is a policy and statute that says whatever it takes, we want to be sure that these eligible kids get immunizations, lead screening, general developmental screening, diagnostic services, follow-up treatment. That defined benefit was what low-income populations need. That, as opposed to, "We are going to give each kid or each family $1,000—have a good day." That's a huge, huge difference.

When you start shifting costs onto low-income populations it is very quickly downhill. They can't handle it. It may be a different matter with my kids. But for these populations, they just don't have the resources, period. And without the entitlement, they will go without, unless they are close to a community health center or a rural health clinic or a public hospital that will take them. If so, great. But that's not going to work in a lot of communities. If you are thinking nationally, for a low-income population that you know is at higher risk for poor health, the individual entitlement is the best way to go. It promotes a better public health result.

It does create fiscal exposure problems for the state and federal government because you don't know exactly from year to year how much you are going to spend. You don't. Life is a risk. Not everything is certain. There is just no question about it. But I think the investment, particularly given what we know now about early childhood development and how much of a difference these small little interventions make, is well worth it.

This investment is what the EPSDT entitlement protects. It's the best way to protect it in my judgment. Is it working as well as it could? No. Is it creating some financial problems for some states? Yes, there is competition for resources. How are kids going to do against people who can vote? Not too well, right? That is why an individual entitlement is essential.

I don't have a lot of empirical basis for this, but I will argue that having the individual entitlement to necessary medical services would encourage entrepreneurs to invest in developing technologies and therapies for the covered population, knowing that potentially there is a market there. An individual entitlement, with open-ended federal funding, creates a different investment environment than one that says you are covered to $1,000 and that's it. If you are an entrepreneur, or you are a firm thinking about where to put your next research dollar, would you necessarily enter a market in which the coverage is a fixed dollar amount? I think a defined benefit that is guaranteed creates a more favorable climate for investment.

SMITH: Yeah. I like use of the term entrepreneurs. Seems to me this is particularly an area in which rather sensitive and well-calculated changes can make an awful lot of difference in the kind of entrepreneur you encourage.

SCHNEIDER: Absolutely.

SMITH: And if you want to get the golden rule types in, that's one thing.

SCHNEIDER: Well, you need to have a little bit of sensible regulation. That is part of it, because it's a down side if you have an individual entitlement. It does require that there be some intelligent and continuous government oversight to protect its investment....and that is challenging, particularly in a program this complicated, with this many constituents. It's challenging for federal agencies and it's challenging for state agencies. No question about it.

SMITH: There may have been a lot of maturing in the Medicaid program. Seems to me there are many—certainly in leadership states—that can handle this kind of stuff.

SCHNEIDER: There is definitely a lot more expertise now than there was when the program started. But, you know, a lot of the state administrators are under the gun because of salary freezes and limits on the number of FTE's. The political pressure on these particular leadership positions is just enormous. It's enormous because of the large role that the program plays in state budgets and the unhappiness that that creates for all the other programs and constituencies. It's a very tough job and I can't believe it's adequately compensated in most cases. Running a state Medicaid program is definitely a public service challenge. And one I hope that a lot of people will take up.

SMITH: Well, I think I can say for both of us we're glad you're one of those who has taken up that challenge.

MOORE: Thank you for your time.

SMITH: Thank you so much

INTERVIEW WITH SARAH SHUPTRINE
JUDY MOORE AND DAVID SMITH – JULY 16, 2003

SMITH: This is an interview of Sarah Shuptrine by Judy Moore and David Smith and it is July 16, 2003.

MOORE: We should probably say that Sarah is the director of the Southern Institute on Children and Families.

SHUPTRINE: President and CEO.

SMITH: Maybe we ought to start with some of your personal history, especially as relating to the southern governors.

SHUPTRINE: Okay, I probably should say, Judy, president, CEO and founder. Because the story leads into that.
Well, when Dick Riley was governor of South Carolina in the early '80s B- he was elected in '78 and took office in '79—he appointed me to the Staff Advisory Council for the National Governors Association Human Resources Committee—NGA Human Resources Committee.

We had at that time already spent a lot of effort in South Carolina working on the Medicaid program with regard to opportunities for the elderly to stay out of nursing homes and be able to get help in the community.

Dick Riley had chaired the joint legislative committee on aging and I had been the research director for the committee.

MOORE: Was he in the legislature then before? Before he was elected?

SHUPTRINE: Yes, he was a senator. And he chaired a joint committee that was composed of three members of the South Carolina House, three members of the South Carolina Senate, and three members appointed by the Governor. I was the staff person for the committee. And we had developed an 1115 Medicaid waiver so that we could pilot a community-based long-term care program. So when we went into office, Governor Riley and I, we were more aware of the elderly side of Medicaid. And as we began to get into the issues related to the AFDC program and Medicaid, including some of the just completely counterproductive policies that were a part of the AFDC Medicaid program at that time, we could see a tremendous need for leadership in this area. And back in those days, think early '80s,

President Reagan was in office and the whole idea was no growth in the federal budget. He slapped a cap on the Medicaid program which was in place for three years.

He also took an action that restricted the people that could be eligible for AFDC, by changing the way their income was calculate, and it threw a lot of families off AFDC. It restricted both the AFDC program and the Medicaid program right at the time that we had made the decision that the Medicaid program was the way to try and cover more of the low-income uninsured in South Carolina, particularly children.

So it threw a wrench in our policy agenda. It was around 1982—when we were really formulating our ideas. And what we had discovered was that we could separate out the income level for Medicaid from the income level for AFDC. Not many states knew that at the time.

But we could do that and make a very small AFDC payment in order to give Medicaid health coverage to the families. So that was the road we were on and we got derailed by this cap situation. So we proceeded with our policy work and formulated what became the Medically Indigent Assistance Act in South Carolina, which passed in 1985.

We formulated our plan. We decided we were going to double the AFDC eligibility level for purposes of Medicaid, not for purposes of the cash assistance check. By doing so, we were going to bring in over 40,000 parents and children into the Medicaid program so that they would have health coverage and preventive and primary care, which they currently did not have because they could not afford to pay for it.

These were working families. They were working part-time, some of them working full-time, but they just weren't making very much. So the cap, which went in, I believe in 1981 and lasted through '84, was just a major issue for us. We took the issue to NGA through me on the Staff Advisory Council, and started rousting people about it because it was just totally restricting the ability of states to be able to do anything for the uninsured using the Medicaid program. So we took it on then, with Dick Riley being a major force for the removal of that cap, and certainly advocating against the extension of it.

SMITH: At this point were you dealing much with Congressman Waxman? Because it seems to me that this is a movement swelling up from the states that's anticipating a lot of things he later wanted to do.

SHUPTRINE: Well, I'll get to Waxman. He did not come into our picture until later, until SOBRA in '86. We fought really hard to remove the cap. I was back and forth with Senator Strom Thurmond's staff because they were trying to support the president.

And, I mean, the wires got pretty hot between the Governor's office in South Carolina and Strom Thurmond's office. We knew that if we could get him to support the removal of the Medicaid cap, it would make a huge difference and it would be a real help to us to be able to get some Republican support.

Of course, it was good public policy to try and cover the uninsured families that were working and needed this health coverage through Medicaid. We played hardball at the staff level, not between Senator Thurmond and Governor Riley, but at the staff level.

And I have some war stories, which I won't share with you but they are amusing. Anyway, we avoided a lot of leadership on removal of that cap. We were able to get Strom Thurmond to vote against that cap.

And the cap did in fact come off. We were able to do that through NGA—it was Dick Riley, Mike Castle, of course, who is now in Congress, who at the time was Governor of Delaware, and Bill Clinton who was Governor of Arkansas, and Lamar Alexander who was Governor of Tennessee. There were a number of very progressive Governors at that time that were all members of course of the Southern Governors Association.

Once we got the Federal Medicaid cap off, we passed the Medically Indigent Assistance Act in South Carolina. We doubled the AFDC level in order to make more low-income working families eligible for Medicaid. They would receive a very tiny AFDC check—but they got Medicaid coverage. We also covered intact, two-parent families.

And we created a medically indigent assistance pool, of $15 million of state funding to go to hospitals so that they could provide care for people who were not eligible for Medicaid, but who were indigent.

The primary funding source for the Medically Indigent Assistance Act was the Medicaid program. It was signed it into law in 1985. And when the New

York Times in 1985 or ‘86 was looking for the state in the country that had been the most aggressive in health, they came to South Carolina and wrote about what we had done, because we were taking more action here in their view than any other state to try to deal with the issue of the uninsured and health issues. Their article recognized South Carolina because we were addressing the need for community long-term care and the needs of the low-income uninsured. So from that point on then, we envisioned using the Medicaid program to begin to expand coverage.

Right at that particular point in time, the Southern Governors Association and the Southern Legislative Conference decided to jointly create the Southern Regional Task Force on Infant Mortality.

And that is where the leadership came for the ultimate passage of the 1986 SOBRA Medicaid Amendments, which I think were the most significant amendments to Medicaid since it has been created. The amendments separated Medicaid from welfare for purposes of health coverage for pregnant women and infants, and this action led to future amendments allowing children ages 1-18 to receive Medicaid without being on welfare.

Now to relate the way that happened—I’ll bring you back to ‘84 and ‘85 when we started the task force and we met during ‘85. Those reports are available. I’ve got copies of them if you can’t find them anywhere, but they are probably in the Library of Congress because I think they received all of the task force reports.

The reports were compelling. The discussion at the final meeting was quite contentious because the folks that were AFDC advocates were scared to death to lose the connection with Medicaid because Medicaid had the strongest constituencies.

They didn’t want Medicaid and AFDC to be separated for fear they would lose any support for increasing the AFDC payment level.

At which point, it was pointed out that no states were doing that anyway—and that increases in the AFDC eligibility levels weren’t on anybody’s radar screen. So all they were doing was holding the Medicaid program down.

I chaired the staff work group for the Southern Regional Task Force on Infant Mortality, which Governor Riley chaired. The membership of the staff

work group included a lot of state commissioners and some congressional staff and heads of private organizations.

We had some knock-down drag outs trying to deal with this public policy issue, and it came down to the fact that it was wrong, and counterproductive public policy to deny prenatal care and early infant care to pregnant women and infants, because they were not associated with the welfare program. That to simply make them be on welfare to get prenatal care and early infant care was wrong and highly counterproductive from a cost standpoint as just being bad public policy.

SMITH: Were the numbers on infant mortality particularly striking at this point? Was this a very big talking point?

SHUPTRINE: Oh, they were very striking. The South of course was at the top of the list. Southern states had the highest infant mortality rates in the country. Now, you realize the South as defined by the task force was the Southern Governors Association Region. That was a region defined by the Southern governors and it was a group of states that shared common problems and could work together to resolve them. That's why when I founded the Southern Institute in 1990 it was a region that I was familiar with, had relationships in, and I knew that we could make a tremendous difference when we come together.

The task force report came out in November '85 and was endorsed by both Southern Governors and the Southern Legislative Conference.

Then Governor Riley decided to take it to NGA because we wanted the federal law to be changed to allow pregnant women and infants to be eligible for Medicaid without having to be on welfare. It was that simple.

So that meant I had to take it to the NGA Staff Advisory Council before he took it to the governors. My co-conspirators were Carol Rasco with Governor Bill Clinton of Arkansas and Cathy Way with Governor Mike Castle of Delaware. Well, we got into a number of extremely tough conversations, discussions at the Staff Advisory Council meeting. The NGA staff for the Staff Advisory Council at that time were highly concerned about the federal budget because the word was that there was no support for increased spending.

It was my understanding that increased federal spending was not to be supported by any of the Republican governors. Again, President Reagan was

in office at the time that all this was stirring around, and word was that the White House would not support this action.

But we managed to get it past the Staff Advisory Council and that meant that Governor Riley could then take it to the National Governors' Association at their winter meeting in early 1986.

SMITH: Now, you say you managed to get it past the Staff Advisory Council. Was there any kind of key thing that helped you get it by there or just talking and talking, or what?

SHUPTRINE: Just support, basically. I lined up support of the various staff members of the governors. This action was hard to argue against. It was real hard to argue that pregnant women and infants must be required to be on welfare to get prenatal and early infant care health coverage through Medicaid.

I mean it just makes all the sense in the world to do this. And we had all the information. We were passionate about it and we weren't going to take "no" for an answer. So that was the setting.

And we got it through that group. Then Governor Riley was planning to attend the winter NGA meeting in Washington and bring it before the governors.

As you know—and both of you have probably been in that room—there is this huge table with all the state flags around it and all the governors sitting around this huge table and their staff sitting behind them.

Well, this issue was to come before them. We got word that the White House did not want this provision to pass. The information we had was that they had lined up two Republican governors, which will remain unnamed, to fight it. This was certainly something we had to take on.

So when we got to Washington for the winter meeting, Governor Riley pulled together the leadership of the National Governors Association, which at that time was chaired by Tennessee Governor Lamar Alexander, whose wife Honey Alexander had served on the Southern Regional Task Force on Infant Mortality as did Hillary Clinton, as did Lynda Bird Johnson. Three first ladies were [also] on the task force.

And so Governor Alexander, who is a progressive thinker anyway, had this background of coming from the South and understanding the issue. He was predisposed, I think, to be for it but there was the opposition of the White House to contend with. He was not one of the two governors, by the way, that was lined up to fight it.

I can't overemphasize the leadership that Governor Riley demonstrated during those couple of days—he was just incredible and led the fight to get NGA approval. We were all there working real hard on this to line up support. And by the time it came to the vote, it passed.

So we took it from the National Governors' Association winter meeting to the Hill. And once again the strategy was I work the staff, he works the members.

Rae Grad, who was the executive director of the Southern Governors Association Task Force on Infant Mortality, and I went all over the Hill. I spent a lot of time in Washington meeting with staff on this issue. And of course the big issue was the federal budget.

And I'll never forget it. At some point in time, and I quoted it I don't know how many times, Don Muse, who was head of the [health budget section of the] Congressional Budget Office at the time, called this, I think it was $100 million federal expenditure, called it "budget dust." We made good use of that assessment by the head of the [health budget section of the] Congressional Budget Office.

It was an incredibly important policy statement and policy change for the federal government to make. Well, we lined up support with Republicans and Democrats, worked it really hard.

And I'll never forget when we did the press conference introducing the bill in the Senate that Senator Kennedy and Strom Thurmond were on the podium, Lloyd Bentsen, Lawton Chiles, and a number of other leaders of the Senate. You know, the South has consistently had a very strong leadership role in the Senate. Senator Bentsen was Chairman of the Senate Finance [committee]. So what happened with regard to getting Strom on to that bill was interesting—I don't know how much of these back-of-the-scene stories you want. Is this interesting or should I just end it?

SMITH: No. This is wonderful; we can't get this detail anyplace else.

SHUPTRINE: We had a meeting, Governor Riley and I, which I set up with the same staff person that had to be taken on in '84 over the removal of the Medicaid cap. And this staff person was highly concerned about us seeing the Senator because Governor Riley and Senator Thurmond got along well and Riley was very convincing on this issue.

Well, we got into the Senator's office, and the Senator's staff decided he was going to take the seat by Governor Riley, and leave me sitting over there where I couldn't get to my governor in case I needed to write notes or whatever. Governor Riley generally did not need anything like that. But the staff person posted himself over there with Governor Riley.

And so the staff member opened the meeting, Governor Riley explained the amendment and why it was important. We needed Senator Thurmond desperately. Somebody had to show leadership on the Republican side that was very high up. We were working with our Republican senators in the South and of course Senator Thurmond was key. At that time, he had a lot of power in Congress.

So after they talked back and forth, well, Senator Thurmond turned around and he looked over at me and he says, "Well, I want to hear what this pretty girl has to say."

I grabbed the opportunity. I knew Senator Thurmond was devoted to prevention. He believed in that subject and to be able to prevent infant death and disabilities would make all the sense in the world to him.

I launched in to the prevention and primary care aspect of this issue and how it certainly can be translated to savings and costs: what it cost for one baby that's born and has to spend a great deal of time in neonatal intensive care versus a baby that's born healthy. And just on and on. He just said, "Well, you know," he says, "that just makes good sense to me." And he turned around to his staff person and he said, "I think we need to support this legislation." After that meeting, he opened up the door for us to talk with Senator Bob Dole, who was Senate Majority Leader.

And we worked with Senator Dole and his staff and they supported it. After that, it was just not going to be the thing to oppose anymore.

So when we got up there to the press conference on the Hill, we had a good mix of folks. Senator Kennedy got up and he said, "You know," he said, "I'm

looking around here." And he said, "It's not normal for me and Strom to be on the same podium supporting the same legislation."

He said, "I'm a little worried one of us has not read this bill." Laughter erupted at that point. And then the Washington Post the next day had an article about the unusual political coalition of bedfellows—or something like that—supports infant mortality legislation.

Well, in my opinion, and I've had others express that view, the passage of that legislation in SOBRA of 1986 was the defining moment on separating Medicaid and welfare. It was not 1996. It was 1986, because that was the chink in the armor that broke that historical connection between welfare and Medicaid, that had forced families to be on welfare to get access to preventive and primary care through Medicaid. So then we—that was the Senate side of the story. The House side –I'll pick up on Congressman Waxman. And so when I approached the House side and start working staff, I met Andy Schneider. Although pleased, he had difficulty believing that the South was rising up in support of increased Medicaid spending.

Congressman Waxman was very supportive of it and provided strong leadership on the House side.

And Congressman John Spratt from South Carolina, was a big supporter of it, as well as Congressman Jim Clyburn—all these folks that had been there for a while and have great leadership over there—so we were able to get support on both sides of the aisle and it did pass.

Looking beyond passage, it was important to make sure that this opportunity was not squandered.

I'm going to flash back now to 1985 and the passage of the South Carolina Medically Indigent Assistance Act. Remember I told you we had estimated about 40,000 parents and children would be eligible for that act. And although the estimates were soft they weren't mushy.

Almost a year after the bill had passed we were on our way out of office. Governor Riley gave his last State of the State speech in January 1987. So in the summer of '86 we had removed the cap and gained passage of the SOBRA amendments, putting us in a great position to expand Medicaid coverage. We started examining the enrollment members for the Medically Indigent Assistance Act and only 10,000 individuals had become enrolled.

And that's when I found out, Judy, about procedural barriers that were keeping families from being approved. We found out at that time that there were between 25,000 and 30,000 applications that had been denied and the primary reason for their denial was "failure to comply with procedural requirements." And I think you can understand that at that point, I knew that something had to be done to identify and remove procedural barriers that kept eligible families and children from getting Medicaid coverage.

MOORE: Yes.

SHUPTRINE: I and my colleague Vicki Grant have been after that for over 15 years. And it has taken a total turnaround. We had to go in and of course get the data on eligibility outcomes. You have to have data and information to make your case. And we showed through our research that barriers did exist. We had a story on the front page of the New York Times in October 1988 reporting on our work on procedural denials, that it was not right to be denying families because they didn't return all information requested by the eligibility agency, especially when it was a document that was not required for determination of eligibility.

But at that time, the mindset of the eligibility system was being driven by the quality control system. And I see some of that coming back around now and I'm very worried about it because it is a great backdoor way to keep people out of these programs.

There is not any substantial evidence at all that simplifying the eligibility process lets people in that are not eligible. So we went about documenting the problem and did a number of studies. We conducted numerous studies and produced reports. We went to several communities and did exhaustive research.

SMITH: Now, who at this point is "we?"

SHUPTRINE: At this point the we, is Sarah Shuptrine and Associates because Governor Riley was no longer in office. I couldn't imagine working for somebody else. There were ideas being supported for me to take a high level public agency position, but that wasn't appealing to me. I really loved public policy, being able to look across systems and programs with the primary focus being the family and the child.

And you can't do that in a single agency. And so I decided I would open up a public policy research firm. And that's what I did in the summer of 1986.

Sarah Shuptrine and Associates produced the basic research behind procedural denials and the impact of these denials with regard to restricting access to the Medicaid program for eligible families.

And Judy knows that I worked that issue very hard, speech after speech after speech, and worked it every way that I possibly could. And I am so pleased to say we have seen progress.

Through Covering Kids from 1997 to 2001 and Covering Kids and Families, that started in 2001 and will go through 2006, projects are continuing aimed at simplifying the eligibility process, conducting outreach to families, and making sure that the systems of health coverage are coordinated so that children don't fall through the cracks. Both initiatives are sponsored by The Robert Wood Johnson Foundation, with national direction and leadership provided by the Southern Institute on Children and Families.

And I am very pleased to say that the state officials, as well as the people that are working on these projects, are totally committed to trying to keep simplification in place. And, you know, simplification is best for the eligibility office as well as for the families.

SMITH: So it sounds to me as though much of how you work is seeking out and talking to individual, fairly well placed people. I mean you're not trying to stir the grass roots as much as you are trying to build a consensus and explain the case and gather the data and so forth and so on.

SHUPTRINE: Yes—for leaders—people that can make things happen.

Back in the 1980's and early '90's it was something people had never even focused on at all. And now it's a big focus to try and simplify the process. What I see happening at this point in time, is that there are questions being raised that are not well founded with regard to whether or not the simplification policies and procedures that have taken place are allowing ineligible families to become enrolled.

We're going to try to gather some information to examine the issue. It is not easy to do because the data are not easily accessible. You have to do special studies. But we have seen a major sea change with regard to where this issue was.

Now, back in 1990, I created the Southern Institute on Children and Families, which is a non-profit, totally freestanding, independent non-profit.

That was a hard way to do it. Had it been connected with another entity it would have been easier to establish.
But I wanted to make sure that we were freestanding so that we could conduct independent research with the focus on the well-being of low-income children and families and not be impacted by factors associated with another entity.

I had seen too much of that and I didn't want any part of I, so we had to be freestanding. So, in 1990 we were approved as a 501(c)(3) by the IRS and began the work of the Southern Institute, based on that same 17 state plus DC region that I was familiar with.

We did a couple of reports with grants on uninsured children in the South. The first one was in 1992 and the update was published in 1996. These reports had a tremendous impact, from what we could see, with the States understanding the number of eligible children that they were not covering with their Medicaid programs. The actions identified or needed were outreach and simplification of the eligibility policies and procedures.

And remember that State Medicaid programs were not capped. This was a matter of state commitment. Congressman Waxman in the meantime was busy expanding the age groups. We went up to age one with the 1986 SOBRA amendments.

We had to go back, several years later, when our field research showed that eligibility workers were taking the baby off of Medicaid when the mother's postpartum period had expired, which is two months after birth. Because of the way that the legislation was written it was not clear that the baby was supposed to be eligible for up to a year, but it was clearly the intent that the infant was eligible up to age one.

It was Senator Jay Rockefeller who picked up that issue and got a Medicaid amendment passed to assure continuous coverage for infants up to age one, as long as the infant remained with the mother.

In 1997, Sarah Shuptrine and Associates was conducting work with the South Carolina Children's Hospital Collaborative(SCCHC), which we had helped to create. Through support from the Duke Endowment, the SCCHC supported our policy work and data analysis in South Carolina. In 1990, through Sarah Shuptrine and Associates, we returned to Congress with research on eligible infants losing Medicaid coverage at two months of age. We found that there were three times more pregnant women on Medicaid

than there were infants, which provided evidence for the need for legislation to make sure that Medicaid infants remained eligible.

Our research produced data to demonstrate significant evidence of "churning" of the Medicaid caseload, which means that closed cases were having to be reprocessed and were found to be eligible. In the interim, children's health coverage and care was disrupted. Members of the SCCHC and I took the issue and our supporting data to President Clinton's staff and to members of Congress in 1997. President Clinton supported the amendment to allow a coverage option in the Medicaid law, because continuous coverage wasn't just needed for infants, it was needed for all children. The amendment passed, and that happened during the same whirlwind summer that the state SCHIP program passed.

I mean, and if you think about it, it is not so long ago that in 1986 that, except for the medically needy program, you basically had to be eligible for welfare in order to get any Medicaid assistance at all. And now in this country 200 percent of poverty is considered a floor for child health coverage. It is widely believed that that's where state eligibility levels ought to be. Now, not everybody is there. But since the mid '80's, there has been an absolute sea change. To assure that policy was implemented, the procedural denial piece was important to simplify the eligibility process so that eligible children and families could access the coverage. But the other piece was increasing awareness of families that these services, these benefits were available to them.

And the Southern Institute did a study—March of 1994 was when it was published—that provided the first research that would show for certain that the families that were on the welfare system and transitioning off that system did not know in large measure that they could keep Medicaid benefits for their children.

And we got onto that—as a real cause—that we had to communicate clearly to these families. Because if you talk about an incentive to be on welfare—it was Medicaid. So we had to get word out that the Medicaid program was available for the children without the family being on welfare. And it's substantially higher earning levels than families would have ever believed. By that time, states had substantially increased the eligibility levels and, as you know, the federal government had set mandated levels by age group.

Congressman Waxman continued his movement until in fact it began to backfire with the Governors because of all the mandates, primarily the

mandates related to required benefits. There was a knee jerk some time in the 1990s. But he had managed to get the eligibility levels mandated in Congress for the infants up to 133 percent, children from 0 through 5, 133 percent, and then children 6 through 18 at 100 percent.

So that gave it a secure floor. And then beyond that the states could move up. And many, many did. But we took that research in 1994 and through the Southern Institute convinced Robin Britt who was the Secretary of Health and Human Services in North Carolina to provide research to the Southern Institute to be able to do what we call "information outreach" research.

And we went into 6 counties in North Carolina and tested, pre-tested and post-tested, and we developed materials that would communicate the benefits that were available to families. We developed three brochures and we then held meetings in 10 counties to inform community organizations and employees about benefits for low-income working families. This information is on our web site at www.kidsouth.org under the information outreach section.

The research and process of development of the information outreach brochures are reported in our February 1998 report.

There is a whole chapter in the report on the pre-test/post-test results and the brochures. Well, what we found out through the development of our brochures—again, we went into 6 counties in North Carolina and conducted 27 focus groups to develop those brochures. Nine of them were with community organizations like advocacy groups and hospitals and churches. Nine of them were with families that were either on welfare or transitioning off and nine of them were with employers.

You never put employers in a focus group session with other people. They have a totally different perspective. We developed an employer brochure and two brochures for the families that community organizations and employers could use.

All the artwork in the brochures is original and it's kind of cartoon-like on the family type brochures. It's not on the employer one obviously. All of the original artwork was approved by the focus groups.

If anybody had a problem with anything with regard to artwork we took it off. For example, we were trying to develop a little yellow brick road theme

that if you leave welfare—the theme was “leaving welfare for work isn’t as scary as it seems,” because we heard “scary” so much in the family interviews.

If we heard it once, we heard it a thousand times, when we would be talking to families over the years. They were scared to death to leave welfare because they thought they lose everything which they didn’t, but that’s what they thought. What they lost was that measly little check. It was especially small in the Southern States. They didn’t lose Medicaid for their children and they didn’t lose food stamps. They lost the welfare check. And when that finally dawned on a lot of those families in the focus groups, they said "Well, good grief." They could hardly believe it.

And it’s really sort of astounding that these changes were made in 1986, separating welfare from Medicaid for pregnant women and infants, and Waxman took them up through the age groups. And we were sitting there in the mid ‘90’s doing these focus group sessions and they were arguing with me, insisting that they had to be on welfare to get Medicaid for their children.

In 1995 when we were doing the research in North Carolina, the families would say, you’re mistaken. You know, they just couldn’t believe it. I mean, the grass roots truly believes you have to be on welfare and we’ve been fighting it and fighting it.

We wanted to make sure that the brochure communicated without being presented. They are much more effective if an eligibility worker would use them to present information on available benefits for working families not associated with welfare. It takes about two minutes to run through the programs that you can have and not be on the welfare program.

You can have the brochures tell them Medicaid was available for their children, and they specify the eligibility levels for the particular state. Again, the families were just astounded in the focus group sessions. They had no clue that they could earn that kind of money and have Medicaid for their children.

When we tested the readability and comprehension of the brochures, we went out and we did the pre- and post-test with every group. The gain in knowledge from one read through of the brochure was statistically significant in all groups. We have all of that in the 1998 report.

One of the three brochures was called, "Leaving Welfare for Work Isn't as Scary as It Seems." And the timing was just perfect because we did the brochure in 1996 and guess what happened? Welfare reform. So all the Southern States were very interested. The Southern Institute sought and received a grant from The Robert Wood Johnson Foundation, prior to Covering Kids, to market and replicate the brochure in the South.

North Carolina, Georgia, Florida and Tennessee had already contracted with the Southern Institute to tailor the brochures for use in their states. We were able through the RWJ support in '97 and '98 to go to every Southern State that had not adopted the brochures and market them. And every state adopted the "Leaving Welfare for Work Isn't as Scary as It Seems."

I think somewhere between 10 and 15 adopted the brochure "Have you Heard About Benefits for Working Families?" Many fewer states used the "Facts for Employers" brochure because county agencies just didn't know how to use them with employers. There would have to have been a lot more training for county staff to understand how to use the brochures in talking with employers. It just didn't come naturally.

The Department of Social Services offices that did use it—and one of them was Asheville, North Carolina—found it extremely effective. They would go in and work with employers with that brochure in their hand and they felt it gave them a professional approach. We were told they had to listen for 10 minutes while employers spoke negatively about "welfare" before they could talk about benefits for low-income working families.

Then they would say, okay, let's review some facts for employers. Did you know that the low-income employees that work for you could be eligible for these benefits: Medicaid for their children, the EITC, food stamp program, child care?

The least available benefit was child care because it is not an entitlement, so you couldn't say for sure that it was available in every state. If the state is progressive, and it allocates some state money in addition to bringing down the federal money for child care, even though we know it's not adequate because the federal government has never funded child care the way it has purported to in its policies, then child care for working families not associated with welfare is more available.

Employers were interested universally. We went from our North Carolina project over to Georgia where Michael Thurmand was heading up the

Department of Family and Children Services. He is now the labor commissioner in Georgia. And he was very interested and gave us funding for the Southern Institute to do focus groups in three counties in Georgia with the same three groups—families, community organizations and employers. And then we did 10 community presentations. We had breakfasts for employers that were sponsored by the DSS local offices and the DSS Director was the host. And it was one of the most successful things that you can imagine. It gave the local DSS Director something positive to be out there with in the community. Employers were grabbing at the brochures when they left. Many of them didn't know at the beginning whether they would get anything useful out of it or not.

So now as Judy and I'm sure, David, you know too, it is commonplace for people to do much more understandable and attractive brochures and applications. It's just the way things are done now. That again is just a sea change.

MOORE: On Covering Kids and Families you have certainly had a huge impact.

SHUPTRINE: You know The Robert Wood Johnson Foundation came to me in '97 and asked me to be the national program director for Covering Kids, to focus on this area they referred to as maximizing coverage opportunities. Covering Kids started out as a 15-state grant program. Every state applied. The Foundation then allocated funding to provide a Covering Kids grant in every state.

And so we were able to give grants to all states and the District of Columbia and they had local projects associated with those statewide grants, 170 local projects.

So it was a huge effort and we were able, as Judy knows, to maintain a lot of visibility because of The Robert Wood Johnson Foundation support. We were able to keep the visibility high and keep the progress going.

SMITH: Can you offer any kind of judgment about the kind of impact you had? Now you've got an awful lot of people interested. Can you track out the kind of impact it may have had on an actual enrollment?

SHUPTRINE: No, we have never tracked or evaluated specific strategies because we've been too busy doing. So I don't know. I think other people

have tried to do that. I think Urban [Institute] may have tried to do that and some other research organizations.

But the simplification measures have definitely been in place now long enough for people to do some good evaluations of the progress.

Now, I'm trying to think who it was that was doing some research, trying to look at that. Now, we know that when SCHIP came, there was all this talk about a simplified process. We'd already taken measures to start to simplify Medicaid in many states. Then when SCHIP came in, well, all those methods were there and the SCHIP programs took advantage of them to make their coverage more accessible. It was good to see the states that did separate programs incorporate simplification measures. They didn't make it difficult for the families to get the state CHIP programs. So it was really interesting, too, to point out to some of those states, well, wait a minute, if you can simplify your state CHIP program and make it more dignified and family friendly, why aren't you doing that in your Medicaid program? That was a very compelling question. Both programs were providing health coverage for children in low-income families. Well, we know the answer in many cases was that they felt like they had some budget control in SCHIP where encouraging people to be on Medicaid, which again the policy makers often think mistakenly is a welfare program, is a different matter.

Medicaid is not a welfare program. It is not linked to welfare anymore. And we just can't say that too often. It is a work support program at this point in time. Most of the people on the Medicaid program are families and children in working families. And the ones that are eligible and not enrolled are working families so we must reach out to them. **MOORE:** Sarah, what would be your summary statement on the impact of SCHIP on Medicaid over a period of time as you look back on it?

SHUPTRINE: Well, I think the SCHIP program at this point in time has been a good influence on the Medicaid program in the states where they did the combination or separate programs. Where they did Medicaid expansions it wasn't any different. In many of the combinations they have made no differentiation. But the separate programs set an example for the Medicaid people in those states as to how they could simplify the Medicaid process.

But what troubles me is that—there is this huge support for the State Children's Health Insurance Program (SCHIP), but Medicaid stays under fire. Again, both programs serve working families. Medicaid is serving millions of working families and that's what Congress intended—to reduce the number

of uninsured children. When the amount that was appropriated for SCHIP wasn't spent right away, but the Medicaid rolls were going up, well, you know, who should have been surprised by that? And there was this real concern that the SCHIP dollars weren't getting spent, but the Medicaid rolls were going up, when we were trying to help working families, when the goal was being met by the Medicaid program.

MOORE: Right. What lies ahead?

SHUPTRINE: Well, right now I think that the state budgets are just a tremendous burden for all the Governors and legislators that are dealing with these issues. But right now there is still strong support for providing coverage to uninsured children.

They've been holding their ground pretty well through all of these budget cuts. But I think the problem that we face now is this whole premise that is being put forth in some circles that the Medicaid eligibility and the SCHIP eligibility processes are too easy for families and so there are lots of people who are not eligible getting in on them.

Now, there are a number of states with data that shows that simply is not the case. And we're going to get the word out that there is no evidence that simplification increases eligibility error rates. That just has to be countered because you could see that just gaining steam in an environment of reduced revenues based on erroneous argument that simplification increases eligibility errors.

SMITH: Have you ever—when you're not doing something else—have you ever thought of writing up this history?

SHUPTRINE: I have had people suggest that to me before and I am too busy still trying to get the job don

SMITH: Right. I understand.

SHUPTRINE: But at some point in time, I might very well.

SMITH: It would be wonderful to see. It's really quite a tale. It's the part of this history that people don't know about.

SHUPTRINE: Well, I had—I'm trying to think who it was that called me and interviewed me along these same lines years ago, I believe it Kay Johnson. I could find it in my files.
Well, if you wanted to call back and ask Lynn Gregory, she can find the number.

SMITH: I must say we do all sorts of interviews, but it's rare that we have one that's as interesting and inspiring as this one is.

SHUPTRINE: Thank you. I am glad that you've enjoyed it. I have.

MOORE: Well, David didn't know who you were and I told him that this was going to be a special interview and I have not been wrong.

SMITH: No, you have not been wrong. It's a delight.

SMITH: Thank you so much.

SHUPTRINE: Okay.

INTERVIEW WITH GEORGE SILVER, M.D.
DAVID SMITH – MAY 19, 2004

SMITH: This is an interview with Dr. George Silver at his house in Chevy Chase, Maryland. It is May 19, 2004 and David Smith is doing the recording. I notice that you graduated from medical school in '38 and then you got a master's in public health in '48. Now, between those dates you—

SILVER: I was in private practice for three years. In '39 I finished my internship and then I went into practice in Philadelphia, general practice. It wasn't very satisfying. The office was crowded with people but they weren't paying very much and Pennsylvania Welfare Services paid even worse. I wound up getting 25 cents a visit.

SMITH: 85 cents a visit?

SILVER: Twenty-five.

SMITH: Oh, 25. Oh, my goodness.

SILVER: Well, that was how they would divide up the loot. They would get so much in the way of a grant from the legislature. That would be divided up among all those visits that were claimed. They started with two dollars. Then next year it was one dollar and finally it was down to a quarter.

SMITH: Were you a part of the draft? Did they draft you as a doctor during World War II?

SILVER: No, it was the welfare department of the city, money found...by the state. It was matched.

SMITH: Well, then I notice that you got a degree in public health and I wondered whether social medicine preceded public health or public health led to social medicine.

SILVER: Well, the ideas that related to social medicine started in medical school and—

SMITH: I think Henry Shenkin told me that.

SILVER: I attended lectures of Henry Segrist in Baltimore in the last couple years of medical school. And then Mitzi and I married in '37 and we took the gentleman's tour of Europe. And on the Queen Mary we met Segrist and his wife and daughters. And he invited us to come see him when we got back from our visit in the Soviet Union—that was part of our itinerary too—we would just stop in Italy where he had a villa. And we did that. And he was a little disappointed in me because here was—what did he say, Mitzi?—humanity is having its greatest social experiment in the Soviet Union and all it gets from the rest of the world is rebuffs. And from you, he says, and you don't even have an understanding of it.

But we remained correspondents until the fifties. We visited one summer at his villa, Casa Serena, and he asked us to send records, which he may or may not have received. Anyhow, that was my introduction to social medicine and I started reading everything I could about it.

As a matter of fact, I did a review of a Series of Segrist articles published in the PM newspaper. In the American Historical Society there is a Segrist Club. But his experience and sensible approach is usually rejected because of his attachment to the Soviet Union. I had a complete set of his books, which I gave to my daughter.

As for social medicine, I became the Chief of Social Medicine after I finished my M.P.H. and spent three years as an Assistant Professor of Public Health at Hopkins.

SMITH: Then you would have been connected with Montefiore and Columbia between '51 and '65, right?

SILVER: Yeah.

SMITH: So, among other things, you would have seen Kerr-Mills up pretty close in the years between '60 and '65.

SILVER: Yeah. We analyzed it. We were hoping we would get something good like that.

SMITH: What were your impressions and thoughts about it? That something is better than nothing or that—

SILVER: Well, we thought it was pretty good, but it wasn’t good enough.

SMITH: Did you really?

SILVER: Uh-huh.

SMITH: Well, New York took advantage of it, didn't they? I mean, they got involved in the program and got what they could.

SILVER: Well, Medicare had kind of a bumpy start. But Medicaid was seized upon.

SMITH: Now, you're talking about Medicaid. What about Kerr-Mills? You thought—

SILVER: Well, Kerr-Mills turned out to be totally unsatisfactory for poor people.

SMITH: What was it about Medicaid that made it so much better than Kerr-Mills?

SILVER: Well, first of all it was a mixed state–federal program, which meant that if the feds left off something the states theoretically would pick it up. And vice versa. So there was also the hope that Wilbur Cohen had that it be converted to a Medicare-type of plan for people with certain limits, or as he wanted to do with children under 12, it had a kiddie...

SMITH: Had a kiddie what?

SILVER: Kiddie care or kiddiecaid aspect.

SMITH: You must have known Wilbur Mills pretty well.

SILVER: No, I didn't know Mills at all. I worked for Wilbur Cohen.

SMITH: I said Mills, oh, I'm sorry. Wilbur Cohen; we probably owe more to Wilbur Cohen than anybody else that there is a Medicaid program.

SILVER: You ever see his biography?

SMITH: The one by Berkowitz?

SILVER: Yeah. It's very good. There was another article. I'm not sure where it was published. It was by Ted Marmor, in which he compared the

capabilities and the experienced results, compared Cohen and Robert Ball. Different types of individuals in the public service.

SMITH: That would be pretty interesting.
Well, I was wondering about a period in the development of, you know, “pre-Medicaid” when it was still up for grabs whether this program was going to be insurance or vendor payments to what extent it might really build on a public health framework.

SILVER: When they finally developed it, the hope was that health departments would be agents and that the money would be invested in health departments. But there was a strong welfare character from Kansas, and he insisted on it being in the welfare department. And this was more to the liking of the Congress that should dump the welfare responsibilities into one package.

SMITH: Uh-huh. Well, and of course it had grown up as an add-on to categorical welfare entitlements. You know what I mean.

SILVER: Title 18 and 19.

SMITH: I'm thinking now about a time when the Truman health plan had gone down in flames and Cohen and others say, "We've got to do something now. This is not working." And so they move toward an incremental path.

SILVER: Right.

SMITH: And right about then—in fact it was even earlier, it was in '47 that Cohen gets the Social Security board to recommend that vendor payments be added to these public assistance categories. And they do. And then he continues to raise the payments. It's very clear that he has in his mind that this is the way we're going to get to Medicaid. In fact, he says as much in—of course, maybe this is remembering history favorably. But he says as much in a piece that he wrote later for the HCFA Review.

SILVER: Yes. Wilbur's object is—the future he saw was a Medicare kind of coverage for everybody. He was taking a slice at a time, the salami approach.

SMITH: Right. And Ball sometimes would go for the whole sandwich, right? I mean, they talk about incrementalism versus aggregating. And, you know,

sometimes you add Medicare to Medicaid and to Title B. And sometimes you just add an increment to one.

SILVER: Well, it's a political decision.

SMITH: Yeah, right. Right. Well, back to this issue of health services. What else have we got? The Public Health Service is in great upheaval and there's a lot of talk about what they're going to do about neighborhood health centers and things of that sort. And you've got John Cashman and Bill Stewart as the Surgeon General. And they want to go more in this direction of services at the local level.

SILVER: Well, they're actually counting their money then. They thought they were—

SMITH: They thought they were home?

SILVER: Yes. But OEO [Office of Economic Opportunity] beat them out of that. I was designated the liaison with OEO.

SMITH: Is that under Sargent Shriver?

SILVER: Yeah.

SMITH: It's his connections that give him the clout to win it for OEO?

SILVER: Well, he did wonderful things, you know. He did a wonderful job with the Peace Corps. And then the medical section of OEO with Sandy Kravitz and Lee Schoer—it was an exciting time because we were just pushing ahead. Nothing would stop us. Various aspects of Title V and Title XIX were united in their thinking, not in their practice. And as a matter of fact, both OEO and the Public Health Service were competing with one another for the ability to look into the unpaid, unrewarded, uninsured. And the neighborhood health centers which I helped organize were begun by the OEO but the Public Health Service went into the same business.

SMITH: Well, now, back there in '65 you've got Medicaid and you've got things like Heart-Cancer-Stroke. You've got the OEO. Was Medicaid even a blip on your screen?

SILVER: Yes, it was very important.

SMITH: Was it? How so?

SILVER: Because we could use it to start health centers. We would guarantee the payments to the physicians in the health centers and we could inaugurate a new program. One of the big arguments came about drugs—the prescriptions. And some of the health centers had put in pharmacies. And the retail pharmacists, retail druggists objected very strongly.

For a while it was touch and go whether OEO would be allowed to continue. And the Public Health Service was happy that their health centers had prescription centers or pharmacists in their local areas to take over the task. We had pretty good relations with OEO but were competitive.

SMITH: Well, they are always saying that Medicaid was just an afterthought. But of course it has a long sort of pre-history.

SILVER: It wasn't an afterthought; it was a bone both the dogs were after. And it was very grudgingly that the Republicans let Medicare go through. And they fought like dogs to keep Kerr-Mills in there because they were making a fortune out of it.

Clinton Anderson, a Senator from New Mexico, was totally against including the poor as such. It was a breach of equality. If they were going to do Medicare they should do it for everybody. That's the reason why you should have Medicare at all levels.

SMITH: Wilbur Cohen tells this story about trying to persuade Mills, Wilbur Mills, that Medicare isn't going to be the sort of cuckoo bird that ate up everything in sight.

And he said, "Now, if you really want to be sure that Medicare doesn't just continue to expand and expand, you should put in a program like Medicaid." And Mills heard this and—

SILVER: I didn't know that.

SMITH: Yeah, he heard this and he said, "That's a good idea."

SILVER: Well, there's some good history to Medicaid. You know the Stevens book?

SMITH: Yes. Did you know Rosemary Stevens?

SILVER: Very well.

SMITH: Well, we were resuming our chat and I was asking you if you could recall when they were beginning to implement Medicaid, some of the kinds of issues that came up, and for example you said, well, there was lots of planning for how you might be able to use Medicaid to provide health facilities at a local level and how you might adapt it—

SILVER: Right, without regard to eligibility.

SMITH: Was there any thought about cost containment? For example, as early as the summer of '66, 1966, Wilbur Mills is concerned about cost, potential costs.

SILVER: Wilbur Cohen made a promise that costs would not go up beyond $170 million—no, $710 million or something like that. And they were already over that in six months.

SMITH: Right. Now, I was talking with Robert Myers, the actuary. He mentioned a promise by Wilbur Mills to monitor the program; but also people were beginning to get indications of cost overruns and cost problems. And I'm wondering, were you aware of anything like this? Were there important indicators?

SILVER: Well, we were aware of it because of our children's health policies.

SMITH: Because of what?

SILVER: Children's health policies. Children who were treated, were they to be treated under Title V or were they to be treated under Medicaid?

Medicaid people said that they were charged by law to set up a program, so that OEO went ahead and developed the neighborhood health centers, the first one of which Jack Geiger and Count Gibson started, and they tried to move the Title V patients into neighborhood health centers and provide an integrated program.

SMITH: I'm not quite understanding you. They were trying to unload patients from child health onto the neighborhood health centers?

SILVER: Yes.

SMITH: Okay. So you're aware then that there is a kind of problem of utilization or who is going to pay for it.

SILVER: Right.

SMITH: Some people say, well, the way we looked at Medicaid at that point—now, I think Phil Lee said this—was as essentially a state program and we're not worrying too much about telling them what to do. We presume that they obey the law. Okay, that's fine.

SILVER: Yeah. There was a lot of criticism of the kind of people who were in charge, that they were welfare-minded and were not very cozy with numbers, and didn't adhere to any particular system although they guaranteed that the budget would not be overrun.

SMITH: Now, this is at the state level we're talking about?

SILVER: Yes.

SMITH: You were aware of it. Was anything done in response to this at the federal level?

SILVER: The only thing I know is that OEO, the health services group in OEO, were in constant touch with the PHS as to what things could be done together. However, not every official in either was anxious to do it together.

For example, when there was a worry in '66, early, before the law went into effect—you know, it was passed in '65, didn't become operative till '66.

There was a lot of fear, actual fear, that racism was going to break the whole Medicare back, and everybody would suffer.
And they sent all of us around the various parts of the country to make speeches for why health providers should participate.

And I got the cream of the crop. I got Georgia. And one Georgia congressman was on our side from Atlanta. And I walked into a hostile environment where they would say, "Throw him out. We don't have to listen to him."

I ran into a snowstorm which would hold me up half the night.

But we were trying to wipe out remnants of segregation in the hospitals and in doctors' offices. So we had a Plan B, which was to set up points, federally-directed points where patients could get care. We had portable hospitals from the army that could be put up in places like Mississippi where they had to have troops to protect them.

And I volunteered that there ought to be a lot of nurse practitioners trained. So Shriver volunteered to give up $10 million and Wilbur promised that we would deliver 1,000 health assistants or health aides, whatever.

SMITH: Physicians' assistants or something?

SILVER: Yeah. We would provide 1,000 of them by the time Medicare went into effect. And the Medicaid thing was at a cost that represented a significant part of their budget because the states were being very reluctantly drawn into it because they had to contribute.

SMITH: Yeah. Were you, for example, trying to encourage any particular administrative practices on the part of the states at this stage? I mean, later they get into a lot more of let's computerize all this and so forth but—

SILVER: No, I don't think so. Medicaid was never as technologically developed as Medicare got to be.

SMITH: Right. It sounds to me as though the civil rights of this was the very biggest part you were worrying about, at this early stage. You don't hear much about that story, which I think is one of the great unsung stories of that era.

SILVER: It was written up by a graduate medical student. I don't know where she published it, but her name was Preston Reynolds. She's a lawyer—she's a physician now. You can probably track her down. She got a story out of me and all the others about difficulties of setting up the program in advance.

SMITH: Well, what were some of those difficulties in setting up the program in advance?

SILVER: I don't know whether he [Wilbur Cohen] had any difficulties. He was always cheerful about it. Cursed them out a little bit, but we—he figured he would get something a piece at a time.
Academia wasn't very supportive.

SMITH: In what sense? How do you mean?

SILVER: Well, they didn't offer a solution to the problem or give any aid in eliminating segregation.

SMITH: I see what you mean. The Democratic Administration would leave not too long after that. But very soon you get the Social Security Amendments of 1967 and one of the big things they do is to cut back sharply on the medically indigent category, saying you can only go up to 133 percent of the actual welfare payments.

SILVER: We presented them with all kinds of information to show how false that number is. We demonstrated that when they set up the housing standards they didn't use anything to justify any amount because so many of these people couldn't get housing.

And then as far as the nutrition was concerned they would set up their scales at a level far below what they would have to pay for. If they have to pay $30 a month for rent, $40 a month for food, but the food that they listed in the book would be an egg for a half a cent...

SMITH: Oh, right.

SILVER: So you got a family allowance that was presumably livable and it would be 20 percent of what the actual cost of the items would be.

SMITH: We were told by some people that states were divided and one group within the states was really lobbying in favor of the ‘67 amendments because they wanted to put a brake on Medicaid costs. That apparently happened in New York.

SILVER: I was going to say New York and California would be the places that would be most eager to keep it down. Nobody talked about that except in the hallowed chambers of the Congress itself. It was still an era when it would be a sin to be opposed to support for people living in poverty. Bruce Vladeck says they are all doing that now.

SMITH: Was there any discussion that you were aware of, of doing such things as trying to get the states to upgrade their management information systems? I mean, did they begin assessing this already?

SILVER: They complained bitterly about the lack of positive information and that the states did nothing to make changes in it.

SMITH: If you are trying to get the states to do something, what would you do? You would send out Medicaid letters? Would you—

SILVER: Well, usually they would go through the regional offices.

SMITH: Uh-huh. And in some cases there you might have only one Medicaid officer in the regional office.

SILVER: If any.
You bring it all back. Actually, Assistant Secretary for Welfare—Family Affairs, I think it was called. Was very much interested in the whole process and tried to encourage it.

SMITH: That is, improving their management information system.

SILVER: He figured without information you wouldn't get anywhere. And Wilbur Cohen was pressing the Assistant Secretary on what he called the Mississippi Project where every Secretary's Office had to provide information as to what they would do to improve life in Mississippi. I was given health.

I went to Jackson and I found there were four black physicians and about 25 or 30 white physicians and they had never met. They knew the names but they didn't know the people. And we had to arrange a meeting in the Office of the Dean of the Medical School because it was the only neutral place we could find.

SMITH: Well, then did you leave HEW when—

SILVER: ...Secretary Gardner left.

SMITH: You went with Gardner.

SILVER: Yes. That was before the '68 election but it was pretty much a closed deal that Nixon would win.

SMITH: Right.

SILVER: But in the interim I tried to do on a small scale what the government wanted to do on a large scale. I wanted to build neighborhood

opportunities. And I would arrange meetings where we would be discussing all these things that come up as the problems repeatedly attacked in the community studies.

And we tried to get people from every level of society. And the problem was then how to integrate it. That's where I met Ladonna Harris.

SMITH: So it was true that an enormous amount of your energies at this juncture were, one way and another, going into the segregation-integration problem.

SILVER: Oh, yes.

SMITH: And probably there's not much time left over to worry about these little details of whether these medical state officials are keeping their accounts in shoe boxes or whatever.

SILVER: Right.

SMITH: Well, then you left. You went to Yale in '68.

SILVER: Yes, '68 I was temporarily at Yale. I commuted from Washington. We didn't move out of Washington till '71.

SMITH: What were you doing in Washington?

SILVER: In Washington I was the Health Executive for the Urban Coalition.

SMITH: Now, the Coalition, what was the Coalition?

SILVER: The Coalition was a group that represented banking and finance and industry and politics. John Lindsey was a vice president and John Gardner was Chairman of the Board.

SMITH: Kind of a public/private venture concerned with this problem.

SILVER: Yes. Each of the people who served in a senior capacity in the Coalition paid his own way except me. I got a grant from the Milbank Fund and Commonwealth that paid my salary, which was the same as my federal salary.

We were trying to do on a small scale, as I said, what the federal government was trying to do in the neighborhood health centers. And without regard for the income level of the patient everybody got the same treatment. And we set up model cities in which to do it.

And Rhode Island, Providence, we had a union leader and North Carolina was in a medical school.

SMITH: Uh-huh.

SILVER: And in New Orleans it was a king maker, a young fellow who worked out of the Stern Foundation and...and Takoma, Washington we had the regional office of DHS and mostly Japanese.

SMITH: Looking back on this experience at Yale, did you come to any conclusions, change your mind in any particulars, with regard to Medicaid. I know there were all sorts of things you would have thought over again, but did you come to any particular views or conclusions about Medicaid as a program?

SILVER: Well, the income level by which people would be screened, that was a bad thing that had to go.

And we thought that it ought to be run the same way Medicare was. We got the idea Medicare was a pretty good way of handling medical care in the United States. And we thought we should educate more people about medicine: what they need, what they could do without.

SMITH: Yes. So you would agree, I would think, that one of the big things lacking down the road was getting together the insurance and the public health sides of these things. I mean, the payment mechanism and the service delivery.

SILVER: We figured we should have a medical system in which people can be cared for. Stop fooling them with this business approach. What they really want is medical care and a single payer system and a local community to set up their own agency for dealing with these things. And the agency should have public members and representatives of various classes of society.

SMITH: Did you ever run into Thomas Parren? Did you ever know him?

SILVER: Yes.
SMITH: What did you think of him? It seems to me he was in many ways a man of enormous vision.

SILVER: Yeah. He was a good man who would have accomplished more if society would have let him.

SMITH: He didn't make it work?

SILVER: He's remembered for his publicizing syphilis.

SMITH: Well, he just kind of disappeared. I don't know.

SILVER: He was very vocal when he was around. I think he might be working in the public health field, maybe in Atlanta.

SMITH: Thomas Parren would still be around, do you think?

SILVER: When did you know him?

SMITH: I never met him, just heard a lot about him. And when I arrived in Washington there was a lot of noise still about the sort of public health postwar plan that came out around 1944 and had in it the Public Health Service Act and the Joseph Mountin scheme for the integrated hospital systems and the neighborhood health centers and all that.

And of course the part of that that gets legislated is the aid to the National Institutes of Health and the Hill-Burton Hospital Acts and all the rest of his scheme gets defeated. But it seemed to me that for one brief period we were really trying to get caring for the poor and other folks together with a scheme of service delivery.

SILVER: He was a planner. I wonder how—why he got out.

SMITH: Well, of course, he was a Roosevelt appointee and he was the New Deal Surgeon General. And with the failure of the Truman effort in 1949 where was he going to go?

SILVER: Besides, he would be awfully old now, I'm thinking.

SMITH: Yeah, he would be.

SILVER: Somebody with a very similar name who works at the new School of Public Health in Atlanta, but I can't remember what it is.

SMITH: Well, we have covered a lot here.

SILVER: How much of it is true? How much of it is just remembered as true?

SMITH: I know what you mean.

SILVER: We missed a big opportunity.

SMITH: That's for sure. It seemed like there was a huge opportunity there in 1965 for a spell.

SILVER: Yeah...

SMITH: And of course a lot of it was Vietnam. I mean, if we hadn't had the—

SILVER: The war...But according to historians—and Wilbur used to quote this all the time—every 30 years politics changes and...ideas of the politicians change. Well, it's time for another turnaround.

SMITH: Well, that's really a good note on which to quit. I want to thank you very much for this interview and this opportunity to meet with you. It's been extremely helpful and it's been a very pleasant experience. Thanks a lot. 'Bye.

INTERVIEW OF DAVID BARTON SMITH
BY DAVID G. SMITH – AUGUST 16, 2006

D.G. SMITH: This is David G. Smith and I'm interviewing David B. Smith, who is an old friend and who has been long in the Medicaid business, and a person who pioneered studies of segregation in health care. Let me ask you the first question, how did you get into the healthcare field and how did you get from there into your study of segregation and disparities?

D. B. SMITH: You want a short or a long answer?

D.G. SMITH: Well, a brief resume and just tell me how you got into it.

D.B. SMITH: Sure. I was actually going back through it all and thinking about that question and what I was going to tell you. It's not the typical thing someone who teaches in a business school does. I went through the doctoral program in Medical Care Organization at The University of Michigan.

D.G. SMITH: A very good school.

D.B. SMITH: I started my doctoral studies in 1965, the same year as the passage of the Medicare and Medicaid legislation. The doctoral program was supposed to produce applied researchers who could help make a national universal health insurance program work well. Those that set up the doctoral program assumed that such a health plan would be in place by the end of the 1960'sand that Medicare was just the first foot in the door. Solomon Axelrod was the Director of the Bureau of Public Health Economics that housed the doctoral program. Sy spent most of that year in Washington assisting Wilbur Cohen with the implementation of the Medicare program. All of this, in the eyes of organized medicine was a subversive undertaking. About a year latter, when it no longer seemed politically necessary to conceal its purpose, it was renamed the Department of Medical Care Organization.

D.G. SMITH: Did you have an office in HEW back then?

D.B. SMITH: No I did not.

D.G. SMITH: I had a friend, Chuck Gilbert who through Herman Somers got a nice introduction to Wilbur Cohen who took a shine to him and said we will

give you an office here, no one is occupying it, they might kick you out, but you can work out of this. It worked nicely for him.

D.B. SMITH: Later on I did get to share an office there, but I'll tell you that part of the story latter. In the Bureau of Public Health Economics at Michigan, there were two distinct groups of faculty. One group was what I would call the old Medical Careniks who had long been involved in pushing for universal coverage and reform in the organization of medicine. They could all trace their lineage back to the Committee on the Cost of Medical Care that completed its work in 1934. I. S Falk, who latter worked in the Social Security Administration helping to craft the Wagner –Truman national health insurance legislation in the 1940s and latter in developing prepaid groups practice plans and Rufus Rorem, who latter helped set up the voluntary Blue Cross plans, were the senior staff people on the Committee. Nate Sinai was a junior staff member and basically set up the Bureau of Public Health Economics at Michigan. The other group of faculty was behavioral scientists, economists, and sociologists who had been involved with the Institute for Social Research in doing surveys. They were good researchers but not really in tune with the Medical Careniks "social mission."

In retrospect, my guess is that they were still feeling the impact of the McCarthy era of the 1950's and were defensively trying the cast themselves above the political fray as objective scientists. Both groups recognized the political sensitivity of their work and understood that their name "Bureau of Public Health Economics" was chosen to avoid bringing organized medicine's attention to their activities and incurring their wrath.

D.G. SMITH: It was organized?

D.B. SMITH: Laugh. It was certainly well organized in blocking the passage of national health insurance legislation. In terms of providing medical care it was, of course, chaotic, as it still is. My regret was that I identified with the research types and thought of the Medical Care-nicks as dull political hacks. I was wrong and missed a real opportunity to learn from them.

D.G. SMITH: The research types were young Turks: they were trying to expose what was going on?

D.B. SMITH: No, I don't think they were so much interested in exposing, they just thought research methodology was the path to truth. It didn't go further than that. The Bureau was obviously focused on national health

insurance and something then called prepaid group practice which has since morphed into managed care. At that time, though, managed care was considered a left wing thing. The only people sponsoring such plans were labor unions. I actually got involved in doing my dissertation on a plan sponsored by the UAW in Detroit. I ended up doing some of the field work for that project during the riots in 1967. It was a turbulent time and my family, like many, was caught up in it. My twin brother was a Freedom Rider, my mother had went to jail in North Carolina for trying to integrate a department store and my sister participated in the Freedom Summer voter registration drive in Mississippi.

D.G. SMITH: You came about this honestly?

D.B. SMITH: Not that honestly. I was a passive observer, connected to it, but never really got the opportunity to act. My efforts latter though was a reflection of this experience.

D.G. SMITH: Healthcare Divided was not your thesis? This came later?

D.B. SMITH: My thesis was actually on different perceptions of what quality of care was. I interviewed nurses, doctors and patients in that Detroit prepaid group practice. It was the beginning of my rebellion against the research methodologists because you were expected to do a secondary analysis of one of their surveys for your dissertation. You were not expected to go out and actually talk to people and get involved in a real setting where you bumped into corpses in the elevator and talked to people who were dying. That was my rebellion. I began to understand that healthcare was very complex and that the only way to really understand it was to submerge yourself in it. Detached survey research and secondary data analysis tries to figure out what is going on but doesn't capture its richness and complexity.

So that was basically my graduate school training. I went to Cornell to teach and got interested in managed care plans developing in Rochester New York and in the nursing home scandals that broke in New York State in 1975. I spent that the 1975-76 academic year in the Community Medicine Department of the University of Rochester. Ernie Saward, who had been medical director at the Kaiser plan returned to Rochester as Associate Dean and was involved in the implementation of the HMOs in the region. I sat in on his lectures about the development of managed care plans in the United States and it really opened my eyes and I realized that there was more to life than just crunching numbers.

D.G. SMITH: How specifically did you get into your "health care divided" inquiry?

D.B. SMITH: That was much later. My entrée was through the study I did on the nursing home scandals and the regulation of the industry. Anecdotes kept accumulating. I had interviewed a detective who had previously been involved in Civil Rights enforcement. I also spent several years as a half time IPA fellow for the Office of Research and Statistics after I came to Temple in 1976. Several of my colleagues there had been involved with the implementation of Medicare and peripherally in the enforcement of Title VI in the program. Since my position there was half time and half time at Temple, it was nice because nobody knew where I was.

D.G. SMITH: Yes, I see. You had low visibility.

D.B. SMITH: Yes. I spent a lot of time commuting back and forth between Washington and Temple in Philadelphia. I was working with Cliff Gaus who was one of the instigators of the reorganization of the Medicare and Medicaid program that took place during the Carter Administration. They created the Health Care Financing Administration (HCFA) extracting the Medicare program from Social Security and the Medicaid program from Social [and Rehabilitative Services] Administration. It was a traumatic experience for a lot of the staff who viewed it as a betrayal of the Social Security's mission. They were right. It shifted the focus from beneficiaries to the financing of providers. When Bruce Vladeck became administrator of HCFA, I wrote him a note about it and I think he tried to bring some of that focus on beneficiaries back.

D.G. SMITH: Yes, people still use his book on nursing homes.

D.B. SMITH: Yes and I finished my own study of nursing homes in New York State. I was recruited by the National Academy of Medicine, along with Bruce into a working group to encourage Congress to support a thorough study by the Academy of nursing home regulation. (The recommendations of that report were later enacted into legislation and that law still guides nursing home quality assurances activities required of nursing homes participating in the Medicare and Medicaid program.)

D.G SMITH: Yes, that was a successful venture.

D.B. SMITH: The trick in being successful is keeping it simple and I had trouble doing that. I told them you can't look at quality without looking at

the money. They wanted to keep those two things separate and simplify their job by focusing on quality in isolation from the money.

D.G. SMITH: It was a lot easier that way.

D.B. SMITH: Laughter. Yes, but that made it less interesting for me and I was starting to get interested in other things such as learning curves in transplant programs and the related transplant planning and resource allocation policies. I thought I was through with nursing homes. Then I got a call from the Pennsylvania Health Law Project asking me to look at some data related to minority access to nursing homes. Mike Campbell was the person I dealt with originally but Ann Torregrossa was most directly involved and she turned out to be a neighbor of mine in Swarthmore. They had been struggling for about ten years with the problem of providing access for minorities to nursing homes. In the beginning of the 1980's nursing home use rates in Pennsylvania for blacks was about half that of that of whites and this was quite similar to the differences in use rates in the nation as a whole.

It wasn't hard to figure out why. It partly had to do with the location of nursing homes but it also had to do with the lack of oversight of the admissions process. Basically homes were free to decide who they would and would not admit.

D.G. SMITH: Did you do stats on this? There is a big argument about how much you can attribute to poverty and how much to attitudes about race.

D.B. SMITH: Sure. Before you can answer that question, you have to collect the data. That was their first struggle, getting the Department of Welfare to collect the data. My job was just to run the numbers and see what it said. I produced a 3-4 page analysis that summarized the findings. First the nursing homes were highly segregated. Nursing homes in Pennsylvania had a dissimilarity index or segregation index of 85%. That means that you would have to relocate a combined percentage of 85% of black and white residents to equally distribute them across nursing homes in Pennsylvania. Second, the nursing home beds were unequally distributed with predominantly white areas having about twice as many nursing homes per 1,000 elderly as predominantly black areas. Most of the differences in black and white use rates could be explained by where the beds were. Finally, blacks were substantially more likely to be located in substandard homes than Medicaid beneficiaries. In short, race was more important in explaining use rates and the quality of care received than income. Exacerbating these problems of access was the implementation of DRG

prospective payment for hospitals in both the state Medicaid and federal Medicare program in the mid 1980's. Not only did the minority patients feel the pain of lack of access to nursing homes but the hospitals that served them began to feel the pain. These hospitals had patients that no longer needed acute hospital care that they were not getting paid for and that they could not find a nursing home to discharge them to.

D.G. SMITH: Interesting.

D.B. SMITH: At the same time that DRGs were put in place, the state Medicaid program decided to eliminate capital cost reimbursement for nursing homes. Basically, that meant that if you were in an area where the majority of your patient population was Medicaid recipients, it was an act of financial suicide to try to expand. The only areas where it was financially feasible to expand were in the most affluent areas of the suburbs.

D.G. SMITH: Is this because they could pay the differential or?

D.B. SMITH: Assuming a high occupancy rate, there is a magic number in terms of the proportion of private patients a home needs in order to break even. Private rates are above and Medicaid rates are below actual costs in most homes. As a result, a lot of homes were not accepting "first day eligible" Medicaid patients. With the implementation of DRG hospital payments this created a crisis particularly in Philadelphia. Temple and a lot of other hospitals had trouble placing patients in nursing homes.

Furthermore, it was not just Medicaid patients, race played a role in placement as well. Discharge clerks in hospitals [who] were under a lot of pressure, began to figure out where they could get particular patients placed. The whole seamy story was clear. I had put together this four page report and they shared it with the Department of Welfare. Two days later I got a call from a producer at "60 Minutes." They wanted to do a story and wanted to come down and talk to me about it. Talk about being a babe in the woods! I treated them as if they were my students and doing a paper and suggested all these people they could talk to and I gave them their telephone numbers. Then I got these calls from some very angry people saying, "Don't you ever sick those people on me again!" The producers told me they had a slot for the story for Diane Sawyer and I had a crush on Dian Sawyer at that time.

D.G. SMITH: Yeah, she was beautiful and a lot of these people look better in real life than they are on the screen!

D.B. SMITH: I was really excited about this but it fell through. I think "Sixty Minutes" has to have visual impact and White, the black Secretary of Welfare, just didn't fit their formula. Visually it was a contradiction. They like to zoom in on the sweating face of the person they are confronting with the facts. If he had been white they could have done it. The important thing I learned from this experience was that you don't make enemies with a public official by suing them. It often helps them move a bureaucracy. My understanding was that White was really pleased that we had sued him.

D.G. SMITH: It gives him some wind at his back.

D.B. SMITH: Yes it gave him some room to maneuver and to try to change things.

D.G. SMITH: Let me ask you a question related to this. As you are talking I get the sense that often in this kind of situation the only way to get movement is to bring a suit.

D.B. SMITH: I would go even further, at least from the perspective of a researcher. The only way to understand how the system works is to sue it. Everything starts coming out and you find out how really well the "system" works. The Taylor vs. White case was a beautiful illustration of this. If you don't collect the data the problem doesn't exist and the first thing [the] Taylor case did was force the collection of data. The collection of this data showed that the Capital Cost freeze had a discriminatory impact. It also showed how closely tied the industry is to those regulating it.

D.G. SMITH: You would expect Pennsylvania to do better about this, given the Secretary and all that stuff. Pennsylvania, if not a model state should be doing better than average and this is what you get.

D.B. SMITH: Yes. The more you got into it the more you saw how structural the disparities are and how most people who write about these things miss this point. For example there was a large literature in the 1980's in gerontology devoted to explaining why blacks used nursing homes more infrequently than whites. It all had to do with such things as culture, family structure, and the financial support through SSI that the elderly person helped provide for the family, etc. It was all total bullshit. There is no reason to believe that any of these things have changed that much but now black elderly use nursing homes more frequently than whites. Why? It really has to do with how the structure of the industry has changed and the resulting increased access of whites to alternatives to nursing homes.

D.G. SMITH: You have to tease out all this stuff in a sense. Who is the villain in this? Is it the industry or is the industry afraid of [what] the response of consumers [is] going to be. I know one thing that you developed that was quite interesting is the difference between vertical and horizontal medical care.

D.B. SMITH: Unless somebody kicks the tires, things keep going on as they always have.

Take the history of racial integration. All facilities were segregated: schools and hospitals. With the introduction of the Medicare program (I go through a lot of this in my book, Health Care Divided), there was a very aggressive and effective effort to force integration in the hospitals using such compliance as a condition for receiving Medicare dollars. They also recruited a very creative and committed group to do the inspections. They would meet secretly with local chapters of the NAACP and members who were also hospital employees would go through all the things in the hospital that needed to be corrected. I t was virtually impossible for the hospitals to hide anything. All the hospitals had black employees and all of them were now involved in the Civil Rights movement. If they resegregated the babies in the nursery, the inspectors would get a call that would say, "come on back, they're at it again." The problem with the nursing homes was different because they became eligible for Medicare six months latter after the Civil Rights backlash had begun. Lyndon Johnson was loosing popularity rapidly because he had a war going on. A similar plan of inspections had been developed but it was cancelled at the last minute. All that was required of nursing homes participating in Medicare was that they sign a statement saying they didn't discriminate. No data was required and no on site inspections were made.

D.G. SMITH: Well, I remember in your book you talked about ways that were successful in desegregating hospital admissions. But, you then have a secondary level: blacks on the staff, patterns of referrals and so forth. How, beyond getting in the hospitals, do blacks get access? Were the limitations in what happened because the politics changed and Johnson was out of favor or was it because the task was just too big even for the Great Society?

D.B. SMITH: There was one critical gap in what the Johnson Administration was able to accomplish. Part B of Medicare, was specifically exempted from Title VI enforcement. That meant that what the medical staff of a hospital did or didn't do in terms of assuring equal treatment didn't matter. The Mobile Infirmary was used as a test case to try to extend Title VI

enforcement to the admission, referral and treatment patterns of a hospital's medical staff, arguing that a hospital had responsibility for assuring that its medical staff didn't practice in a discriminatory fashion. The Infirmary had signed all the assurances that it did not discriminate, but admissions were all white in a service area that was 40% black. The Office for Equal Health Opportunity refused to give Title VI certification to the Mobile Infirmary so it could receive Medicare funding. This test case effort was abetted by a very courageous doctor who served as a mole for the Feds in reporting what the medical staff was doing to assure that admissions would remain all white.

Her name was Jean Cowsert and she was eventually found dead with a bullet in her chest on her front lawn. The Assistant Surgeon General had gone to Mobile to try to broker a compromise with the Infirmary and had talked to her by phone over the hotel switchboard in Mobile. Several days latter she was dead and the coroner ruled it an accident.

D.G. SMITH: You forget that stuff like this happens.

D. B. SMITH: It's the stuff that should be in movies. All the records related to the case have been destroyed or have disappeared. I wrote a short version of the story that's in Health Care Divided.

D.G. SMITH: We could get Meryl Streep to play her in the movie.

D.B. SMITH: That's who I had in mind. (Laughter). It was a critical watershed event. The Mobile Infirmary got its Title VI certification shortly afterwards, the issue of staff referrals and treatment patterns was never raised again. We are still publishing articles about disparities in referrals to specialized services and bemoaning the fact that race specific data on treatment patterns is lacking in most hospital settings. If that test case had succeeded we would have resolved both these problems long ago.

D.G. SMITH: I read somewhere that racial disparity in a lot of services has been improving for a while and then getting worse again. Is that correct?

D.B. SMITH: The segregation rate at least in Pennsylvania nursing homes is higher now than it was ten years ago.

D.G. SMITH: Do you know anything about national trends?

D.B. SMITH: I know from what I have seen in the Philadelphia market that services are going where the money is. You are getting over utilization of

specialty services in suburban areas and under use of such services in poorer urban areas. The best thing CMS has done recently is to cut the fees for some specialty services. All the providers were developing business plans to go after these highly profitable services rather than the maternity care and other kind of services that are in short supply. What really worked in reducing disparities in use was money. What is working against us now is reduction in Medicare and Medicaid payments for services. Providers increasingly fight for the profitable private pay and more predominantly white segment.

D.G. SMITH: Money is fungible?

D.B. SMITH: It is driving the re-segregation of care.

D.G. SMITH: You think it is mostly money? You do not think that people have simply gotten more racist?

D.B. SMITH: They haven't gotten more but they haven't gotten less racist. It's the money that is driving this.

D.G. SMITH: It makes you realize that the concept of institutional racism is important, since things like this happen if you do not pay attention and do something about it.

D.B. SMITH: One of the things that Pennsylvania did that made things worse was the termination of Certificate of Need. It had forced a lot of people in the suburbs to go for specialty services at the urban hospitals. For example, Episcopal hospital survived and then went under when they no longer were one of the more exclusive providers of angioplasty and some other specialty services. It really served as a cross subsidy for the safety net hospitals. When the suburban hospitals were permitted to provide such services, Episcopal lost the volume in one of the services that was keeping them afloat.

D.G. SMITH: In a way it's like the safety net problem. Many of the institutions that were part of the safety net are vanishing because they can't make a living anymore.

D.B. SMITH: Yes because CON was sort of an underhanded subsidy for these safety net hospitals. You got a franchise to provide profitable services because you were doing the right kind of stuff. It was a sort of Robin Hood principle. Rich suburban people have to travel there for services that are

highly profitable for the safety net hospitals. That's all gone by the by the wayside. Many of these safety net institutions have either closed or consolidated.

D.G. SMITH: You are suggesting that not everything about Robin Hood was bad. (Laughter).

D.B. SMITH: The good old fashioned Robin Hood principle worked pretty well.

D.G. SMITH: If you read the organization chart and look at the various activities of CMS, they are doing things about segregation and disparities have become a popular topic in the research literature.

D.B. SMITH: Disparities yes, but not segregation.

D.G. SMITH: I was wondering about that point. There was a big difference between the Institute of Medicine report and a Civil Rights report.

D.B. SMITH: Yes, the Institute of Medicine report pretty much ignored the structural barriers in terms of the segregation of care. The fact that people are going to different providers with markedly different resources explains much of the disparities. The most promising thing is that we are beginning to see in the research literature an acknowledgment of this obvious fact.

Blacks are going predominantly to hospitals that have higher severity adjusted death rates for both black and white patients. You are getting to this structural civil rights stuff, but it has been a long time coming. For a long time it was sort of off limits to talk about stuff like that.

D.G. SMITH: You spent a lot of time in this field. Do you have a sense for what might work to improve the situation from the standpoint of segregation either for nursing homes or for healthcare institutions generally? Does it take lawsuits? Is it a question of more money? Is it a change in payment mechanisms?

D.B. SMITH: Well, let me get back to my story. The recommendations to collect data by race to enforce Title VI in the Medicare program were first made in several Civil Rights Commission Reports at the end of the 1960's. The Institute of Medicine in its first report on race and health disparities made a similar recommendation in1981. In 2001, twenty years latter, making no mention of its earlier report, the Institute of Medicine made a

similar recommendation urging the collection and analysis of data on treatment by race. You can't correct a problem that you don't see and don't want to see. First things first, you need to have good data and then you can start. Things become important only when you measure them. If they are not important you don't bother to try. I'm afraid we are still a bit stuck in taking the first step.

D.G. SMITH: Yes, we could take the first step. The problem is that you have 50 state Medicaid programs. Some don't care for people telling them what to do with their program. It's a situation where in our political system we can only nibble at the edges and will be lucky if we can do better than that.

D.B. SMITH: That brings us back to what you can do legally to shame people into doing something. In the Taylor class action suit against Pennsylvania's Secretary of Welfare the three nursing home associations joined in the defense of the Department of Welfare. Not only did they join with them, they amassed a war chest to fight our suit of over a million dollars. Not only did the state associations get their members to contribute, they got additional money from the national associations. They were worried that the case might set a precedent similar to one brought by Gordon Bonnyman in Tennessee.

D.G. SMITH: Oh yeah, I know him.

D.B. SMITH: In Tennessee a nursing home could "spot certify" beds for Medicaid so that private patients could convert to Medicaid but no first day eligible Medicaid patients, disproportionately black, would need to be accepted. Bonnyman's suit ended this practice. It essentially forced all the nursing homes that wanted to participate in the Medicaid program to take first day eligible Medicaid patients and that terrified the entire nursing home industry in the country. Talk about David and Goliath, here I am being deposed by ten attorneys.

D.G. SMITH: All together.

D.B. SMITH: Yes, all together. The private, voluntary and public nursing homes didn't trust each other and they didn't trust the Medicaid program and the Medicaid program didn't trust them. As a result, lawyers representing each of these groups had to be present. The lawyers and their firms were really excited. They saw the potential for a highly profitable new product line. One of the lawyers made a presentation at a national

conference to promote their services against the threat from Pennsylvania that would spread across the country. All the time I kept thinking, what is going on? I thought all this stuff got resolved in the 1960's. I published a couple of papers documenting the obvious, that the "Emperor" (Medicare and Medicaid Civil Rights enforcement) had no clothes. Gordon Bonnyman asked me to come and make a presentation to an organization which at that time he served as chairman of its board, the Poverty and Race Research Action Coalition. It's a really neat and interesting group. It was created by public interest lawyers and social science researchers that were interested in issues related to social justice. The notion was that researchers could help generate the results that lawyers could work with in legal actions. What evolved out of our discussions was a class action law suit, Madison-Hughes vs. Shalala, challenging the failure of DHHS to collect the data essential for effectively enforcing Title VI of the Civil Rights Act of 1964. It landed on her Donna Shalala's desk in 1992 on her first day in office. Basically the suit said that the Department had responsibility for monitoring civil rights compliance related to the more than half a trillion in public dollars flowing to the health care industry but had done nothing to collect the information necessary in fulfilling this responsibility.

Again, you learn a lot of things you can't learn any other way but by bringing a law suit. In this case, I discovered that it was not just the Pennsylvania Department of Welfare that had "friends," we had friends too. There must have been more than fifty different minority interest groups that filed amicus briefs on our behalf.. Alaskan natives, Hawaiians, different Indian tribes, Asian and Hispanic groups. They all wanted to be a part of this because they all felt information should be collected about them. It was one of the highlights of my career, all these different groups that wanted to be my friend! (Laughter)

The suit was eventually thrown out. The federal courts basically said, we're not going to micromanage a federal agency and you guys have no standing to bring this kind of suit. If a federal agency decides they do not need data to carry out their responsibilities, you can't bring a suit to force them to collect it. In the meantime, the same thing happened in the Federal bureaucracy that happened in the Pennsylvania state bureaucracy in the Taylor case. A lot of decent people used it as pretext to do something. A moribund inter-agency committee on the collection of racial data got new life. There was a second tier in the federal bureaucracy that had been frustrated by inaction on this and now they could say, these powerful, evil people are suing us and they are going to force the Secretary to do things and we need to cut the wind out of their sails. In HCFA (now CMS) which

had stonewalled for years saying that for technical reasons they could [not] analyze Medicare data by race suddenly started doing it.

D.G. SMITH: What do you suppose was going on there? Was it politics?

D.B. SMITH: Sure, but interest group politics too. Derzon, appointed by Carter came from the hospital industry and wasn't interested [in] doing anything that would create more tensions with this group. Schaffer was interested in not disturbing his relationships with health plans and, of course in the Reagan years nothing happened. It had not been a top priority of any of the Administrators until Bruce Vladeck. In the early Clinton years he was a breath of fresh air.

D.G. SMITH: Recently there has been a spate of this sort of activity within CMS and HHS. I can't say if it is more than a few committees.

D.B. SMITH: Basically what I saw from the outside was that HCFA started publishing information of Medicare beneficiary treatment by providers by race in 1994. They published a really interesting paper in the New England Journal on racial differences in rates of procedures on Medicare beneficiaries. It was a whole different kind of atmosphere in terms of these issues. I think we could take a little bit of credit for that in terms of loosening thing up and creating opportunities for the "lifers" to do what they really wanted to do and to make their information more socially useful.

In any event, after the suit died, I decided this was enough for me. It was too frustrating. I decided to write a proposal saying what really should be done in terms of research. No body would fund it and I'd be off the hook to do things that business schools think are more important. I applied for a Robert Wood Johnson Foundation Health Policy Investigator Award. I said in this proposal, this is what has happened and I want to find out why nothing has been done about it. I didn't pull any punches because the whole objective was not to get funded. I thought I was being self- righteous, making a big deal about something that nobody else seemed to care about.

D.G. SMITH: Then you were funded.

D.B. SMITH: Ironic isn't it? I said this is what should be done. I really didn't think I'd be asked to do it. Now I felt a special obligation because I knew no one else was going to get the chance to do it. It was a pretty amazing adventure. I interviewed more than one hundred people in different parts of the country who had been involved in the early efforts to

integrate health care. Most of them are now dead. Five years later, most of the story would have been lost forever.

D.G. SMITH: This was Health Care Divided. Fantastic. Its reassuring that this is the book you did at this time. I was thinking this was a power house. This at the beginning of his career. I think it's a great piece of work. Its fantastic and it is still in print.

D.B. SMITH: I still get calls to talk about it. We are actually working on a project now that brings a lot of this full circle. I'm working with Vince Mor at Brown and the Commonwealth Fund on a project to measure the effects of nursing home segregation on the racial disparities in the quality of care people receive. We have data on all the residents and all the nursing homes in the country so we can look at variations in disparities in local communities where you probably have the best opportunity to do something about those disparities. The problem with the National Health Disparity Report Card is that you can only look at disparities at a national or regional level which makes it a lot harder to figure out what to do about them.

D.G. SMITH: As a note to end on, you talked about the "lifers." I am impressed by them. Most of the people who get into Medicaid are "lifers."

D.B. SMITH: Yes, I have been impressed by many of them too. Some of them were the real heroes in Health Care Divided. I was honored to be invited, on the 40th Anniversary of the 1964 Civil Rights Act, to a ceremony where Secretary Thompson awarded some of the people I wrote about in my book, with medals for their courage in working tirelessly, and often at great personal risk, in assuring the integration of the hospitals in this country at the time of the implementation of the Medicare program.

INTERVIEW WITH ELMER SMITH
JUDY MOORE AND DAVID SMITH – MAY 26, 2004

MOORE: This is Judy Moore and David Smith interviewing Elmer Smith via telephone on May 26th, 2004. And, Elmer, I think I have told you about this project before. And what we really want to concentrate on with you is the early days, the sixties. As you undoubtedly know, there are not very many people around anymore who maintained a connection with Medicaid over a substantial number of years after it really began in the sixties.

E. SMITH: Right.
MOORE: And actually it was Bill Toby that reminded me that you were one of those folks. And I should have remembered that myself.

E. SMITH: Okay.

MOORE: So maybe we should start with you just telling us how you got started in the Department and what you were working on.

E. SMITH: Okay. I got started in the Department in 1956 and I was a budget examiner in the office of the Assistant Secretary for Budget and Finance. I covered almost all programs except public health programs. And at the time EPA was in the department and I did not cover EPA programs. But I covered a wide range of social welfare programs, education programs, and supposedly Social Security.

But in those days SSA submitted their budget and it was more or less rubber-stamped by the Department. In 1963 or '64 I went with the Welfare Administration as Assistant Executive Officer and that got me closer to the AFDC and old age assistance programs, of course, Kerr-Mills.

And it also got me closer in some ways to the Social Security program. When Roy Weinkoop, who was then Executive Officer of the Welfare Administration, retired I became the Executive Officer, so in a sense the right-hand administrative advisor to Ellen Winston, who was the Administrator of the short-lived Welfare Administration.

I have forgotten what year it merged into the Social and Rehabilitation Service. I think it was something like 1967. And then I became an Assistant Administrator for

Administration in the Social and Rehabilitation Service. And although I enjoyed working for Mary Switzer, the long-time head of Rehabilitation Services who was appointed head of the combined agency, I was a little further down in the hierarchy then in the Welfare Administration, and I found it less congenial.

So I went to Mary Switzer and told her at this stage in my career I would rather go out to the field and get slightly closer to what I considered the interface between the federal government and state government. And she said to me, "Well, I'm not sure that's possible because you are a little too advanced in grade and stature and pay status for the field."

And I said, "Well, I know there are salary-saving provisions. So even though I'm a 16 and the position in the field would be a 15, GS-15, I know that my salary would continue at the same level, at least for a period of time."
So I then spent two idyllic years in Charlottesville, Virginia as the Deputy Regional Commissioner, a deputy to Corbett Reedy, the Regional Commissioner, and again had a broad purview over social welfare, child welfare, AFDC, social and rehabilitation services, and Model Cities programs. Medicaid had a regional presence there. And then there were such things as the Model Cities programs, which were assigned to SRS. And in 1970 the regional office in Charlottesville was closed and essentially the functions and the staff were being transferred to Philadelphia.

I had lived in Philadelphia in the period 1947-48, which of course was a long time prior to 1970 when the regional office closed in Charlottesville. But I thought of Philadelphia as a rather staid Quaker city and I did not wish to be transferred to Philadelphia. So I began to actively canvass other possibilities.

SMITH: Like W.C. Fields theme song?

E. SMITH: Right. That's right. I kind of had the W.C. Fields attitude. I was actively pursuing going either to Atlanta, since my wife's family was in the Atlanta area, or Seattle, Washington, which I had visited on occasion and which I thought was similar to Charlottesville, a kind of an idyllic place climate-wise and in terms of the size of the regional office and what have you.

I had been interviewed previously in a very tentative way for both the San Francisco regional office and the Atlanta regional office. The San Francisco regional office, I went out there and I stayed several days.

The idea was that an offer was going to be made to me if I wanted it to be made to me. But when I got out there and I saw the city and I was advised to go to certain suburbs which I might probably want to look for property to live in and so forth and discovered that the suburbs had some of the quality of a very arid desert, I decided I didn't want to live in the San Francisco area.

Atlanta, I was being task-sponsored by a man who later went to head up...for President Nixon and his name escapes me now. But Bill Toby will remember his name very well. But I would have gone as the Deputy Regional Director. And the then-Regional Director in Atlanta objected to that. He apparently had some other candidate.

So I was left a little bit at sixes and sevens, wanting to go to Seattle and Atlanta. And I spoke to the head of the Social and Rehabilitation Service, at the time John Twiname.

And he said, "We want you to go to New York City." I said I wouldn't consider going to New York City unless I went as a GS-16. John Twiname, a very, very nice man was naive in the ways of government administration. He said, "Oh, that job is a 16."

I said, "John, that's a 16 being filled by a 15. I am not going up there filling the job as a 15. It's a too important job and it's one with too much pressure and so forth to go up there as a 15. So I'm either going as a 16 or I'm not going at all."

So luckily my brashness paid off and I was transferred to New York City as a GS-16—much to the chagrin, I think, of the then-Regional Director Bernice Bernstein. But she was not able to find sound enough grounds for objecting. Bernice had terrorized every regional commissioner up there in the regional office. And as Bill Toby can tell you, I made it clear very early on I was not to be put on her list of people who were dangling there, waiting to be terrorized by her.

So I found that to be one of the most—probably the highlight of my federal career partly because the Social and Rehabilitation Service, partly knowingly and partly unknowingly, had delegated to the regional offices many important authorities, including approval of plan amendments and the approval of Section 1115 waivers.

They thought 1115 waivers were nothing, so why shouldn't the regions have them, and so forth. I think we showed them differently in very short order in the New York region.

Anyway, that's the background of how I got there. When I got back to the central office Bruce Cardwell came and recruited me to the Social Security Administration. I had had misgivings from the beginning because I said to him the kind of position he wanted me to take was Associate Commissioner for Policy and Planning.

I said, "Bruce, my experience tells me this is not a civil servant's job, this is a political appointee's job. This is a huge agency. It has a huge impact on the federal budget. It has a huge impact on the national economy, and it is not some administrative job."

Bruce at the time said to me, "Oh, no." He said, "There are only two political appointees in the Social Security Administration: Arthur Hess, the Deputy and I." So I put my misgivings aside and went with SSA, which turned out in about three—or in a couple of years, less than two years my forebodings took fruit.

Because when Joe Califano, Hale Champion, and Jimmy Carter came in they immediately reorganized Social Security, threw out the old guard and appointed a whole new level of political appointees as associate commissioners.

So temporarily I was kind of fobbed off into the Disability Determination Administration, or whatever the official title was. And I had that job for about six months when somebody in SSA and somebody in HCFA worked out a trade in which I went to HCFA and Rhoda Morgenstern came to SSA.

In HCFA I became the Chief of the Office of Medicaid Eligibility. And there was no one else in HCFA who knew as much about Medicaid eligibility as I did. It wasn't that I knew so much, it was that they knew so little.
And so I essentially kept that position till about 1990, from about 1977 to 1990, at which time I took leave and made a trip to Russia. When I came back from Russia I discovered that in the interim my office had been abolished and on the organizational chart my name could not be found anymore.

So when I went to the powers that be and asked them, "Well, where am I? What am I doing?" I was given various vague answers: Oh, you're attached

to the head of the Medicaid office, which included eligibility reimbursement and services. And then I was put in something called the Office of Special Services as a Deputy.

SMITH: Has a sinister sound.

E. SMITH: And it was supposedly doing special projects of a variety. But let me say that I was relatively unhappy from that time on, and to be quite frank was given very little to do, and finally hung on long enough till I could retire in '96 with 41 years of service.

About 1984, however, something quite interesting happened from my point of view. And that is the Public Health Service was called before the Waxman Committee to testify what they were doing for persons suffering from AIDS.

SMITH: Right.

E. SMITH: And at one point PHS said, "We need somebody there from HCFA," because they woke up to the fact that the Medicaid program had the potential to be extraordinarily important in helping to provide services to persons with HIV and AIDS.

Everybody in HCFA reminds me of the famous Thomas Nast cartoon of the Tweed ring where everybody stands in a circle and points to everybody else. Everybody in HCFA got flustered, saying, "Well, I don't want to go." It was a little bit like Chicken Little, you know, "No, not I. No, not I."

And finally they said, "Let Elmer Smith go up." So I went up and testified before Waxman and—oh, what was his assistant's name?

MOORE: Tim Westmoreland?

SMITH: Westmoreland, Tim Westmoreland. And so from that point on I kind of became the HCFA spokesman on matters relating to HIV and AIDS and served for a number of years on the Surgeon General's Task Force on AIDS and sat there with the people from the National Institute of Infectious Diseases and others, such as Dr. Koop. And again, I found that to be a wonderful thing, wonderful area of contribution and service. And as a result of that I was asked to be on the Robert Wood Johnson Advisory Committee on the first grants that they made to cities on AIDS treatment and prevention, and went around the country with their task force.

SMITH: Very interesting. One question I wanted to ask just about early impressions of the differences between Social Security and Welfare Program Administration.

But as Bob Ball put it, he said the difficulty was more complicated programs and smaller staffs, and he contrasted it with both the less complex Social Security programs and the larger, better trained Social Security staff. Wonder what are your impressions...

E. SMITH: Well, my impressions are quite similar. First, the Bureau of Public Assistance, which was one component of the Welfare Administration, was very thinly staffed. And of course most of the action was taking place in the states and it depended upon state options as what they wanted to do with their program.

How generous did they want them or how stingy did they want to make their program? How much did they want to pay the providers under the programs, and so forth? And although the federal government had an oversight responsibility and struggled to exercise the oversight responsibility, it was tremendously outclassed not only by the number of state people involved but by the political clout of the state people involved.

The state welfare directors were a very important force as organized in the APWA, just through access to their own governors, to the Governors Association and that type of thing.

And also the federal government had to rely on reports from the state and probably the reports either were deliberately kept on the slim side in terms of the kinds of statistics that were gathered or some states were very slow and in some cases absolutely refused to report certain items.

SMITH: Such as what?

E. SMITH: Oh, in terms of levels of expenditures or what they were projecting for the next year or the next two years or something like that. And so consequently there were—people who were dealing under very difficult circumstances.

States were loath to tell the federal government at the time if they were contemplating plan amendments to either broaden them or change reimbursement rates or that kind of thing. So frequently the federal

employees didn't know until after the fact and then were criticized for the fact that they hadn't properly estimated what the program impact would be. At the time, Wilbur Cohen, who was Assistant Secretary for Legislation, kind of kept a running telephone line open to Dorothy West, who was one of the chief estimators and statisticians in the Bureau of Public Assistance.

Wilbur Cohen had this wonderful attribute: He didn't stand on ceremony or rank or anything else. If he thought you knew the answer to a question, when you picked up the phone there was Wilbur Cohen on the other end asking you that question. And he, as I say, was in relatively constant touch with Dorothy West, who I'm sure has by this time probably met her reward and is no longer around.

MOORE: Did Dorothy West become Dorothy Rice?

E. SMITH: No. I think those are two different people.

MOORE: Okay.

SMITH: Now, you were there when Medicaid was starting up?

E. SMITH: ...Absolutely.

MOORE: Elmer, do you remember what happened with regard to the early implementation of Medicaid in terms of getting policy out to states or if there was such, or whether the states really pretty much came to the feds and said, "Here's how we're going to do it"?

E. SMITH: Well, Ellen Winston was an activist so there were things; policies were sent out. But the policies were very broadly stated. And states both in terms of the timing of when they implemented the policy and in terms of how closely they adhered to the policy either seemed to have a lot of discretion or took a lot of discretion in the process.

And Wilbur Cohen, for example, got beat up terribly in the Congress in the early years because every year when the Department went up, the estimates for the Medicaid program, as contrasted with the actual level of expenditures, were way off.

And usually the expenditures were much higher than had been predicted in the estimates. Now, some people said that was Wilbur Cohen's tactic, that he, you know, kept the estimates low in order to get what he wanted to pass

the Congress, and then you let it go wherever it went under this open-ended legislation.

Which reminds me of another element of difference between Social Security and these public assistance programs. The Social Security program was a program with a fairly defined both legislative and regulatory mandate, whereas in these programs we were matching state expenditures. And I'm sure that you guys know that it was a reverse matching program. It wasn't the states that matched us; we matched what the states did. And so consequently it was a constant estimating guessing game. When would a policy be developed? How many people would it cover? When would it go into effect in the course of the year? And would any retroactive claims be made back to the beginning of a quarter, and so forth?
And so it was very difficult to make estimates. And

I think people attributed too sinister motives to Wilbur Cohen. I think there was a great deal of play in the estimates, but I think even Wilbur Cohen was surprised by it.

MOORE: We have also heard a couple of people who were around the Department in the mid '60s suggest that there was a certain amount of either real or pretended naiveness with regard to the states and what they would be willing to spend.

In other words, there were people who said, "This Medicaid program won't get out of control because the states are never going to spend that much on it so it's okay for us to sort of automatically match whatever they spend."

E. SMITH: Right.

MOORE: Do you remember that kind of discussion?

E. SMITH: Just I think it was something that was in the background. It was in the ethos, and so forth. It may have been the thinking of some people, but I never heard it enunciated quite that distinctly.

MOORE: Starkly.

SMITH: You always hear these tales and you hear them fairly early on about fraud and abuse in the early days. Or was that something that came along or was that just primarily on the AFDC side, a great deal?

E. SMITH: I think they were both on the AFDC side, you know, this was the beginning of discussion about welfare queens with Cadillacs, and so forth. I think there was some of that and I think there was some of this in the Medicaid program as well.

But I think that because the monitoring capabilities, and I'll say at both the state and federal level, were so relatively weak it took years for people to atch onto what was going on. I think it was pretty well entrenched before anybody in some position of authority really had their attention captured. or example, I'm thinking of when I went to New York, and it was 1970 then, about the people who were ripping off people in nursing homes and so forth, you know, by—doctors by walking down the hall and looking in doors and so forth and counting that as a visit, and so forth. And the entrepreneurs, who had figured out how to get a maximum amount of money out of the Medicaid program by running what were supposedly skilled nursing facilities but were staffing them with less than skilled people, and that kind of thing.

So I think it was beginning to grow in the sixties, but as I say, because the statistical and financial support systems were so weak I think the patterns were not appreciated early on in the administration of the program.

MOORE: And those statistical and financial support systems were based on the earlier public welfare systems, correct?

E. SMITH: Right. That's basically correct, of which Kerr-Mills was only a portion. So whatever programs there were in the public welfare programs in their statistical and financial reporting and so forth carried over into these health care programs. That's correct.

SMITH: One of the things we were told by a very good lawyer who I won't name, was that Supplement D to the Public Assistance Manuals which was added to deal with the Medicaid program, was really a kind of a guide to administration in the states, though did anybody in the states think that was so? It seems to me that this was a federal guide, that didn't seem to get there in time or didn't seem to provide much guidance, or be used by states.

E. SMITH: Well, I think there were two points of view and I think you have expressed them. I think from the federal point of view this was felt to be important guidance, if not indeed direction to the states. And I think at the time the states, pressed with whatever problems they then had in trying to provide health care to these populations thought of it or looked upon it as,

well, that's great but that doesn't exactly fit our problem. Or even if it does fit our problem we're going to essentially ignore it.

There were all kinds of questions being raised, compliance questions about whether the states were complying with the federal manuals and so forth. But the states caught onto the fact that there was not the political will in the federal government to really do anything about it, you know.
The federal government was not about to use the

Big Bertha of withholding funds from the states. And so, consequently they were placed—the federal people were placed in the position of cajoling or trying to convince
or—

SMITH: Jawboning.

E. SMITH: —persuading or whatever because everybody who played in this arena knew that the ultimate sanctions were not going to be used.

SMITH: Right. Wasn't it President Johnson who once said, "The only real power I have is the atomic bomb and I can't use it"?

E. SMITH: Right. So that in part those things were a starting point for negotiation. You know, if the federal people didn't think they went far enough or they weren't hewing closely enough to the line of the manual and so forth, a long period of negotiation would ensue.

But again, there was a great reluctance to flatly turn down a state plan amendment. The cards were all stacked toward trying to cajole or convince a state to make this or that or the other change in its plan amendment so it would more closely conform to the federal law and regulations.

SMITH: Uh-huh. Did you spend much time or did you do much with things like directors' letters or direct telephone conversations, things of that sort?

E. SMITH: Those kinds of things were done almost daily, I would say in the Bureau of Public Assistance and by Ellen Winston herself, you know, when it got to be something of sufficient importance. But the activity was going on almost constantly.

SMITH: Uh-huh. What about technical assistance or partnering or going out there and kind of talking with people locally and helping them. You didn't have the staff for that, I would assume.

E. SMITH: The staff really was not there. I mean, an extraordinarily minimum level of such activity took place. I think more of it took place after the SRS was formed and more delegations of authority were made to the regions and regional staffing was beefed up. So more of that took place at that point.

SMITH: We kind of got the impression that in fact someone told us—and I forget who it was; I think maybe it would have been George Silver, and he would have been at the ASPE level, or ASH, Deputy ASH at this point. And he was saying that an enormous amount of their efforts was taken up by civil rights concerns and issues of that sort. And of course maybe that was more handled at that level.

E. SMITH: Right.

SMITH: But then also in the last years of the Johnson Administration the mood was so bad and they were so overwhelmed with Vietnam and things of that sort that they weren't really making much headway and they weren't really trying to make a heck of a lot of headway, that it really almost took a new administration to get things started up.

E. SMITH: I probably am not qualified to comment too deeply on that subject, but I think you're right. I think a lot of those initiatives were being handled in the Office of the Secretary. And so I do know when the Model Cities program came along—and I don't know what year that was enacted.

It was probably '65-'66-'67, somewhere along there, there was a great deal of proactive efforts since this was directed to poor inner city types of persons, the emphasis on non-discrimination in the area of civil rights and the provision of service and so forth came to the fore somewhat more through the Model Cities special demonstrations possibly than in the broader program administration.

MOORE: David, do you want to pursue any of the questions with regard to New York State and the early days? Elmer wasn't there in the first couple of years but he was there obviously in the early '70s when some of the—

SMITH: Well, there were just two other early questions. I would like then to get into New York State. And one of them dealt with your impressions of Dr. Francis Land and his leadership in the Medicaid program. And then the second is whether you got any kind of help in relations with the Social Security Administration.
Did they partner with you in anything? Did they offer you help with setting up statistical programs, so forth and so on?

MOORE: And on the latter are you talking about Medicare and Medicaid primarily?

SMITH: Whether they helped them in any way. In other words, they are around there and they're physically located somewhere near. And they could have helped with Medicaid. Naturally they would be concerned about Medicare. But I just wonder if there was any spill-over at all with respect to Medicaid.

E. SMITH: There were two things about the Social Security Administration during this period that I think addresses your question. One is, they were extraordinarily conscious of the fact that they were being paid from so-called trust funds for things that were their responsibility.
So my recollection is, they gave almost no assistance for things outside the agency like the public assistance or Medicaid programs.

SMITH: Right.

E. SMITH: Because they didn't see it as within their legal mandate, basically. And this whole thing about the sanctity of the trust funds was such that they felt that they had to justify every cent that they spent in terms of the exact authority they had under the Social Security Act.

SMITH: Well, sometimes they would spend $20, saving one cent.

E. SMITH: Right.

SMITH: And any comments about Dr. Land and his administration?

E. SMITH: I think Land was there before I got to New York and I wasn't closely associated with him, you know, during the period he probably was most active.

SMITH: And did you leave before the '67 amendments?

E. SMITH: Did I leave where?

SMITH: To go to New York?

E. SMITH: No, I went to New York in 1970 but I was—in 1968 I went to Charlottesville.

SMITH: Oh, that's right.

E. SMITH: To the Social and Rehabilitation Service.

SMITH: Yes. I think maybe we would like particularly to hear about the experience in New York and to what extent did it get out of hand and to what extent was it sort of New York City show versus the rest of the state, and some of those issues?

MOORE: Yeah, maybe you can just describe the sort of the state of the Medicaid program as you found it when you went to the regional office.

E. SMITH: Well, the Medicaid program in New York, you know, was administered separately from the public welfare programs so that the eligibility was under George Wyman but the health service part of it was under the Commissioner of Health.

So there was always a kind of a problem there that wasn't experienced in every state because some states had combined these two functions. Secondly, there was always a tension between the city, which wanted to always move ahead, seemingly more proactively than the state. The state, you realize, had to respond to conservative upstate legislators. And so New York City was in a sense outclassed in its political weight even though it had the enormous population and it had its own local funds to contribute under the New York state system of reimbursement.

Nonetheless, it was—Jules Sugarman, during part of this time, was the commissioner of social welfare in the City of New York. Jules Sugarman was always politely but nonetheless firmly indicating to the regional office that he would want to go farther and be more expansive in terms of services and eligibility and so forth than the state would let him be.

MOORE: And did he go ahead and do it?

E. SMITH: No, he couldn't, because he didn't have the legal authority to do it.

SMITH: Well, I guess part of Governor Rockefeller's skill, and some would even say almost genius, was managing somehow to maintain something of a balance between those two forces and work them to his advantage.

E. SMITH: Right. That's exactly right. At one point when I was in New York the head of the committee in the New York Senate who had jurisdiction over welfare programs started making direct contacts with the regional office on policy questions and so forth.
Is this permissible? Can we clamp down in this area or that area, or what have you? And started to use us as a technical advisor, as a kind of a counterweight to the governor's office.

SMITH: That wouldn't have been Jim Tallon?

E. SMITH: His name was Smith. He was from Horseheads, New York. I remember that and I can't remember his full name.

SMITH: Well, if you were going to draw some contrasts, how would you contrast experience in New York State with experience in Charlottesville? Because they are two very different kinds of jurisdictions.

E. SMITH: Oh, it was as different as night and day.
In New York very shortly after I got there it turned into a quite adversarial kind of relationship in the sense that New York State was trying to use the social services authority and the Medicaid authority to get every possible element of state government and expense matched by federal government expenditures.

They tried to get their vocational education program declared a social service. They tried to get their probation and parole declared as a social service. And these are just two examples of things that they were constantly coming to our office in a very aggressive way, coming down from Albany and saying the governor wants to do this, the governor wants to do that. And then they would say, they are doing this in California.

SMITH: Uh-huh. And would they land with six limousines? I have heard about the Rockefeller treatment.

E. SMITH: Well, I never saw whether they came in limousines or not. But anyway, we got to the point where Bill Toby and I had a joke. We said when New York State would come down and say probation is a social service or drug addiction services are a social service or vocational education is a social service. And we would say, "Well, we're not sure that that qualifies under the terms of the social services authority," which, by the way, was very broad and very vague.

We laughed. And we said, "Well, how long is it going to take?" And it usually took about an hour. People who came to our office would call the governor's office. The governor's office would call the White House. The White House would call the Secretary of Health, Education, and Welfare. And at the time it was the deputy secretary—now, what was his name? He was from Madison, Wisconsin. Can't think of his name right at the moment. There was a special assistant in the Office of the Secretary, Tom Joe. Who had been in the State of California.

MOORE: Oh, this would have been when Jack Venneman was Under Secretary.

E. SMITH: Venneman. That's probably right.

SMITH: Well, and Joe was his assistant.

E. SMITH: And then they would call us and they would say, "What was it you just told New York State? And why did you tell them that?"
Now, the funny thing was, no one ever gave us a direct order and said, "That's not right and you have got to tell them something different."
They would just raise these questions with the obvious intent of making us both think about our answers, and I always had the feeling making us feel uncomfortable.

But the funny thing was I never got a direct order to reverse anything I had ever said.

SMITH: Well, it's a little like those phrases, going to make you an offer you can't really refuse.

E. SMITH: Right. Occasionally we would say, "But we're being told they're doing this." We would say to our own headquarters in the Social and Rehabilitation Service, "But we are being told that they have approved this kind of thing in California."

I remember that distinctly because I was told, "Don't use that as a precedent."

I said, "How can that be? How can there be one law in California and another law in New York State?"
And they said, "Just don't use that as a necessary precedent."

MOORE: I think that Bill Toby mentioned to us that in these days in the early '70s you all had some very significant and serious problems with claims processing and the whole kind of administrative functioning of the Medicaid program in New York.

E. SMITH: Right. And Bill was closer to that than I was because that was somewhat more under his purview as Deputy. He was the Deputy Regional Commissioner for New York State. So he was—we had a Deputy Regional Commissioner for New Jersey. He was Deputy Regional Commissioner for New York and for the islands. So he was somewhat closer to that kind of an arena than I was.

SMITH: That would have been about when, that you were picking up this kind of a problem with the claims processing?

E. SMITH: I was there from '70 to '75.

SMITH: Right.

E. SMITH: And Bill's tenure extended after '75. So it probably began during that period and carried on after I went to headquarters to the Social Security Administration.

SMITH: We were talking with someone in California, name was Jeffrey Hiller, I think. And he had worked for California Blue Cross and Blue Shield, which became the fiscal agent out in California. And so he had a pretty good sense for a lot of the things that were happening.

And he was describing it and he said, of course, things got out of hand financially in California. But it was, more than anything else in his view, the number of things they had to cope with rather quickly with a lack of equipment.

That is to say that all of a sudden people who hadn't been using health care were using it. People who had somehow been getting health care were now being covered by public programs, doctors were now getting fully paid for this. They were having to try to install some kind of system of UCR. There was a certain amount of fraud and abuse going on. But it was the number of problems hitting quite rapidly and the relative lack of preparedness that was, I guess, 85-90 percent of the total problem. It wasn't that there was so much fraud and abuse or that any one thing was wrong, it was everything.

E. SMITH: Well, to some extent that was the case in New York State as well. It was a kind of a replication of the problem at the federal level at the state level. That is, they did not have the necessary systems to point out patterns of malpractice and so forth at the state level either. And so I think that this characterization that you have been given is, my understanding, probably equally applicable in New York State as it was in California.

SMITH: There seems to be considerably less knavery in all of this than most people suppose.

E. SMITH: Yes. I don't think—I think there was plenty of knavery on the part of unscrupulous providers but I don't think there was corruption—let's put it that way—on the part of the state people. I think it was they just didn't have the tools at hand.

SMITH: Right. And many of them were trying very hard, as a matter of fact.

E. SMITH: Right.

SMITH: Yeah. Well, I must say, any reflections from your experience as to what we should have done differently with the Medicaid program? I mean, you have had a wealth of experience here.

E. SMITH: Well, you can't—I think my basic reflection is, you cannot have a huge national program with as many possible options permitted by law and regulation from state to state and even when giving waivers within a state as you do in the Medicaid program if you do not have strong analytical tools at hand and you don't have a strong capability of both providing constructive technical assistance and follow-up investigation and inspection.

SMITH: Right.

E. SMITH: And unfortunately the Medicaid program during the period I was associated with it stumbled on both fronts. It didn't have strong T.A. because they didn't have enough people. It didn't have a good follow-up in terms of really knowing what was going on, partly again because of shortage of people but partly because of inadequate statistical and financial reporting systems.

SMITH: Uh-huh. Uh-huh.

MOORE: Elmer, you said you cannot have a huge national program with so many options and without analytical tools and T.A. and follow-up. I have the sense from talking to some folks, though, that people didn't really necessarily focus in on the fact that this was going to be a huge national program, but rather it was kind of a continuation of Kerr-Mills.

And maybe it just really wasn't necessarily recognized, at least by a large number of people who were participating in it, as a potential huge national program. On the other hand, there are others who certainly saw it as the beginning of a universal health program of some sort. What is your observation of those two views of the implementation stages of Medicaid in '65-'66-'67?

E. SMITH: I think policy-wise the Medicaid program was like Topsy. It "just growed." You're quite right. I think there was a sense that it was growing out of very small and very meager administrative, statistical and financial systems' roots. And it constantly kept stumbling over itself as a result because these systems did not catch up with program growth.

And as the provider communities began to realize sometimes in advance of the states what the potential was for program growth, I think there were some people—and I would count Wilbur Cohen among them—who did have a broad vision that eventually they wanted to move this country in the direction of a universal health care program.

SMITH: Uh-huh.

E. SMITH: But Wilbur Cohen's great strength, as I look back over it, he was an incrementalist. And he would gladly take an important but very small step today with the idea this wasn't the end of anything, this was the

beginning of something. So there were both elements there contemporaneously.

SMITH: Yeah.

E. SMITH: I mean, the systems were being outgrown by leaps and bounds but a few visionaries kept thinking, well, we are moving or nudging this program in the right direction.

SMITH: Well, this is certainly a marvelous example of making lemonade.

E. SMITH: Yes, yes.

MOORE: Well, that may be a good place to stop. What do you think, David? Have you got other questions?

SMITH: But I would just like to thank you very much because you have been responsive to these questions in a way that's more helpful than almost anybody I know.

MOORE: It really has been great to talk to you, Elmer, and your memory is fantastic. And you had such a wonderful sweep of experience over a lot of years. And we're glad to get you on tape for posterity.

SMITH: There you are. You're now immortal.

E. SMITH: Well, thank you very much. And if you need any follow-up at any point, why, don't hesitate to call me. I am a bit of a mayfly. I'm here, there and everywhere. But since we were able to set this up I am sure we could do something more in the future if the need arose.

INTERVIEW WITH VERN SMITH
JUDY MOORE AND DAVID SMITH – JUNE 5, 2003

SMITH: This is an interview with Vern Smith. Judy Moore, and David Smith are conducting this interview and it is June 5th, 2003. We wanted to talk with you first about your career and where you started in this Medicaid business and where you have gone since.

V. SMITH: All right. Well, I had the good fortune while I was in graduate school in economics in Michigan State University of one day to have one of my professors ask if I would be interested in interviewing in the Michigan Governor's office for a position which they said was to write sections of the Governor's economic report.

I went down and interviewed with a gentleman named Jerry Miller. Jerry at that time was the head of economic research for Governor George Romney. He had responsibility for writing the Governor's economic report and doing revenue forecasting.

The same office handled the state budget. I interviewed with Jerry, sitting in was the head of the budget unit that handled health and human services. At the end of the interview they offered me the job and asked if I would be willing to handle the budget for this brand new program called Medicaid as well, because the other job was seasonal. So I thought I could handle this Medicaid budget in my spare time.

SMITH: With your left hand, so to speak.

V. SMITH: I had no idea what that was about, so of course I agreed enthusiastically. That was in October of 1967. Michigan had just initiated its Medicaid program. And so it was my job to forecast spending in Medicaid at the time.

When I started we only had five or six months of expenditure data to do the forecasting because the program was brand new. It was all handled by Blue Cross. My biggest challenge was getting data from Blue Cross so I could do the work.

At the time there were four people in all of state government that handled Medicaid: a medical director, a pharmacist, and a couple of administrators. Their main job was to oversee Blue Cross.

Blue Cross was also handling Medicare and they regarded Medicaid as just a state version of Medicare. So they treated it exactly the same way, which actually led to some dynamics which are very Michigan state-specific that didn't happen anyplace else in exactly the same way.

Like most states, Michigan didn't have the capability to process the claims, didn't have any expertise in that arena. So the Blues were a natural place for that to be done. Other states used Blues or contracted with another fiscal intermediary.

I discovered that a lot of my job was interfacing with a counterpart, a specific person in Blue Cross, trying to get the data. So I did budgeting and forecasting. There was no precedent for this. People had no idea how much it was going to cost.

I remember my first meeting on this with the state budget director, a gentleman named Glenn Allen. Mr. Allen asked me what I had been able to do with the data that we had from Blue Cross. Essentially I had no choice. I could apply all the sophisticated econometric models I wanted to, but basically a ruler was the best tool we had to forecast.

I remember forecasting pretty close to a round number of $100 million, which was a very large number and in itself was larger than the budget director had expected for that. But he put it down and he used it.

I remember very clearly three months later we sat down, with three months' more data, and the budget director asked me the same question. And I said, "Well,
Mr. Allen, I underestimated this the first time. It's not $100 million, it's $200 million." And that was back when $100 million was a lot of money.

SMITH: A lot of money.

V. SMITH: That was a lot of money and it was quite a distressing conversation I had with him. But it was very clear that spending was taking off and this was going to be a pretty expensive program. And of course, the ride has just continued since then.

SMITH: Right.

V. SMITH: I was in the budget office from '67 until '70 and then I joined the agency that was responsible for Medicaid, Welfare, and Human Services. It was called the Department of Social Services.

For a couple years I headed up the welfare research and analysis operation, which included analysis of the inter-relationship between Medicaid and welfare. In 1975 I then became the agency budget director, again handling the Medicaid budget. And then in 1978, Paul Allen asked me to come to Medicaid and then head up the policy and provider relations and so on.

My entire career has been related to Medicaid directly or indirectly. But that's just in a nutshell. I need to tell a story about the part that is idiosyncratic to Michigan, how Michigan used Blue Cross and then how that became a problem and why Michigan moved away from Blue Cross.

That's also the story of why Paul Allen came to be Michigan's first Medicaid director. The Blues paid the claims, fine. And they would give us reports with information on how much money was spent or actually how much money they wanted us to pay them for the claims they paid.

My challenge for the three years that I handled this budget was that I needed more information. The Blues, for reasons I couldn't understand then and to this day I can't understand, simply said, "We don't have to give you any information. Here's the invoice for how much we spent and you need to reimburse that plus our administrative fee." That's all they would give us. Just very general information. We would say, "Well, we need to know how much you spent for hospitals and pharmacists, physicians." Well, maybe they could give us that.

And on a summary basis for a year's time they would give us some information, or maybe on a month's time. But it was pulling teeth to get the most rudimentary information from them. And this wasn't just their response to me as a junior analyst, this was the response to the department head.

Then, as we felt that we needed more information to run the program it became a request from the legislature. There was one very significant hearing before the Senate Appropriations Committee in which the chair of the Senate Appropriations Committee asked Jack McCabe, the president of Blue Cross, who had been asked to testify on Medicaid and these issues.

And the legislators asked for—demanded—information and he declared that they didn't have to provide it. And this so annoyed—miffed—the legislators, that the Speaker of the House indicated that he then would support Michigan bidding out this intermediary function. And so the agency set out then in '68 and '69 to develop an RFP. And it turned out then that among the ideas that came forward was that the state could do this itself. But we also decided that we shouldn't do it ourselves unless the state competed on a level playing field with everybody else.

And so the state itself bid. There were appropriate separations in place so that the folks preparing the bid didn't interface with those who would review the bids. The state put together a proposal on how it would do it if in fact it were to do it. There were other bidders, the Blues and others, EDS, who bid on this.

It turned out the state was the successful bidder. That's when the state went on a national search and recruited Paul Allen, who was just retiring from the military and who had the necessary system skills to put together a large-scale system. Medicaid is fundamentally an information system, a data system, and Michigan created what at the time I think was the largest non-Defense Department computer system in the country. It was not just to process the claims for Medicaid. It was built to accommodate the whole human service enterprise, including welfare and Medicaid. One of the advantages to the state was that it could develop the Medicaid system in a way so that it benefited the welfare system, which was not yet computerized at that point in time.

SMITH: You would have been ahead of most of the other states at this point, were you not?

V. SMITH: In terms of creating that kind of a system?

SMITH: Yes.

V. SMITH: When that system was created and became operational in April of 1972, it was the state-of-the-art system. It was the only system that really had optical scanning capability so that the claims would come in and be optically scanned and they would be then processed very expeditiously.

And it became kind of an irony, a kind of a joke with the provider community, that we didn't pay a lot but we paid quickly. And actually,

paying quickly was enough for many years because we paid more quickly than anyone, including the Blues or any private insurance company.

No one had a better track record—and these are all very available statistics—on how long it takes from the date of receipt of the invoice to the date of payment. But we didn't even have to share the statistics. The doctors sang our praises. Hospitals sang our praises. And we also did some other things that made our system advantageous compared to other payers.

For example, we created an interim payment system for hospitals and for nursing homes—and then we would reconcile actual approved claims against the amount that they were paid on the interim basis. There were actually some very sophisticated and shall I say savvy approaches that were taken that built a lot of goodwill between the Michigan program and the providers. And it really worked very, very, well. You have to give Paul Allen a lot of credit.

SMITH: This probably put you a good bit ahead of the game when it came to fraud and abuse and things like that.

V. SMITH: Well, the nice thing about this was that it was our system and we didn't have to go to any intermediary and say, "Could you do for this us?" and, "How much would it cost extra for you to do this?" Everything was within our control.

So we knew what was going on and any little question we had we could go into the system and get it. And, you know, when you are building a system or when you are developing policy you can never anticipate every issue that is going to come up.

So at some random time when an issue comes up in the legislature we could then go into the system, not in a timely way at that time because we didn't have the data warehouse capability yet. But every week you could submit queries and get a response back in another week. And that was very timely in those days. It wouldn't meet today's standards but...

SMITH: I am curious about the quality of civil service in Michigan. Was this of a very high order?

V. SMITH: It was. And actually, that is a very good point to make because Michigan, perhaps like Minnesota or Wisconsin, has had a tradition of a very

fine civil service. I have to admit I did my undergraduate work in Indiana and I did a good part of my growing-up in Indiana.

The impression one gets as an ordinary citizen in Indiana about the civil service is not the same as I came to have of the Michigan civil service. When I first accepted this job in Michigan state government, I never—I would have bet a million dollars that I wouldn't be there but a couple years until I finished my graduate work and then I would be off as an economist, teaching or with some company.

That was why I was there, to get the degree so I could do those things as an economist. Never did I entertain a thought about being a public servant. And once I got there I discovered, well, here's Jerry Miller who hired me. He has a Ph.D.

And here's this person in the budget office. They have a Ph.D. Everyone I worked with in the budget office had a master's degree and an MPA or MBA. I discovered this is a very worthy place to be. And not only is it a worthy place to be, but the rewards from working in these programs were so great that after three or four years I actually had a job offer at a college that I was very interested in. I accepted the job originally and I was prepared to go there.

And then I had to call the president of the college, who happened to be somebody I knew, a contemporary of my father, who was a college professor, and had to tell the president of the college and the dean that I wasn't going to take it because I was really enjoying what I was doing.

So, the civil service in Michigan was a real asset. And it surprised me as someone coming from outside Michigan at that time, the high level of it. And, you know, things have changed a bit over the past 35 years but it still—there are a lot of very good people who work in Michigan state government.

SMITH: Well, in the health care field it seems to me one important asset that you have there is the possibility for a good public-private interaction. You've got a good civil service that is respected by the people in the private sector, and vice versa.

V. SMITH: Yes, that's absolutely true.

MOORE: Back to the systems question that we were on before. When the federal MMIS came along did that create massive problems for you?

V. SMITH: Just a challenge. We just took on the challenge. I don't recall anyone saying, "Oh, we can't ever do that." It was simply kind of moving on recognizing that, you know, there was a change. It was an important thing to do. It was all within our control to do it; so we did it.

SMITH: Well, you had already largely achieved much of the purpose of MMIS.

V. SMITH: Absolutely. I mean, it's hard to believe actually when I think about it. That system went live in April of '72. It's still being used today. When I think about it, how many things in the technological world are still being used 31 years later? I mean, there's been a lot of upgrades over time. It's not the same system it was then. But—

MOORE: At the core.

V. SMITH: Yeah.

MOORE: Now, I remember you as the director of research. Did you move from that job or did you also do a lot of research?

V. SMITH: Research was part of what I did in all of these positions. From 1978 when I stepped away from being the budget director and became the policy director for Medicaid there was some research that was—I mean, we had a policy staff of maybe 40 people. But, you know, when you are doing policy development—that was actually the name of the unit—then you end up doing a fair amount of research as well.

MOORE: Yes.

V. SMITH: And that position was policy development and provider relations from '78 until the '90s...

SMITH: What were the big issues in policy research and the kind of things you were trying to develop?

V. SMITH: Well, in the beginning, the state was more focused on just having Blue Cross do its job in the sense that it would do all the provider

enrollment, pay the providers, and so on. There wasn't a lot of policy interest and there was certainly no capability.

As I said, there were four very senior people. These were all very senior administrators within the agency. They were the people who had responsibility for Medicaid.

But when the state took it over, first creating the project to develop the system, and then creating the entire organization, and then because this required a certain specialized expertise the organization actually was populated with some very good and smart people from Travelers, from Blue Cross, from John Hancock, CPAs, other people who knew insurance, private insurance, people who knew how systems worked in paying claims.

And so it wasn't like just forming the organization from bureaucrats or people who had passed an ordinary civil service exam. They were people who did this very same thing before they came but they tended to be folks in early career. So now when you think of it, there has been a huge turnover in the last decade, and especially in the last five or six years of people who came to Medicaid in '72 and then after 25 years they are retiring.

So it's really a very different group of people now, with a few folks that are still there who were there in '72.

SMITH: By '78 were you beginning to think about other lines of development, more in the way of managed care or—

V. SMITH: Well, yes, because we actually signed our first contract with an HMO in 1978. I'll tell you this anecdote. Now, I knew a little something about Medicaid, of course. I represented the agency, including the Medicaid budget before the legislature. I actually had the privilege of appearing before legislative committees on Medicaid issues for something like 26 consecutive years through that period of time. So I say this just by way of saying that I should have known better.

When I came to Medicaid as the policy director I pulled my staff together, I said, "Well, it's 1978. You have been doing this now for 6 years and the program has been in existence for 11. So I assume most of the problems are solved and the policy issues are settled. So can you just put a list together for me of all the issues that you are dealing with right now?"

And they gave me one of those looks like, "You're new, aren't you?" And they persisted, and a few days later they gave me a list. There were 151 issues on the list.

SMITH: Oh, my goodness.

V. SMITH: That was an early insight into how complex this program is and how it's ever-changing, because those were just the issues that were under development at that point in time. In 1978, there were 151 issues that the policy staff listed for me. And I guarantee you, the list has never gotten shorter.

SMITH: We take that to mean that as you solved one another one came up.

V. SMITH: Well, what was it Eric Severaid said, you know, "Our problems are born of our solutions."

I have always remembered that. But the fact of the matter is, it is a very complex program. You are always working to take advantage of or respond to the changes in the health care marketplace, the changes that the legislature makes decisions on, the policy priorities of the Governor and all the other things that are happening out there. There is no end to it.

SMITH: Well, a point grows out of what you are saying. I was reading a recent survey of disability policy. It drew a contrast between handling of disabilities in the state of Illinois and the state of Michigan.

One of the points that they were making about Illinois was the more it changes, the more it is the same. They've got a huge institutional district, they've got trade unions, they've got all that sort of thing. Not that much changed, you know.

Whereas Michigan, by contrast, is much more pluralistic, much more dynamic, lots of things happening. Big private sector people, big public sector people, et cetera. So is it also true that Michigan is more dynamic than many other places?

V. SMITH: Well, maybe so. But also maybe it was because of the way we organized ourselves so that we had complete control of the program and we took ownership of it. And, you know, a lot of these policy issues are operational issues.

Some of them are things like well, we had 400 edits in the system. A lot of people don't realize all of the tests that a claim goes through. And some of them are integrity edits and some are eligibility edits and qualification edits of one kind or another...screens and so on.

But, every one of those edits has a policy basis of some kind. So, we were involved with that. It took me a long time after I got into Medicaid to realize that we in Michigan were running an insurance company; while a lot of other folks in other states were running a program and had the insurance company helping them.

We were doing the whole ball of wax and that's why I had 500 employees working for me when I was in Medicaid. Under Paul Allen at one time we had 630 people at the high point. That didn't include the data processing folks who were in a separate area.

But, it's a large organization. A lot of different specialties. Just think around the organization from the claims-processing side and all of the things you are doing there. We were paying 60 million claims a year, 1.2 million claims a week. We were paying a quarter of a million claims a day. So, we used to say, you have to keep up. If you start getting behind, you get behind in a large way, very quickly.

But when you are doing that and watching the statistics every day about how you are doing paying the claims, then you also pay attention to what is it that is causing claims not to get paid, what is it that is causing claims to pend, what is it that is causing them to reject.

If too many claims are rejecting, why is that? That's a trigger. That's a red flag. You've got to look into that and find out why that's happening. Are people not billing correctly? Is our policy not clear? Or do we have the edits set in the wrong place?

It's this constant process. Looking back, it was a great privilege to sit around our staff meetings twice a week with every part of the organization, all interacting, every day, all together. I could see how the folks doing the cost settlements for hospitals and the cost settlements for nursing homes were doing and how that interrelated to the claims payment and the interim payment system.

SMITH: You are making a very good argument to work at the state level rather than the federal.

V. SMITH: Oh, well, I am sure there is a lot more in Medicaid at the state level than at the federal level. I mean, you can have fun as a federal person with Medicaid, I'm sure. But this is a different kind of fun.

SMITH: The picture you are drawing, you say you work very much like an insurance company. And in the early phases of the Medicaid, fairly early, let us say '67 to '77-'78, a little beyond that you think of it—or I think of it as in many ways getting the program established but established as a claims-paying organization with program integrity and worrying about fraud and abuse and things of that kind.

When people talk about flies that got into the ointment back then they often mention EPSDT and disability. Were these road bumps for you or did you just take all of that in stride?

V. SMITH: Well, they were kind of taken in stride as they came along. Michigan was one of the few states—Sara Rosenbaum may have shared this with you—Michigan was a state that actually had to be sued before it would implement EPSDT.

That was during the period of time when I was off doing the budget things. And I'm not sure exactly why that was, but it just somehow or another didn't fit in with the timetable of doing things at the time. And so there was a lawsuit. Michigan implemented it very quickly under the pressure of the legal action and there was never any resentment about that.

But, it did take a little while to get some of these new things into the system. There's no question about it.

MOORE: You were credited with having started or begun the discussions that led to the current child health technical advisory group and a lot of activities around looking at children's health and expansions from that time. How did that come about? What do you recall about that?

V. SMITH: Well, I had the very good fortune during that period of time to be working with Paul Allen, who expected me to be aware of what's going on nationally and expected me to interact with national issues as well as within the state.

So he took me to Medicaid directors' meetings and that kind of thing so that I could meet other folks at the state level and the national [level] from the beginning.

Paul was chair of the National Medicaid Directors' Association at the time. So he had other things to do at these meetings. It was good for me to be along as a sidekick.

One of the issues that came up in the '78-'79 time period—I don't remember exactly, but in that period of time—EPSDT was being implemented. There was variability. There was a sense in the Congress or from some quarters and in the Congress that there should be penalties attached to non-performance or poor performance.

And the Congress enacted a provision in federal law that provided the basis for a penalty attached to poor performance. And HCFA set out to write the regulation that would impose a penalty on states for not complying and meeting all the standards of EPSDT.

I think HCFA was really compelled to write the regulation. It was in the law...but nevertheless it was a punitive penalty provision from the state perspective. It really held states accountable for things over which they could never have control and almost certainly would have—if it had ever actually been implemented—would have resulted in some very egregious penalties on states.

At least, that was our feeling. And so we were a party to a number of discussions. And Paul Allen as chair, asked me to lead some of these discussions. And I am remembering very specifically at a Medicaid directors' meeting.

I don't remember exactly where it was but my impression was that it may have been in Nashville or Memphis. I do remember it was a foggy day and because it was foggy Mary Tierney's plane was late. Mary Tierney was the HCFA person who had been given responsibility for developing these regulations.

I was to speak representing the state perspective. I remember this because I was actually speaking before she arrived. When she did arrive, it was a very good, pointed discussion. The outcome was that we felt that we needed to have a forum to discuss this issue.

Out of that discussion on the penalty regulation came EPSDT TAG. It was known by that name for a number of years. I had the privilege of chairing it for 14 years. The mission of it changed very substantially over time. But in the beginning it was primarily a forum to deal with the penalty regulations and then to get on with it. And, you know, it's entirely possible that would have been it. But it turned out not to be the case. Since we are talking history here, I just have to tell you this little story. This was a very important issue for states and we had a meeting of the TAG in the Switzer building here in Washington.

I remember we were talking about these regulations and they were on track to go. There seemed to be no way for them not to be issued at this point in time. We were there to discuss the implications and to make a last plea that they not be issued.

We had a discussion—I remember this very well—and in the course of the discussion Dick Heim came into the room and—the listeners won't be able to see. It was a room about this size and on one side there were some tables just like this.

And Dick Heim came in. He didn't say a word. He went over and sat on the edge of the table and just listened. He just listened. He listened for maybe an hour, maybe two. he just listened. Then he stepped off the table and he said, "We're not going to issue this regulation." And he left the room. That was a very powerful moment.

SMITH: I can believe it was.

MOORE: He told us a little variation of that.

V. SMITH: I would love to hear his recollection.

MOORE: He remembers it well. I believe he could tell you the date that was.

SMITH: Well, we'll dig up and see what we've got there.

V. SMITH: I would love to see his recollection of it. But I was so impressed with Dick and I remember that to this day. I have just the highest regard for Dick Heim because of the way he responded.

SMITH: There were other occasions where he just did it the way he thought it should be done and took the flak.

V. SMITH: And, you know, in retrospect I don't think he had the authority not to issue those regulations. He just did it.

There were a lot of other issues that came up over time and the advisory group became the maternal and child health advisory group in the mid-1980s. The issues changed in part because of managed care and because of increasing Medicaid eligibility for pregnant women and children.

As Medicaid began to cover more and more people who had been part of the core constituency of public health, Medicaid became a big threat to public health. And—oh, gosh, I'm going to end up telling another story.

MOORE: That's all right.

SMITH: That's grand.

V. SMITH: I believe it was probably 1986. There was in October a Medicaid directors' meeting, a state-only meeting, in Tampa, Florida. But some people from ASTHO had asked to come, including Dr. Novak, who was the president of ASTHO at the time.

And Marie Meglen, who was a nurse from public health in South Carolina. And I am trying to remember the name of a physician, a lady O.B. physician from Oklahoma, whose name I forgot for the moment. Three very capable people who were representing ASTHO.

They had come to the Medicaid directors' meeting for the purpose of explaining to—I'm going to say this in a pejorative way, pardon me—explaining to the Medicaid directors the Medicaid reform proposal they had developed which they were going to be releasing in a day or two in Washington but which none of us had known anything about.

I believe they expected that we would be very receptive to their proposal, they were about to lay in front of us, even though it was coming as a surprise. And I remember sitting listening to these good people from the public health community explain their view of how Medicaid should change.

And the folks on the Medicaid side, just kind of collectively, their jaws were dropping because the proposal did not make sense from a Medicaid perspective at all. And when they were done there was silence.

And then someone who you would know, Faye Baggiano, as only Faye could do—she was the Alabama Medicaid director at the time—and she stood up and said whatever everyone else was thinking.

And let's just say it was not kind. It was very pointed and very direct. And so we went from one uncomfortable moment while we were waiting to see how we might respond to the public health presentation to another uncomfortable moment as we were trying to figure out how everyone in the room was going to respond to this outburst from Faye, as she blasted them for this proposal.

And so as we waited there, I stood and said, "You know, we have a technical advisory group that might be an appropriate place to discuss this issue."

SMITH: Wonderful.

V. SMITH: And so, instead of dealing with the proposal then, the way we dealt with it was to say, "Let's let this EPSDT TAG deal with these issues relating to public health." So, we invited the public health folks to join us at our TAG meeting.

Now, when we started off we didn't expect this to become a permanent arrangement. But it became a permanent arrangement and I believe it exists even till this day.

MOORE: Yes, it does.

V. SMITH: And it's overall been very productive. At first, my colleagues on the Medicaid side were very suspicious of this arrangement. But I think it turned out to be a very productive arrangement and allowed us to talk about a lot of issues.

And we, in fact, shared chairmanships. There was a public health chair and I was the chair from the Medicaid side and we worked together and decided when and where to hold meetings together, and so on. It actually worked out very well.

MOORE: What's your response to the eligibility expansions that resulted from Congressman Waxman's initiatives? It's turning Medicaid into a program that did not supplement but supplanted, in some sense, the public health—MCH programs.

V. SMITH: Right, exactly. The same thing happened with mental health about five years later but in a slightly different way, but for the same reason. There was concern as Medicaid began financing the functions. In reality this was an enormous opportunity, and I think everyone came to see that within a few years. But at the time it was very threatening to public health because Medicaid was beginning to finance the health care of these individuals, mainly pregnant women, the prenatal care and delivery and child health, that had been their responsibility.

Suddenly these folks had Medicaid as a health coverage. But in order to get the Medicaid money there were Medicaid rules that had to be followed. And this meant claims had to be filed.

You couldn't just serve somebody because they were there. You actually had to see their card. There was a push back. And there was not a good understanding. We all see the world from the position in which we sit. And the public health community tended—this is an over-generalization—but tended to think that the Medicaid money was good but there shouldn't be any need for the public health community to change any of their rules in order to get the Medicaid money. And the Medicaid folks kind of felt like, well, the Medicaid money is good and we're happy to help but here are all the rules that you have to follow in order to get it. And when Medicaid explained the rules there was a sense that Medicaid was trying to control the public health side.

That wasn't at all what we were trying to do. But I am quite confident it was interpreted that way quite often.

And I remember very clearly—this is a Michigan anecdote but it illustrates what was going on. During this period of time one senior administrator in our department of public health asked for an appointment to see me.

He came over to my office and this person said to me, "You know, we would really like to do these things in our child health program that are now being done in a nearby state. Medicaid gave a grant for $10 million to them in order to do this."

And I said, "Well, I'm quite sure that that's not the case because Medicaid has no authority to give such a grant."

This person was quite confident. If that state could do it, then we should do it, too. I should write a check for $10 million.

I explained that I couldn't do that. I was trying to figure out how in the world this could work, whether they could do it, and I was not coming up with anything. I basically said, "This is the way we can do it under Medicaid. I believe we can help you in this way."

I was told, "Oh, no, no, no. That's not acceptable. We would like to have a grant." Later, I came to understand that in the HRSA world, getting a grant was the way things were done. There wasn't any experience with a matching program like Medicaid. They just didn't understand how it worked and simply assumed that, well, the Medicaid money can come along in a grant. Later this person actually came to understand Medicaid quite well and was able to help bring in the Medicaid money in a way that was appropriate.

But at that period of time I think there was widespread misunderstanding of the opportunity to have Medicaid. And a tremendous feeling of insecurity about what Medicaid might do if it took it over because the public health mission would be lost. Medicaid should just be a financing mechanism. Otherwise, programs would be driven by money and not by the values of public health.

But, that was a hurdle we had to get over and I think we finally got through it in a very productive way.

SMITH: Well, if you weren't particularly getting into the running of programs as such but as you were getting more and more into these substantive program areas that had been formerly public health—it was made to order for a major sort of a culture clash.

V. SMITH: It was. And I remember speaking to the Michigan Association of Public Health Directors. I'm not sure exactly...the association of the local public health administrators that ran public health at the local level during this period of time.

At this meeting there was a great debate about whether local public health should remain in the service delivery business or should they get back to the

core mission of public health, of assuring the public health of the community.

As opposed to running free clinics. By then so many of the people who had been the core constituency at these clinics were acquiring Medicaid coverage. And this was changing the whole dynamic. As a matter of fact, many, if not most of the public health departments in Michigan got out of service delivery during this period of time. This was very painful for many because they were heavily invested in the service delivery aspect of public health. It was one of the things that came about, I'm sure not just in Michigan.

It was a transition as Medicaid began to be a mechanism for financing health care broadly across the spectrum.

SMITH: And Michigan was one of those states in which public health was a very powerful tradition.

V. SMITH: Yes. Oh, yes. And highly respected within the state as well as outside I think.

SMITH: Well, Judy was mentioning the incremental Waxman expansions of eligibility. And from your perspective in the state was this seen as a welcome initiative or was it seen as here comes Waxman again?

V. SMITH: Well, I think it was probably kind of a mixed feeling. On the one hand people recognized the value of the health coverage that Medicaid offered. And, as you know, the option to add coverage was politically attractive.

I must say in the context of today's debate the fact that there were federal matching funds was probably the key to the state opting into it. Were it not for that, it would have been a different discussion. States may not have opted into it. There was a cost involved. It wasn't exactly an unfunded mandate, because the state chose to do it. I mean, except for the children born “on and after September 30 of 1983.” But, there was a side to it that was a federal mandate. That there was an increasing draw against the state revenues was a bit of a problem.

On the other hand, it's not a bad thing to have health coverage and these people weren't otherwise covered. You could certainly build a case,

especially for pregnant women and children, that it was a very valuable thing. So I don't ever recall this being a difficult sell in the legislature.

SMITH: Wasn't it also pretty much true that Michigan generally maintained a stance of program innovation and wanted to do more, and was not a state that was grudging about moving ahead?

V. SMITH: Actually, I appreciate you saying that because we took pride ourselves in that. It was part of our self-image that we wanted to be trailblazers in Medicaid. That was part of when we talked internally.

We were looking for opportunities where we could move forward and be out front and be one of the early innovators. Managed care would be one area. We were one of the early adopters in managed care. I think at one point in time, what was it, 95 percent of all the managed care enrollees in the country were in four states and Michigan was one of them. And we were first to implement a primary care case management system, the PCCM, which was made possible in OBRA '81.

That was another time of great state budget difficulty. We were in a recession, so we were looking for ways to slow the great growth of Medicaid spending and working every possible option. Managed care was one of the options we were looking at in 1981. We presented the medical community with an option of a fee cut or, if they could come up with some alternative solutions, we would work with them on that for equivalent savings.

In the working groups that were formed after we laid out this budget savings target, one of the ideas that came up was taking advantage of this new provision. As a result, we were in a position to implement a PCCM on the day that the law said you could do it, July 1, 1982. And on that day, we implemented. And so—so that's an example of how we took pride in being innovative whenever we could. And there are other examples besides that. We had one of the country's first mandatory second-opinion programs and different policies like that.

SMITH: You said you welcomed some of these initiatives. We get the sense from talking to various people that many of the governors did so, and I don't know to what extent that was shared in the Medicaid directors' fraternity. But many also said, well, there's such a thing as too much of a good thing. And do you recall a point where you began feeling maybe there is something to this unfunded mandate stuff and there were too many

strings to these things and the Feds should back off? Was it a gradual sort of thing? Did it hit real hard with the recession or—

V. SMITH: I would have to say I don't recall a particular break. We could wax eloquent on how bad unfunded mandates were. And we did. In retrospect I don't know if what Congressman Waxman did was intentional or it just turned out that way. But it was skillfully done. And it presented states with an opportunity to gradually expand coverage in a way that was politically acceptable, state by state.

And when Mr. Waxman's time is done and they write something on his tombstone, somehow they should acknowledge that. It was really a singular accomplishment. I mean, just in terms of the number of people affected in this country—the number of people who have had health coverage as a result of those opportunities to expand health coverage step by step at state option. It's millions and millions of kids...

SMITH: Some have mentioned the combination of events out of all this catastrophic business, like the Cheshire cat that went away and left the smile behind. You were left with the dual eligibles.

V. SMITH: Right.

SMITH: And there were these elaborate and proscriptive nursing home reforms and there were a number of changes that came through around 1988 to 1990, and about 1991 and '92 you can begin hearing governors say this is too much.

Then by '94, quite a number of them were prepared to say, well, we'll accept a block grant if you can just get rid of all this business.

But did that phrase, '88 to '90, seem like a—

V. SMITH: It was just another change in the federal law and we responded to it.

You know, on the eligibility side—well, let me say this. I think this is kind of an important point to make. Medicaid eligibility in some ways is different from running a Medicaid program. And the eligibility side is handled by the welfare side of an agency or in some cases a different agency, a welfare agency.

And so Medicaid ran its program based on the number of persons who actually qualified. But the eligibility determination was made by a different group of state employees. Somebody else was responsible for that, at least in Michigan. And so, yes, we did deal with it. But on the welfare side we were dealing with the complexities of eligibility. And so some of us actually then had the luxury—it's not true in every state, but in Michigan Medicaid had the luxury of actually not having to deal with the eligibility side too much. I was always appreciative of that.

SMITH: Right. But I just was reading this piece that you did dealing with DSH. And of course DSH begins to get [to be] a very, very big thing just about this time.

And I was fascinated in reading this. It opened up all sorts of questions—what was the motivation behind all of this exploitation of DSH, how much of it was just to replace funds that were being taken away, how much of it was to try to turn this crate of lemons into lemonade.

Could you say a little bit about your take on DSH? Was this the glue that held the program together? Was this manna from heaven? Consider the so-called leadership states. You'd want to say that here's a bunch of smart, honest bureaucrats and leaders that are doing what they can do under the circumstances.

V. SMITH: Exactly.

SMITH: And other people would...

V. SMITH: Exactly. Well, let me say this, that first of all there is a legitimate policy basis for all the DSH category of spending. It has truly helped out. There are a lot of hospitals that would have had a much more difficult time were it not for the DSH payments.

But DSH also got Medicaid folks thinking in a particular direction that they really hadn't been thinking about before. And that was looking how to finance DSH payments. Is it possible to have these intergovernmental transfers to help finance them? Are there ways to do this...in a way that—legally allows a state to come out financially advantaged?

And I recall being in a number of discussions in this period of time where we were asking ourselves, well, what can we do with this? There is one thing about people in the Medicaid community at the state level. They are very,

very wary of crossing any line that would make something potentially not legal.

So we really would be very, very careful. Let's do a careful reading of the law. What is it that you can do. And what are the limits of this? Many states tested the limits out there, and Michigan tested the limits also.

The question was: How far can you go to do this? We had an open discussion with our budget director, the governor's office and department heads about the risks involved.

This was controversial from the beginning in terms of how states were doing this. We decided that the risks were worth taking as long as we knew everything we did was legal—we totally ruled out doing anything illegal—then we should go ahead and pursue it.

The real risks that we were looking at were the political risks. What if HCFA were to decide that we had overstepped and they were recovering money? Not doing anything criminally, not putting anybody in jail, but the political equivalent of that is to have a newspaper headline that says, "Feds demand $300 million back." That's not good.

SMITH: Michigan state director resigns.

V. SMITH: Yes, right. That's not good. So we wanted to make sure that we didn't ever cross that line. And of course it never happened. There never was a crossing of that line. But in the course of doing this you would test a little bit, get your feet wet, and find what HCFA would approve.

In these discussions we would have with the leadership in the legislature, with the governor's office and with the state budget director, we discussed that there was a certain risk that this might come to an end. But as state officials representing the taxpayers of the state of Michigan we really had an obligation to do these things while we could that advantaged the taxpayers of the state of Michigan, and advantaged the hospitals of the state of Michigan.

If we eventually got into a situation where what we were doing was declared to have crossed the line, then we would have to pay it back. That might create some difficulties from a budgetary standpoint. But we knew that this was an un-blazed trail. We had to find our way as we went along.

So that's what we did. And as it turns out, limits have been placed on it by Congress over the years to achieve some control over this. But all the while you have the states trying to figure out what they can do within the rules.

You know, you had Tennessee out there doing these things. In effect, TennCare in 1993-94 was the product of the limits that were going to be imposed on its DSH program. If it didn't do something like this to lock in the federal money, it would have lost all that money.

That's one response to this kind of a situation. But I must admit to a certain sense of awe on my part as to what you could do.

I hesitate to think that it's part of the record, but I can describe this with a real example. Whenever I describe this people say, "Wow, you could do that." Well, yes, we could.

One morning after this had been arranged on the appointed morning we wire-transferred to the University of Michigan $500 million. On that payment, a legitimate legal Medicaid payment, we earned $277 million in federal matching funds.

Over lunch the people from the University of Michigan Hospital admired their bank account. Had a very nice lunch, felt very good about themselves, and later that afternoon wire-transferred to the state of Michigan—not to Medicaid but to the state of Michigan—$500 million.

They had had the money long enough to take possession of it. It was a legitimate Medicaid payment. It qualified for Medicaid matching in every way. There was nothing at all questionable about the payment. And later that afternoon the hospital made a donation to the state of Michigan—state of Michigan general fund, not to Medicaid—of $500 million.

Now, on that day the state made $277 million. You know, it didn’t pay for any benefit directly that accrued to any Medicaid beneficiary. The hospital didn't get any net benefit, at least out of that transaction. It was just the way the system worked. No one would ever claim that this was good public policy. But it was a legal thing to do, and from a state perspective we were really compelled to do these things. If you didn't you could be accused of...misfeasance for not having taken advantage of getting all the federal money the state was entitled to.

SMITH: Well, there is one school of thought that really doesn't raise too many questions about doing this as long as you devote it all to health care.

V. SMITH: Yes, exactly. Well, I would say this. If you talk to anyone in Michigan about the expenditures, they will tell you that every dime of the proceeds just goes to support the Medicaid program or health care...There is no question about that.

You would never find anyone, I don't think, who would say otherwise....so that is how we talked about it and we all agreed and believed that's what would happen. And the politicians agreed that that's what would happen.

And we also all agreed that that's what we would say. Because it's important. The perception of this is important. And we point that out at every turn. Now, I also want to say this, that because this was controversial, the General Accounting Office came looking at several states. And in particular I am recalling one GAO report that focused on Pennsylvania, Michigan and Texas.

We always felt we were not going to do anything where every detail couldn't be examined in the light of day, even by a GAO auditor. When the GAO auditor came into my office and sat down to talk about this subject I was prepared to show him every detail.

I had documents. I had what amounted to a flow chart that showed how this money did flow and the timing of the transactions, who would be advantaged, how it was done, so on. Everything was there, all the documentation, the state plan,...everything.

I just opened the books and said, "Ask us any question. Do you want to talk to the budget director? Do you want to talk to the treasurer? Do you want to talk to the governor's office? It doesn't matter. Anybody. We'll arrange that. We'll answer all your questions. A staffer was there who answered all the questions. And our reward for this was that when the report was done I think there were 3 pages for Texas, 2 pages for Pennsylvania, and we had 17 pages.

But that was okay. It was okay.

MOORE: ...funny.

V. SMITH: Yes. But, I mean, we were a little annoyed at all that attention. But on the other hand I was privately satisfied that we had been reviewed so carefully. There is so much money in Medicaid. There is a fundamental ethic that pervades all Medicaid administrators that I have ever known. And that is a complete commitment to fiscal integrity. And I always felt there wasn't a thing we were going to do that couldn't be described in the light of day. And it didn't matter whether it was a HCFA auditor or a GAO auditor or a legislative analyst or whomever it might be. We were going to describe exactly what we were doing; and we did.

We really believed it. It was a strongly held belief that we should always be open with what we do.

SMITH: One question I wanted to be sure to ask you. Michigan has been remarkable for how far they have gone and are going with managed care, Medicaid managed care. And I think it is one of the few states that really seems to have put in place a pretty sophisticated, maybe even workable risk adjuster.

What is your thought? Do you think that—can you go too far with managed care? Do you think it's important that a very high proportion of the Medicaid managed care entities be not-for-profit? Any restraints on this? What about the safety net providers so far?

V. SMITH: Well, let me just kind of go back. Part of our philosophy, sort of my philosophy we tried to act on over time is that this is public policy we are doing. It all should be done in a public way. That's partly reflected in what we were just talking about a few minutes ago on the fiscal integrity side.

But it's equally true on the public policy development side and implementation side. So we tried—when we first implemented managed care it was in 1978. At that time there wasn't a lot of managed care in the general marketplace.

We tried to take advantage of that. We tried to encourage it and foster it. And one of the things that we implemented in the early 1980s was something we called a clinic plan, which was a partially capitated approach. I think there only had been one or two other states that actually did this.

We tried to create entities that could grow into HMOs. We called them clinic plans. The clinics were capitated on the ambulatory side and the state then

paid the inpatient hospital claims directly. The clinic plans, by managing hospital services, were able to earn a bonus.

So we encouraged clinic plan development. There were five or six of them that actually accepted the opportunity. Two of them today continue as honest-to-goodness licensed Medicaid-focused HMOs. That is a long-term statement of success.

We became real converts to the benefits of managed care. And the reason we thought they were so important was really a quality issue and an accountability issue. With unfettered fee-for-service, people were left adrift and had to get a health care system on their own. They had no idea who their doctor was. Oftentimes they would randomly access the system.

Heaven knows, it's hard enough for those of us who are reasonably sophisticated to navigate the health care system. For these people, it's really hard.

So just having your doctor's name and phone number on your Medicaid card was a tremendous benefit. Before managed care, sometimes I would get the call from the local social services director or the local case worker saying, "I've got a pregnant woman here and we can't find anybody to provide prenatal care." Or, "I've got a sick kid here. We can't find any doctor, pediatrician, who will serve this sick kid. Help us." By the time it got to me—and I might be 300 or 400 miles away from them, it had gone way past the point of desperation on their part.

Then I would call the state medical society and they would contact the local medical community. We always found something. But Medicaid had real access problems before managed care.

Managed care solved the access problem. To me, that alone would have been reason enough to go into managed care. But then we also had the other benefits.

We had somebody to hold accountable so we could actually measure quality for the first time. Couldn't do that before. And it was a desire of ours to do that. And then it also turned out we could set the rates so we guaranteed ourselves some savings.

And even in the non-risk PCCM we saw emergency room rates drop by 50 percent just by the simple act of putting a doctor's name and phone number on a Medicaid card. And so, we were strong, strong believers in this.

Now, that's not to say there weren't problems and issues. The same feelings about managed care that were in the general population were among the Medicaid population. Everyone didn't rush out to embrace this concept even though they were being required to join it. We formed advisory groups. We gave advocates an unrestricted grant. In the 1980s, the legislature earmarked $30,000 specifically for a managed care monitoring committee.

We simply gave the money to one of the respected advocacy community organizations. We asked them to answer the questions, to monitor implementation, to generate information independent of us about how things were going. It was a great resource for identifying issues and problems and tweaking our policy so we could make it better and more acceptable. It was just part of the way we tried to do things at that point.

SMITH: Are your HMOs nicer people than they are elsewhere? In Minnesota, I certainly think they are nicer people than they are elsewhere. They are better than they are in Pennsylvania.

When you hear people saying, well, you can really work with HMOs, I think it has a lot to do with what kind of HMOs we are talking about. And I notice in the program that Michigan now has not only a risk adjuster in place, but before BBA 97 they were doing a lot of these things.

So does it depend in some measure on the kind of HMOs you have in Michigan?

V. SMITH: Well, it probably does. And we have not had any of the horror stories that have come from the press in Florida or California, just to take a couple of examples. In Michigan, we were fortunate in that regard. I don't know how to explain that exactly. There are for-profit HMOs in Michigan but there's also kind of a non-profit ethic that exists even in the for-profit organizations.

But, no, they have been good—they were good to work with. They were cooperative. They were responsive. We had issues oftentimes revolving around rates. But they were willing to do what needed to be done. I don't recall any real problems that we had.

But, you know, in those days in the '80s and early '90s we were really focused on mainstreaming individuals. And of course that was the time of the 75/25 rule in terms of Medicaid and non-Medicaid populations. So that was really part of the ethic: mainstreaming.

It wasn't until after I left Medicaid in '97 when there began to be this mass exodus of health plans from Medicaid.

At first it seemed like a bad thing to me, that only the Medicaid-focused health plans were the ones that were left. But I have really come to believe now that that's a good thing. That the Medicaid population does have characteristics unique and different from the employer sponsored population and it really does take a different approach. In '95-'96 there was a general perception in the managed care community that if you weren't in Medicaid you should get in because, number one, there was an opportunity to make some money. And there was all this population in many states now being mandated, so if you didn't get in now you wouldn't be able to get in. So folks got in, discovered that the Medicaid population was very different, that they weren't equipped to deal with all the issues. And, of course, it didn't take them but a couple years to find out they also weren't making money...

They quickly began exiting the program. At first I was a little concerned about that. But I have really come to be quite comfortable that the plans that are serving Medicaid now, they are really Medicaid-focused, in some cases 100-percent Medicaid, and do an excellent job.

SMITH: So it's a little bit like people that go into pediatrics can't make much money at it so they get people who are interested to serve.

V. SMITH: Right, exactly.

SMITH: I would just like to ask you this question because it brings up aspects of people's philosophy. We are seeing all this talk now about putting a lid on Medicaid and/or disentitling it. Do you think it's important that Medicaid continue as an entitlement or do you think it's not very important?

V. SMITH: Actually, I spent a lot of time thinking about this in '95 and '96 when we were going through the Medicaid reform discussions. My governor was one of the lead governors on that issue. I was privileged to be part of those discussions in a very up close and personal way. I spent a lot of time thinking about what does it mean to have an entitlement when you have health coverage. And, I mean, is Blue Cross an entitlement?

Well, no. But yes, it is, actually. I mean, if you have the coverage then you are entitled to everything that is part of your coverage package. And I have kind of gone back and forth about how important the entitlement is. If you qualify then you are entitled to things.

But the question is if non-entitlement means that there is a five-year limit on eligibility then that's a very different thing. That would be a problem area. I don't know.

SMITH: Well, I struggled with this.

V. SMITH: I think—I do think this. The issue of entitlement has some political-ideological overtones to it. My personal feeling is they are a little bit overblown, that the program is an entitlement. The entitlement is set forth in the statute. And that's a very powerful statement.

If it were not an entitlement I am not sure how different the program would be. Personally, I am more comfortable with it being an entitlement but I am not sure how it would change if it were not.

SMITH: It would be hard to put this egg back together if you scrambled it.

V. SMITH: It would. It would. It definitely would. But, you know, SCHIP is not an entitlement. And yet for all practical purposes there is no distinguishing SCHIP coverage from Medicaid coverage.

SMITH: ...the commerce committee may think differently but—right.

V. SMITH: There is a difference in the rules. You have premiums, you have co-pays, you have limitations on coverage. Coverage is similar in SCHIP as it is in Medicaid. But those kids that have Medicaid, I mean, you can also have...But once you are enrolled there is really no distinction. There is a distinction, obviously, that the state says that X amount of money and we are not getting funded any more than that. And once we reach that amount, then that's it. I don't have a problem personally with an entitlement.

SMITH: It was a comfortable feeling for a long time that it was an entitlement and therefore you had it. But that stopped.

V. SMITH: It is back in the public discussion even as we speak.

MOORE: In the 30 years you spent in the Medicaid program what kind of conclusions have you reached with respect to the federal-state relationship? I used to think that there was some sort of pendulum swing from one emphasis to the other, but as I think back and I reflect and I have talked to so many people, it seems very much related to personalities. Have you given that any thought?

V. SMITH: Well, I think you are actually right. But, you know, I sometimes thought even back when the Medicaid directors' executive committee was meeting with the leadership at HCFA...You were part of that group, Judy, as I was for many years. I do think federal officials and state officials see the program differently.

There is discussion about the federal-state partnership. And I think that's good to say. And from the state's perspective we would love to see it as a partnership. But from the state perspective, Medicaid is a state program. We saw it as fundamentally a state program. All of the important decisions about Medicaid are made by states. And it's been that way from the beginning. Now, of course, there is federal law that sets out parameters for the program.

There is federal law and regulation lays out what you have to do if you are going to participate in the program. But fundamentally what the law and the regulation does is set forth the terms and conditions under which the state can earn federal matching funds.

That's what the law does. And so from the state's perspective what we have is, fundamentally, the role of HCFA and CMS is to determine whether the things a state does, as it spends its Medicaid money, allow it to qualify for federal matching funds.

And from the state perspective, the fundamental state mission is to make sure that the things do fit within the federal requirements. So the state is responding to the incentives, to the boundaries, to the parameters that are set forth in law and regulations. So the state is regulated and CMS/HCFA is a regulator. And, you have this tension that is inherent between the regulator and the regulated.

Most of the tension that has existed in this relationship really comes down to how the federal agency has administered this regulatory role. When the states have felt that there was a direction, an inclination to be supportive of states, states came up with their innovations. The world was always

changing. There is no end to the creativity of states in responding to the rules that are there.

And, you know, you can be sure somewhere out there right now someone is thinking of a new way to interpret something which has been there for years, and now someone has been thinking about doing it differently.

And certainly with all the new opportunities with HIFA waivers and 1115 waivers and so on, new interpretations of how to use the waivers, people are thinking all the time, responding to the situations in their state and seeing an opportunity maybe to go in a new direction. There is a political opportunity opening to go in a certain direction because someone is a champion of a particular direction.

If there is a way to do that and to get federal matching funds for it, someone is thinking of a way right now out there. You can be sure of it. What the states are always doing or trying to do is find a way so what they want to do with their program is interpreted by CMS as being allowed. And, you know, I think that is a partnership, there is no question about it. But even when seeing it at its friendliest, it's been a friendly auditor, it's been a friendly regulator. And that's why it's always good to have, you know, a regulator with a smile.

SMITH: This is your friendly IRS representative calling on to you.

V. SMITH: Right, exactly. I mean, I think the analogy to the IRS is a very good one. In fact, I was thinking of this in a discussion I was having just recently on the issue of the upper payment limits and intergovernmental transfers.

Someone had portrayed this in a way that made it sound like states were ripping off the federal government. I had to say, "Look, the states don't have a chance to rip off the federal government. They really don't. It's impossible for a state to do so."

Just think about the process, about how Medicaid works. First there is the law, and then there is the regulation that is more specific about exactly what you can do. And then within that the state has to submit a state plan to CMS and get that approved.

And then after the state plan is approved the state has to promulgate policy. The state, just as the federal government, has this contract which is called

the state plan, that lays out the terms and conditions under which the state can qualify for federal matching funds.

The state has a contract with providers that lays out the terms and conditions under which a provider can qualify for payment. And so the state then, after it gets approval from the federal government for the state funds, has to promulgate policy.

And then under the terms of that policy it has to make that payment. And it makes that payment out of its own money. There is no federal money when that payment is actually made. The state makes its payment. After the payment is made the state prepares its HCFA 64 form to claim the federal matching funds every quarter.

So then it includes the amount that it spent on this form that it submits to CMS for approval. And that amount is fly-specked. That claim is reviewed by CMS in great detail to make sure that every dime that is claimed is appropriate and meets all the tests. It's an expenditure for an allowable service for an eligible person provided by an eligible provider and it's something that fits within approved state plan.

After all of that is done, then the federal government determines that it can pay its share to the state. And that's the way the program operates. That's the way states get their federal matching funds on the program.

And where in that equation is there an opportunity for the state to somehow rip off the feds using an upper payment limit in a governmental transfer strategy? And the answer is: There's no place. The states are only doing what they are allowed to do within that very defined construct.

And if a state didn't do some of these things that we were just talking about—you can't do what I described earlier with the University of Michigan Hospital, but what they are doing now is the upper payment limit. If a state didn't do that it would be like me saying to you, "I know you are buying this house and you have a mortgage but you shouldn't claim that interest on your mortgage when you file your federal taxes."

I know you are entitled to it, but don't you think it's kind of a ripoff when you claim that interest? Why should the federal government subsidize that interest? Well, for a state, the state is just following the rules. It's exactly the same thing.

SMITH: Thank you so much.

INTERVIEW WITH MARY TIERNEY
JUDY MOORE AND DAVID SMITH – JULY 17, 2003

SMITH: This is Judy Moore and David Smith doing this interview and it is July 17, 2003. And we thought we might start by asking you a little bit about how you came to be a staffer for Congressman Roy and then what happened subsequently.

TIERNEY: Okay. Well, I had for a variety of personal reasons, I was engaged and had decided to take a year off between my first year residency in pediatrics at Children's National Medical Center here. And I was supposed to go to New York and I didn't get under the time line so I just took a year off.

TIERNEY: And so I ended up in Washington, D.C. and looking for a job. And a friend of mine who I had just met said, "Oh, I have a shirttail relative of mine that works for Congressman Roy. His name is Paul Pendergast. I'm going to call Paul and maybe they can set you up with a job."

So my friend, Janice Mendenhall called Paul who said "Have her come on in." So I met with Paul, Dr. Brian Biles and the Congressman, brought in my resume. I told them I needed a job so that I could pay the rent. That's youth for you!

SMITH: That's right, that's right.

TIERNEY: And so I went and had an interview and Brian Biles was just thrilled that he would have another physician there. And so I agree to work until I started my residency with Columbia Presbyterian. And so I worked from about December through end of June and then went up to New York.

MOORE: And that must have been in the late '70s?

TIERNEY: Early '70s.

MOORE: Oh, okay.

TIERNEY: I had done my residency at Children's from 1970 to 1971 and then I worked for Congressman Roy and then I finished my residency in New York from—they're always July to July, as you know. July 1972 to July1974.

SMITH: Right. What did you work on when you were working for Congressman Roy?

TIERNEY: The main thing that I worked on were two pieces. One was the Emergency Medical Services Act, which subsequently passed and was signed by President Nixon in 1972 or 73, I believe. I wouldn't want to pin that down exactly.

SMITH: No, no.

TIERNEY: And then sickle cell anemia. That was a hot issue. I didn't take on some of the big long issues because I wasn't going to be there long enough.

SMITH: So then what brought you back to Washington?

TIERNEY: I just found that I liked Washington, D.C. And so I initially thought I wanted to live in New York. By this time I decided that this engagement wasn't going to work out so I said, oh, I'll come back to Washington. And so I came back and Lee Hyde who was then working for Congressman Waxman, was it, or Rogers? Paul Rogers.

MOORE: Rogers.

SMITH: It would have been Paul Rogers, yes.

TIERNEY: Paul Rogers who I still see once in a great while. He's wonderful. Anyway, Lee Hyde helped me get a job at the Institute of Medicine on a study that was on health manpower issues with Ruth Hanft.

SMITH: That was very hot right then, wasn't it?

TIERNEY: Yes.

SMITH: What were they going to do about it and so forth? The theory [was] that they were going to break the bottleneck here and have doctors all over the place.

TIERNEY: Right, uh-huh. So they have done a superb job of that, haven't we?

SMITH: Did well.

TIERNEY: Yes. So anyway, I then moved on and I worked at the PSRO program. And I was minding my own business when Jay Constantine called me, at the beginning of the Carter administration. You know, it was 9 or 10 months into the Carter administration.

So he said, "A friend of mine, Dick Heim, is going to be the Medicaid director and I'd like to get you in because the EPSDT Program is in trouble."

SMITH: Uh-huh. Now let me back up just one second.

TIERNEY: Yes.

SMITH: Because you were talking about the PSROs and I know that Jay was a great enthusiast of that.

TIERNEY: Yes.

SMITH: But of course he had a conception of it that you were really going to get the doctors into this and they were going to take it seriously.

TIERNEY: Yes.

SMITH: And it was going to be kind of self-government of the doctors.

TIERNEY: Right, right.

SMITH: And what was your take on it at that point?

TIERNEY: Well, knowing physicians I was—

SMITH: Herding cats and so forth.

TIERNEY: —dubious. Yeah, herding cats. I think it was less, you know, the fox guarding the chicken house, which was what some people thought, than it was herding cats. There were two sections—there were several sections to that office as I recall.

Mike Goran was head of it at that point. And I was in sort of the, if you will, with the policy health care professionals and there were two subsections within that. One was the utilization review, I think we call it utilization

management now, and then there was the quality assurance, which is performance improvement now.

So I was in the quality assurance section. We didn't do as much with utilization. Another section, the lady sat right next me headed up the UR section under that.

SMITH: Well, now some of these things, like health planning, you didn't have to think very far to realize that thing was going to be pretty much in trouble from the beginning.

TIERNEY: Right, yeah.

SMITH: Was that the case with PSROs? Many people thought "that's not going to fly" and we've seen this early disastrous history of utilization review at the hospital level and so forth and so on.

TIERNEY: Right.

SMITH: Were you confident about it?

TIERNEY: I think I was young enough to be confident about it although I did know it was herding cats. I do think though in looking back on it that it, we still have these organizations.

SMITH: We still have them.

MOORE: Yes.

TIERNEY: Performance improvement in hospitals, and in physicians' offices, and accreditation, and you have NCQA and JCAHCO and all of that—

SMITH: Right.

TIERNEY: —are all doing this and they are developing performance measures. And I think that piece of it is left.

SMITH: Well, many thought from the beginning the thing that what should have been emphasized was the quality improvement.

TIERNEY: Right. Exactly. And I never thought you know, there's always that margin of stuff that is absolutely unnecessary, whether utilization review is going to save you huge bucks—

SMITH: Right.

TIERNEY: —of that, I'm dubious about that. It's hard to measure anyway.

SMITH: Right.

TIERNEY: And I think the quality component of it still lasts and, I mean, I have a friend who is now heading up the Delmarva Foundation here in the Washington office and she's a crackerjack person. And AIR here does a lot of stuff with the CAHP's project which measures quality in Medicare and Medicaid. I'm not involved with that, but that is measuring quality and member satisfaction and all that. And of course you have NCQA and JCAHCO and everybody becoming accredited. So I think it lives.

SMITH: Now, when Jay hired you to come and do something about the children's program this was EPSDT?

TIERNEY: Right.

SMITH: Right.

TIERNEY: Yeah.

MOORE: I would say Jay didn't hire her, but Dick Heim hired her.

SMITH: Well, Dick hired her, yes.

MOORE: Jay encouraged her.

TIERNEY: Yes.

SMITH: What was kind of the message to you? This thing is in big trouble; you save it? Or—

TIERNEY: Yeah, yeah.

SMITH: I see.

TIERNEY: Yeah, and you know, I was horribly young but I had when I walked in to the Medicaid office and reported to Dick the whole place was rocking and rolling because Joe Califano had fired Bob Derzon and had replaced him with a fellow by the name of Leonard Schaeffer, who—

SMITH: Yeah.

TIERNEY: —nobody knew who he was at that point. And he had a business background.

SMITH: Right.

TIERNEY: So that was about a couple of weeks worth' of doing nothing. And I was hired as a special assistant to Dick and then subsequently moved over to becoming the Director of the Office of Child Health. There was an incident that happened very early on in my tenure as a special assistant. Apparently, Mr. Califano was very unhappy with the way the program was [run].
And he wanted to put a priority. And when Leonard was being introduced, and I know that Leonard knew nothing about this, Mr. Califano—Secretary Califano at that point—got up and went on, a I don't know how I could put this diplomatically.

He got up and made personal attacks on the director, who was Bea Moore, and said they were going to get new leadership and that's what Leonard was going to do. And Bea was sitting in the audience right there. I was sitting somewhat close to her and of course I don't think that Secretary Califano knew who I was from a hole in the ground but I found that very disconcerting.

SMITH: It wasn't a good introduction?

TIERNEY: It was not a good introduction and of course Bea was, you know, understandably upset.

MOORE: Yes.

TIERNEY: Understandably upset, I mean. And I do believe Leonard when he said he knew absolutely nothing about this coming, because he really was a gentleman. And so then I got, if I'm running on too fast, I got appointed Acting Director after Bea decided she would leave.

And Leonard, you know, left her there until such time as they were able to arrange for another job for her and let her leave with dignity is what he said. He said, you know, she needs to leave with dignity.

SMITH: There are various things that have been written about the problems with EPSDT but a lot of them seem to come back to one central theme that they went into this with relatively little thought about how this would be implemented at the local level.

TIERNEY: Uh-huh.

SMITH: And much of the trouble came from that.

TIERNEY: Yes.

SMITH: Yeah, yeah.

TIERNEY: When I took over the reins I think one of the things was that because Bea is a social worker it was more of a social worker model with case management and so on, which is absolutely necessary.

But we needed to get the providers on board. We needed to develop it around, if you will, a health care model as opposed to a social work model with, of course, social work being a very important component of that and the case management and the transportation and getting the...

SMITH: Could you put a little point on that, the difference here between a social work approach and a medical approach?

TIERNEY: Well, if you know, this is going to be coming from my point of view—

SMITH: Of course.

TIERNEY: —as a physician.

SMITH: Right.

TIERNEY: The social work model, at least at that time, I'm not going to speak to all of the social work model. The social work model is much more a case management approach. We have to do the outreach, the case

management, get—you know, let people know about the program, which is very important, do the outreach, do the transportation.

SMITH: Uh-huh.

TIERNEY: Make sure that the infrastructure around the physicians are there and around the health departments are there, and with not much emphasis on: okay, who is actually going to provide the care?

SMITH: Right, right.

TIERNEY: You know, once you have the case management and transportation in place you need to have the providers to actually screen, diagnose and treat the youngsters. So our efforts were to work with the provider community, and to work with the States to implement provider outreach. We also tried to work with the states to understand the importance of provider participation in the EPSDT program. And what was happening at the time and the states were implementing it—well, you know, I always say, when you see one Medicaid state agency you've seen one Medicaid state agency.

SMITH: Right, right.

TIERNEY: At the time it became clear as we started walking through this that what the youngsters really needed was continuity, quality, a physician—as opposed to screening somebody at the health department and then if you find something then they have to traipse over to the physician's office.

And that makes two visits and maybe the physician or the nurse practitioner or somebody could have taken care of that right there on the spot. And then the children need comprehensive, continuous care including emergency services on a 24 hours/7 day a week basis.

SMITH: Right.

TIERNEY: What happens if you get sick? So when we rewrote the regulations and we started rewriting those regs we started talking about continuing care providers so that you would try to—and we worked very hard to work with American Academy of Pediatrics, AMA, other provider organizations and important Federal agencies in what is now the Health Services and Resources Administration (HRSA).

And the other important component was to reach out to the public health people over in what would now be Maternal and Child Health Bureau (MCHB)and HRSA and what is now known as the Federally Qualified Health Centers (FQHC) in the Bureau of Primary Health Care of HRSA, and so on.

So we had a huge child health initiative that Leonard Schaefer pushed us to do, told us to get—basically told us to get into a room and figure it out. It was called the Child Health Strategy. I just wanted to say that Leonard Schaefer was completely supportive of the EPSDT program as a whole and totally supportive of the staff including me. I could not have asked for a better boss and more support than what he gave me.

So the first thing I did was to work with a whole bunch of people in Maternal and Child Health. Ed Martin of course who headed up what would now be HRSA—and I swear I forget what the name of the agency that is now HRSA and of which Ed was the director it had, the community health centers/FQHC's and it had Title V/MCHB; and then worked very closely with the late Vince Hutchins.

SMITH: Now there was one part of this that was certainly getting together with the child health people.

TIERNEY: Yes.

SMITH: Getting together with HRSA—

TIERNEY: Yes.

SMITH: —or the equivalent of HRSA, then dealing with this at the Washington level.

TIERNEY: Uh-huh.

SMITH: The other part was how do you make anything happen at the local level.

TIERNEY: Right, right, exactly. And that was what we had was the penalty. For part of EPSDT which sat in Title IV(a) I believe. And it was sort of the atomic bomb. You know, you could take the state's AFDC funding away if they didn't implement the program.

SMITH: Right.

TIERNEY: Okay.

SMITH: It's an atomic bomb in the sense that Johnson talked about it.

TIERNEY: Yes.

SMITH: The only power I have is the atomic bomb and I can't use it.
TIERNEY: Yes.

SMITH: Yes.

TIERNEY: Yes. So, of course, I don't know that anybody would have taken any money away from AFDC but we developed regulations. And what we tried to do was again to get the continuity, you know, the continuing care which really was in my view was a precursor of what people now call a medical home, you know,

SMITH: That's what I was wondering about.

TIERNEY: It's really the medical home and the American Academy of Pediatrics has been very active in pushing it and you know how important that is. So what we did is we rewrote the regulation to include the "continuing care model", the precursor of the medical home. It also included informing requirements that mandated that all families with Medicaid eligible children be informed of their right to EPSDT services.

Another major change was that you had to use all providers who were willing to provide the full range of services. You couldn't just say, oh, no, the health department is the only entity that can screen your child. And so what we did is we went out and wrote the regulation and then had a bunch of technical assistance [meetings] across the country. I think we did like four regions. And honest to God, I can't remember where they were.

I think that two of them that I remember—one was Columbus, Ohio and another one was in Los Angeles when there was an air inversion and it was the second worst air inversion and the hotel room had no—the air conditioning chose to go off that day.

SMITH: Oh, wonderful.

TIERNEY: It was like 95 degrees in the shade and we were all standing there sweating.

SMITH: Those were the good old days.

MOORE: Was this more technical assistance after the reg was drafted? Or was it consultation before?

TIERNEY: When I came the reg had been basically written. Dick Heim pulled it back because he thought it was a little too punitive.

SMITH: Uh-huh.

TIERNEY: Wanted us to rewrite it, which we did. And then it went out. And we had some state Medicaid agencies as I recall come in to do some consultation on a one-day basis. Okay, that's probably not what I call consultation anymore, you know. But we were also under the gun to get something out.

SMITH: When you say we were under the gun—

TIERNEY: I mean Mr. Califano—Secretary Califano.

SMITH: It was essentially coming from the Secretary's office.

TIERNEY: Yes.

SMITH: Was Congress riding hard on this?

TIERNEY: Jay was concerned that this was—you know, had been pulled back. Jay was much more involved in that than the other side of the Hill, the House side. And I think it was partially due to my being friends with Jay and, you know, he'd call me up, "Mary?"

SMITH: Yeah.

TIERNEY: He took me out to dinner a couple of times and told me what I needed to do.

SMITH: So he sort of mentored you?

TIERNEY: Yeah, he—

SMITH: Along with various other people.

TIERNEY: Yeah, he has been a major mentor of mine in my life. And we have remained friends since then. He doesn't try to tell me as much what to do anymore.

SMITH: No?

TIERNEY: But he still will—

SMITH: But you think of yourself and there is Karen Nelson and—

TIERNEY: Uh-huh.

SMITH: —there is Shelia Burke. These are all—

TIERNEY: Yes, Jim Mongan

SMITH: All these people that Jay mentored—Jim Mongan, an amazing series of people here.

TIERNEY: Yeah, yeah, he really, when he took you under his wing. He helped in any kind of way that he could with me.

SMITH: Did he also scold or did he just help?

TIERNEY: Oh, yes, sometimes he would scold, you know. That was, you know—but, you know, it wasn't like—you know, it wasn't really a terrible thing I guess because we were friends. I took it as just that. And then also he would allow me to argue with him, you know.

And it was fine, you know. And it was fine because I would just tell him, "Well, I'm not finished with my sentence yet."

"Okay, Mary." He's...He would get this grin on his face.

SMITH: Wonderful.

TIERNEY: And other people would go like their eyes would bug out, "You said that to him?"

And I said, "Yeah. Yeah, but we're friends so you could say that to him."

SMITH: How long were you with the EPSDT program?

TIERNEY: I was with it until probably the first six months, eight months of the Reagan Administration. And then I left and I really could not in good conscience, couldn't go along with some of the stuff that was going on in the Reagan Administration. They were going to do away with the Office of Child Health. Somebody from the American Academy [of Pediatrics] met with them and the new Administrator, whose name I have long since forgotten.

MOORE: Carolyn Davis.

TIERNEY: Yes, and she told Academy members when they met with her that they couldn't have an office for every little disease of the month, were her words. And one of the pediatricians came back and said "I didn't realize up until now that childhood was a disease."

SMITH: That's pretty good.

TIERNEY: So that's when I left. One of the things you asked about consultation was that we did, during that time, we also develop a technical advisory group tag, which Vern Smith headed up.

MOORE: Yes.

SMITH: Yes.

MOORE: And he was another person who encouraged us to talk to you.

TIERNEY: Yes.

MOORE: It was the first technical advisory group I think—

TIERNEY: Yes.

MOORE: —that they had.

TIERNEY: It was a child—

MOORE: And it still exists today, as you probably know.

TIERNEY: Yes, yes. And Vern headed that up and we had the lady from North Carolina.

MOORE: Barbara Matula.

TIERNEY: Barbara Matula.

TIERNEY: Nancy Feldman from Minnesota and some other folks whose names I now forget. I think there were some other people. Sorry, folks, I didn't mean to insult you.

MOORE: Mary, when you developed that technical advisory group did it involve MCH in the beginning or was that—

TIERNEY: No, it was just Medicaid.

MOORE: —later? It was just Medicaid folks?

TIERNEY: But MCH very quickly only became sort of a de facto member. Meryl McPherson came in and she was extremely impressed with the quality of the folks that were in there. I mean, you had Vern, Nancy and they are real stars, I mean.

MOORE: Yes

TIERNEY: Wonderful, you know, very knowledgeable. Sara Rosenbaum, of course I can't remember everyone as I am doing my free association of course, we worked with the Children's Defense Fund very closely.

MOORE: That was a question that I was going to ask you about, how you worked with the advocacy organizations and who those organizations were.

TIERNEY: The Children's Defense Fund (CDF), mainly.
We worked with CDF and Sara was the person at that time. She's another person who I've kept in touch with for many, many years. In fact, she's doing a piece of work for me now, you know, here under contract to AIR.

SMITH: I'll happily read anything Sara writes.

TIERNEY: Yes. So, at any rate, so that, you know, Vern and Sarah—I keep in touch with all these folks.

SMITH: Well, now we've seen—

TIERNEY: So we worked with CDF.

SMITH: Yes.

TIERNEY: Worked with them on individual things. Sara was wonderful because she really understands Medicaid. And she's reasonable and rational, comes in, you know, looks for the compromise, able to—

SMITH: Right, right.

TIERNEY: —very smooth to be able to do that. Just wonderful. And she and Vern, she came a couple of times to a couple of the technical advisory groups. One of the people that really encouraged us to do the technical advisory group was Larry Bartlett who was with the governors' association. So we can't forget Larry.

SMITH: Well, we've seen what an enormous success EPSDT became but did you see that it was going to grow into the giant that—

TIERNEY: No. I mean, I was just sort of hoping it could, you know, sort of survive after a while. And I think it still varies with the individual states as to how it is implemented and what it's doing. I think for primary care they've gotten quite a ways—

SMITH: Yes, there are all sorts of places where they provide the wraparound and then—

TIERNEY: Yeah, they do a lot of—

SMITH: —many programs wouldn't exist without it.

TIERNEY: —the wraparound.

SMITH: And so forth.

TIERNEY: Right, yes.

SMITH: Yeah.

TIERNEY: Yeah.

SMITH: It's amazingly important at the local level

TIERNEY: —amazingly important.

SMITH: But it wasn't that way then.

TIERNEY: No, it wasn't.

SMITH: And you were sort of struggling to get a toehold and keep it.

TIERNEY: Yes. And I think we probably succeeded in doing that.

MOORE: Now, where did you go when you left HCFA?

TIERNEY: I did a couple of things. I did some consulting for the Children's Defense Fund, the American Academy of Pediatrics—and a couple of other small pieces of work.

Then I ended up in Baltimore, subsequently became the Assistant Medical Director for the health plan which was at that time Chesapeake Health Plan. It is now—it was bought out by United Health Care?

SMITH: That's the one.

TIERNEY: It's still up there.

SMITH: Yeah.

TIERNEY: Up in Baltimore but we got a Robert Wood Johnson grant to serve people on AFDC up in Baltimore by that time. And we had an 1115 waiver because at that time which would have been 1983 or 1984 or somewhere around there, by that time, that was quite the eyebrow-raiser.

You know, could folks out of AFDC get into what is now managed care? And we did a lot of EPSDT then.

MOORE: Yes, I was wondering if you had ever gotten back into either government or EPSDT child health per se and if you worked more broadly?

TIERNEY: Both. Let me say that. I worked in the D.C. government twice. I've never been back into government since then. Back in the early 1990s, I was with the D.C. government with Forest Haven—folks with mental retardation.

It was one of those old-fashioned places that housed folks with mental retardation. And they went to a much more community-based model and I was also the Medical Director for the kids that were detained and committed to the District government.

That was one time and then in the late '90s, early 2000 I worked in D.C. General as Chair of Pediatrics. We did a lot on EPSDT at D.C. General. And of course, with Chesapeake Health Plan, and I'm jumping back in time, the State of Maryland had a very active EPSDT program. So I served on some consultation with the state through—as Medical Director we developed with the PRO at that time, which was DelMarva, some indicators for EPSDT.

SMITH: Right.

TIERNEY: And then in addition, we had both adults and kids enrolled in the health plan. But when we developed these indicators for the State of Maryland, when there were no indicators of quality for kids. We were again emphasizing Medicare and the elderly.

And so there were a number of us who were Medical Directors, and the system medical directors, as I was at that time, who would sit around the table with Delmarva, "What about the kids?" You know, waving our arms, "We've got to do something for the kids. You know, let's get some indicators for the kids." And then I had to make sure that our provider group was doing the EPSDT examinations, as required.

So I worked with EPSDT of course, and I worked with Medicaid much more broadly on that 1115 waiver, and so on. And then the other part where I really did a lot of work with Medicaid was with Health Services for Children with Special Needs which was an 1115 waiver here in the City for kids on SSI.

SMITH: Yes.

TIERNEY: And one of the things that we pushed and pushed and pushed was EPSDT and getting the kids into a medical home. Every child, and the parents, or the adolescents, had to choose a primary care physician and they were to get their preventive health services as well as their treatment services.

And, you know, we had pretty good success because by that time the primary care physicians were very well aware of EPSDT. And if you don't

mind, I would love to tell you a good story about EPSDT. We had a kid enrolled in our plan.

SMITH: We'd love to have it.

TIERNEY: One of our care managers was called about a two-year-old—well, almost three—who was in and had been labeled as being mentally retarded and was in an early intervention program. And he ended up in foster care because of a whole variety issues including medical neglect. And we get this call from one of the early intervention programs in the District of Columbia saying, you have to get this two-year- old straightened out because he is oppositional and defiant. Now, you have to get him on some medication because he won't listen and he won't do what he's told. I thought, well, now, what is a two-year old besides oppositional and defiant?

Any parent would know that. You don't need to be a pediatrician to know that. So the aunt, I guess or the grandmother—I never knew quite who—said, "Oh, this is just nonsense. You're not putting my two-year-old on this medication."

So he went to Children's Hospital here in town where they did a complete EPSDT exam on him. And the reason that he wasn't listening was because he had a 95-percent hearing loss. And of course he did not have speech because he could not hear, so then he was labeled as mentally retarded and oppositional/defiant. He would have continued to be so had it not been for that EPSDT exam.

And not only is this child not mentally retarded, but he's extremely intelligent. And we got him into Gallaudet and he's going through their program. I didn't know that Gallaudet had pre-schools all the way through university levels.

SMITH: I didn't know that either.

TIERNEY: It surprised me. Wow, I learned something. But he's doing extremely well.

MOORE: Great, that's a great story.

TIERNEY: Yeah.

SMITH: That is a very good—

MOORE: I'm sure there are stories like that everywhere.

SMITH: It's a quintessential story for EPSDT.

TIERNEY: Yes.

SMITH: That's exactly what you want to see.

TIERNEY: Yes, exactly. So, you know, this is a youngster who there is no reason why he can't go through college and if he wants graduate school. There's absolutely no reason. And here he was being labeled as mentally retarded.

SMITH: Yes. Now, you worked on a waiver, a managed care waiver for quite a period of time.

TIERNEY: Yes.

SMITH: Did you?

TIERNEY: Yes. That was—yeah.

SMITH: Did you take away any kind of reflections or wisdom or second thoughts from that?

TIERNEY: I thought it was a great program and it's still a program that's now—it's no longer under an 1115 waiver. It's part of the District's program.

SMITH: Was this a not-for-profit?

TIERNEY: Not for profit. It was a spinoff of—it was a spinoff of the Hospital for Sick Children(HSC), a sister company and then a spinoff really out of the foundation, the HSC foundation. And that's sort of a cute story.

I was at the District government at the time and Georges Benjamin, who had been the previous health department director, Commissioner of Public Health at that time, had said, "Oh, I gave your name to this guy by the name of David Corro," who was looking for somebody as a medical director for this project.

And so I paid absolutely no attention to it. But David called me and then he told me this story that they had—the Hospital for Sick Children —is a hospital for children with long-term illnesses, and so on and so forth.

He had the NACHRI, National Association of Children's Hospitals and Related Institutions, had their national convention in D.C. that year which would have been 1994, I think. And they had a pre-meeting, with all the folks who had the longer term hospitals, over at the Hospital for Sick Children.

And David had two people get up and talk—what he thought would be a filler. One was a mother with a child who had cerebral palsy, I believe, and then a young man who had had an automobile accident and had been healthy until that. And the idea was for them to talk about the Hospital for Sick Children.

Well, David said, they spent about two New York seconds talking about the Hospital for Sick Children. And he said, "Oh, yeah, everything was fine when we were in the hospital. You should have heard what happened to me after I got out."

SMITH: Uh-huh.

TIERNEY: This is wrong, and that's wrong, and that's wrong. The young man complained that he was treated as if he was mentally retarded because he was physically disabled. Providers shouted at him because they assumed he was deaf and other not so wonderful behavior on the provider's part. So David got up and said, "Well, I'm sure other states have solved this problem. How many of you have these problems solved?" And he said the silence was deafening and he said, "you could have heard a roach crawl across the rug."

So Dr. Roselyn Epps, who was on the board of directors said, "Well, what are we going to do about this? We need to do something about this." So that was the inception of that. So David called me and then I took the job.

SMITH: Great, great. And that again is kind of a classic illustration of your using managed care here for access and to extend care.

TIERNEY: Uh-huh.

SMITH: And not thinking of it as a cost-cutting device.

TIERNEY: Right.

SMITH: Right.
TIERNEY: And, you know, it's interesting because over time we managed to cut costs by shifting services from institutions to community-based services. So, you know, and one of the reasons we had to have a separate organization from the Hospital for Sick Children, of course, we were going to be shifting patients out of the Hospital for Sick Children.

SMITH: Uh-huh.

TIERNEY: So we had to have separate board of directors and all that. And we had the whole ball of wax. It was not a carve-out so we had everybody from cerebral palsy, to kids with genetic health problems, to kids with serious emotional disorders.

We developed a whole series of wraparound services, through using EPSDT, and trying to get the kids into care, but also through the waiver. So we were able to do some really interesting things like the horse farm.

SMITH: The horse farm?

TIERNEY: Yes, the horse farm. One of our psychologists on contract to HSCSN called up and he said to me, "I've got access to therapeutic riding for kids with serious emotional disorders."

And he says, "I'd like to put it in the program, if you would." And he said, "I think we can help some youngsters." And he says, "We would have social workers and psychologists and psychology students. I would be overseeing it out there."

This was somewhere in Prince George's County. We can pick up the kids. It's an after school program—pick the kids up and we'll keep them busy. We'll do the therapy. They can work with the horses. They can ride the horses. And it was a tremendous success.

SMITH: Yeah?

TIERNEY: We were able to keep kids out of residential treatment. The last time I talked to Howard, that's Howard Maybry—about a year and a half ago. But we had only lost one child to residential treatment. And these were the highest-risk kids that we had.
SMITH: Fascinating.

TIERNEY: Yeah, that's fascinating and—

SMITH: But some people would sneer at that.

TIERNEY: Yes.

SMITH: Horse riding as therapy.

TIERNEY: Yeah.

MOORE: Medicaid paying for horse riding.

SMITH: There you are.

TIERNEY: Okay, what I said was—you are doing the therapy on the spot. We didn't just have kids running off riding horses. Each child was paired up with a mentor who was around their age who would be in college, a psychology student, probably post-graduate, you know, working on their Ph.D. or something like that.

We had mentors. We had people all the way to guys that were involved with Concerned Black Men and all of that who mentored these youngsters. And they did extremely well and therapeutic riding now is recognized by the psychology profession.

SMITH: Well, one of the things that fascinates me about this is your experience. It doesn't start with kind of a model of service delivery. It starts with some goals.

TIERNEY: Yes.

SMITH: And it starts with some local initiatives.

TIERNEY: Right.

SMITH: It starts with some kind of flexible tools.

TIERNEY: Right.

SMITH: And one of the things that people are looking for is how you make this kind of thing happen at a local level, what should be the responsibility of the feds, of the state governments and so forth.

TIERNEY: Yes.

SMITH: I think partly the answer is you've got to kind of have faith that when it's needed, it will happen if you give people the right tools—

TIERNEY: Right.

SMITH: —and let them do it.

TIERNEY: Exactly.

SMITH: But this didn't have an elaborate service delivery model.

TIERNEY: Well, we had—

SMITH: This was local initiative and—

TIERNEY: Yes, we got all the usual providers.

SMITH: Yeah, yeah.

TIERNEY: We had all the hospitals except Sibley. We got a list of all the providers that were billing Medicaid and did outreach to them. We had a very experienced person in provider affairs. My having been in the city and having been involved with a whole bunch of stuff, I knew a whole lot of the providers on a first-name basis.

SMITH: A lot of this was—were you drumming on the medical school and the hospital or what?

TIERNEY: Uh-huh, yeah. I mean, Children's was in there, Georgetown, Howard. And I'm friends with a lot of these folks so we were able to recruit the wraparound providers. I was asked, "Why would you ask the medical director to go build a wraparound program?" It was because Mary knew everybody. So that's how I go to Howard Maybry. I outreached to a very dear friend of mine who unfortunately passed away a couple of years ago, Brenda Strong Nixon, who ran Associates for Renewal in Education. I knew her from when I worked with the kids that were detained and committed.

And she had everything from group homes for kids coming out of the juvenile justice system to day treatment to day care to everything. Sat

down with her and she was head of the consortium on youth services here in the city. Interesting woman. Lots of clout.

And she said to me, "Come on over and talk to our consortium. We've got about 20 people including psychologists. We need the health component." Sat down, they had schools, school advocacy, a lady we worked with hooked in...lady by the name of Nancy Oplack . . . Brenda, Howard Maybry, all these people.

And we just built this network of wraparound through them and through Brenda Nixon. And Brenda said, "Well, I don't have a program for kids with special needs but I'm going to build one." And she just went out and did it.

SMITH: Well, that's a very interesting story.

TIERNEY: Yeah, yeah, it's an interesting—it was a very interesting program. But it was like the horse farm thing. It was funny because when Howard called me and—well, you know horses and dah-dah-dah-dah, trying to justify the therapeutic riding to me.

And I said, "Well, I'm an equestrian, so you don't have to tell me." I own a horse. I jump horses. I do all this stuff. I play with horses all weekend, you know. So it was really a huge success.

SMITH: You're a pediatrician? Are you not?

TIERNEY: Yes.

SMITH: And Dr. Roy was a pediatrician?

TIERNEY: No, OB/GYN.

SMITH: Oh, was he? Okay, I was beginning to wonder sometimes why there seems to be such a disproportionate percentage of pediatricians in fields like Medicaid and enterprises of this sort.

TIERNEY: I think because we started out being trained to look at the whole child and the family, and you have to look at children in the context of their families, and in context of their community. If you go on the American Academy of Pediatrics (AAP) web site there's a whole section if you go under there on community pediatrics.

I'm not going to quote it correctly, under the community pediatrics section. And what it says is that a child's health and welfare are directly dependent upon, either for good or for bad, the public policy surrounding children and that pediatricians as their responsibility must address those issues in one way or another. You cannot do just one-on-one pediatrics.

TIERNEY: So that's why I've always been interested in that and a lot of my colleagues are. All over the city there's people, and all over the country.

SMITH: Have you been over to Russia, to see what your efforts are producing over there?

TIERNEY: I haven't been back. I was there about a year and a half-ago last fall. And interestingly, one of the people that sort of heads up the effort is a pediatrician also, who is my counterpart. And it's all a bunch of pediatricians.

SMITH: Well, in that case, it is the orphaned—

TIERNEY: Yes, yes.

SMITH: —children in a nutshell.

TIERNEY: Yes, and that's—

SMITH: But you're training other professionals—

TIERNEY: They are also very—

SMITH: Yes, yes.

TIERNEY: Yes, so they are and I'm hoping to get back there soon. We're supposed to train them and do a few days' seminar and at least get them going on adolescent medicine because according to the physicians over there, they are really unfamiliar with adolescents and how to address their health care needs. That's a population that has not been addressed—

SMITH: Yeah, I try to—

TIERNEY: —at all.

SMITH: I try to tell people that it's like Doctors Without Borders but it is focused.

TIERNEY: Yeah, yeah.

SMITH: You know what you're getting for your money.

TIERNEY: Yeah, we're supposed to go over there at some point. And I'm hoping to recruit Renee Jenkins over at Howard to do that and she's been interested. She's really busy right now. We're finding an adolescent medicine physician to go with me to do some of the training.

SMITH: Are things still—are they improving as far as the environment, stability in Russia? I mean there were certain points where you thought maybe the Mafia would take over the whole country.

TIERNEY: Yeah. You know, I don't know.

MOORE: Jay is just back this week.

TIERNEY: Yes.

MOORE: I guess he's the right person to ask...

SMITH: He says they've never lost a shipment.

TIERNEY: No. Well, we are very careful with that.

SMITH: I would think you would be.

TIERNEY: Yes, we haul it in the belly of the plane and carry it over and then it has to go through whatever customs and then the physician comes and meets whoever is coming in at the gate.

And then she oversees it and talks to whoever it is, customs and all of that.

SMITH: Maybe you could help explain to them how they could make EPSDT work in Russia.

TIERNEY: There you go. I sent them over a bunch of information on EPSDT and they—the physicians—are really great and enthusiastic. I sent them over some of the Bright Futures publications, which contain

information on health education and anticipatory guidance for children and adolescents, from birth to 21 years, and their families.

SMITH: That's great, that's wonderful. Well, that's a positive upbeat note on which to end.

TIERNEY: Yes.

SMITH: Thank you so much.

TIERNEY: Thank you.

SMITH: It's been a real pleasure.

MOORE: Thank you.

INTERVIEW WITH BRUCE VLADECK
JUDY MOORE AND DAVID SMITH – JULY 7, 2003

SMITH: This is an interview of Bruce Vladeck by Judy Moore and David Smith and it is July 7th, 2003. First, I would like to focus a little bit on your background, particularly as it relates to Medicaid, which is our topic of concern.

VLADECK: Since none of my formal education has anything to do with any of this stuff, the best place to start is in 1974. Through an odd series of coincidences, I found myself as an assistant professor of public health at Columbia, responsible for teaching health policy, and so forth. And then beginning in about 1976, I began doing research on nursing homes.

SMITH: Why did you take that up?

VLADECK: Well, I'll try to condense the long, complex story.

SMITH: All right.

VLADECK: So I get to Columbia and I have no background in health care. But one of the things they tell me during my orientation is that school policy on attendance at professional conferences is they will pay you half your expenses for one professional conference a year unless you are giving a paper, in which case they will pay your full expenses.

At the time, my principal professional affiliation was with the American Political Science Association. And the 1975 meeting of the American Political Science Association was scheduled to be held in San Francisco. So I really wanted to go, with all my expenses paid.

So I said, "Gee, I have to find a way to give a paper." And I got that book, you know, an issue of P.S. with all the panels and everything, and there was one that actually was relevant to work I had done before I got to Columbia on white collar productivity in the public sector.

And I wrote—I picked up an abstract and I sent it off to the panel chairman, who wrote me back a very nice letter saying it sounded very interesting, but that he had filled the panel. And so now I was desperate. So I went back to the book and there was an affiliated group called the Committee on Health Politics, and they were doing a panel on regulation and health care. So I

had done some work in grad school actually on public utilities regulation, so I figured what the hell. And so I made up an abstract. I figured I had eight months to write it. And I sent it in and it was accepted.
So I spent the next eight months learning to write about hospital regulation—to get it on paper. And it was an incredible panel. It shows how the field sort of evolved, and so forth. But my fellow panelists, who I met for the first time at the conference, were Ted Marmor, Judy Feder, and Walter McClure.

It was really interesting. Anyway, but then comes the Medicaid connection. In the '72 amendments, Senator Moss, who was a great Senator, got into the law a requirement that states be required in Medicaid to reimburse nursing homes on a reasonable cost-related basis.

Nobody knew what that meant. Everybody knew what reasonable cost principles were by then but nobody knew what "cost-related" meant. And HHS—this is still HHS SRS—sort of closed their eyes and hoped that the problem would go away and didn't do anything about it for two years.
And Moss got really mad at them and in '74, I think, in some committee report, sort of reminded them that this was the law and they had to do something about it and put an effective date like July 1, '76, I think.

So they had to figure out what to do. So what they did was they let a contract with a consulting company, another "Beltway bandit," which had a sort of four-part project, one of which was to do a compilation of what all the states were doing, the second of which was to hold a conference.
And so they put together this conference and they decided that one of the papers should be applying public utility models to nursing home regulation. So this is in the days before Google and all that stuff. How they found the paper I had given I don't know.

But they did. And so they called me up and asked me if I would give a paper at this conference. And they offered me $1,500 which is—this is like in 1976, you know, for a young professor, that was unbelievable. So I said sure. And I did it. And in the course of doing the research on the paper I found there was no literature on nursing homes at all. And in fact I had the experience of making up a number, which in the paper I hedged and put in very carefully.

But the idea was to apportion nursing home expenditures that were labor-related—and everybody used at the time—60 percent of hospital expenses

were labor-related. And I was sort of thinking about the difference between nursing homes and hospitals and said it's got to be at least 60 percent. Because they are less technologically intensive, and dah, dah, dah. And of course I then later found that number quoted in Congressional testimony.

But anyway, so anyway I did this thing...and I was really a little frustrated by the fact that there wasn't any literature on nursing homes. But I also—you know, there I was, sort of an assistant professor and I had written some stuff and I'm going to do some stuff on health policy, but it was definitely time to write a book.

So I figured since there were no books about nursing homes that would be a good place to write one. So I put together a proposal and sent it off to the Robert Wood Johnson Foundation, which called me up and said, "We don't do books."

And so I sent it to the 20th Century Fund, which did do books, although they were an enormous pain in the ass. And there were several months of back and forth and they finally agreed to fund it. And two weeks after I got the letter from 20th Century Fund, Tom Moloney [of RWJF] called me and said, "We have reconsidered. We think this is a good project. We would like to fund it."

And I told him to stick it, which had never happened to a member of the staff of the Robert Wood Johnson Foundation before and I think subsequently led to me being hired by them. But in any event, I undertook...solely as an academic to try to learn about Medicaid and understand Medicaid and all that kind of stuff.

And then—I would guess even having done a fair amount of, you know, homework and a relatively conscientious job the Stevens's book was still...

MOORE: It's still right up there.

VLADECK: Yeah. The other thing in the course of doing research on the book that was interesting...Medicaid actually came up last week, talk about wild digressions. But I'm on the phone with Andy Hyman. Do you know Andy? I told him about the invention of the ICF/MR because I was working on the book, and one of the neat things about that research was I got to go out to Ann Arbor to interview Wilbur Cohen, who was then a professor or dean of the School of Education where I first met Wilbur.

But in any event, so at the end of a wonderful hour or so I said, "Who else should I talk to, you know?"

He said, "Have you talked to Lloyd Rader?"

SMITH: Oh, yes. From Oklahoma.

VLADECK: "No, who is Lloyd Rader?"
And he said, "If you want to understand Medicaid in the United States you have to go talk to Lloyd Rader." So in classic Lloyd Rader fashion, I arranged to go to Oklahoma City to interview Lloyd Rader and they scheduled me for three days' worth of interviews and meetings and visits and so forth. And I never met the man.

MOORE: Really?

VLADECK: He contrived to be out of town when I was there. But I met all his staff and—they kept me running, you know, for like two and a half days. I didn't do anything else, really.
But in any event, so I shipped off a revised version of what became Unloving Care at the very end of '78, early '79. And then in January '79 I started as assistant commissioner of health in New Jersey. And my part of the health department was responsible for hospital rate-setting and for nursing home rate-setting.

And hospital rate-setting was part of our move to the all-payer system for hospitals. So there wasn't very much on Medicaid hospital rate-setting. The Medicaid rate-setting tasks were actually performed by us under contract with the state department of human services, which was the single state agency which contracted with the health department to do rate-setting.

And the nursing home reimbursement system had a really neat way of dealing with real estate costs, which are always a major headache in nursing home reimbursement, which was based on an interesting imputed rental payment formula that took all of the incentives out of transactions of any sort. And it was a good system. It didn't take a lot of care and feeding on my part so I didn’t pay a lot of attention...

And then I had two experiences, neither very earth-shattering, relative to Medicaid. They were absolutely classic prototypical Medicaid experiences. The first was the—my boss in New Jersey was the deputy commissioner,...Dave Wagner. He was a wonderful guy, a great guy.

And his jurisdiction included my stuff, which was health planning and resource development and then the licensure and certification. And the deputy commissioner of human services, who really ran all the Medicaid and related stuff, was a man named Jerry Riley who later went out to Washington state, ran the nursing home association out there. A very, very good guy.
And David and Jerry had sort of grown up together in Philadelphia city government and were very close friends and they worked very well together. But we had a classic problem chronically during the three years I was there—the feds kept coming in to do surveys of the state institutions and finding them seriously deficient and threatening to pull their Medicaid certification.

And since Wagner was responsible for the certification under federal scrutiny but Riley needed the revenue to keep the places alive, they were always—well, they were trying to do the best they could but it was always—a sort of hairy adventure. The other classic Medicaid story was we became increasingly concerned once we went to DRG-based payment. In the '80s, hospitals were bitching and moaning, and complaining all the time about losing money, about alternate care patients, patients who were—no longer needed acute care and were ready for...discharge and couldn't get nursing home beds.

And they blamed it all on health planning...that there were all these paper beds in the system that were clogging up the process. And I said, "Well, the problem isn't too many paper beds. We just need more paper patients." And they didn't like that.

But I came up with this scheme to—I don't know what the scheme was, but to create some kind of financial incentives to move patients from the hospitals to the nursing homes in an accelerated way. And I figured out a way where it actually saved the federal government money because—I think people were going to just pay the hospitals an additional rate to keep them there, or something.

But with the 50-percent Medicaid share the incremental Medicare costs would be less and therefore they would save money there. And I went down to Washington, Baltimore, to peddle this to my headquarter project officers, including a certain Mr. Pelovitz, who was my project officer.
And I went through this whole sort of song and dance—I didn't have much hope that this was going to go anywhere, but he said, "You have to remember—first you have to remember one of the basic principles."

I said, "What's that?"

He said, "One Medicare beneficiary is worth three Medicaid recipients." And so I said “oh.”

MOORE: Uh-huh. And next you encountered Medicaid at I.O.M.

VLADECK: Next I encountered Medicaid. Yeah, we didn't really deal with the reimbursement payment stuff, yeah.

SMITH: How did they pick up on you? I mean, I know that people read your book and it seems to have been influential. And then—

VLADECK: The IOM?

SMITH: Yeah, the IOM.

VLADECK: Yeah, I think it was through the book—and related stuff.

SMITH: There weren't really good books out there on nursing homes.

VLADECK: It's still the best book ever written on nursing homes.

SMITH: Well, we would both agree with that. There isn't even close competition...

VLADECK: Right. That's like saying that Armando Reyes is the Mets' representative on the all-star team. And then...adds a lot of validity to it.

SMITH: Yeah.

VLADECK: So the...committee, you know, it's interesting. We talked about the federal regulatory authority emanating from the Medicare and Medicaid role and that was about it. We didn't even talk very much, you know, about federal-state relations in the regulatory process, which is a big hole in that report, I think.

MOORE: Uh-huh.

VLADECK: And is a continuing, as you know, problem in the whole issue. I guess I didn't really spend a lot of time on Medicaid issues again until I was back in New York. I was a spectator, but a front-row spectator, to the

sleight-of-hand maneuvers performed by the New York state policy makers in the mid-'80s to Medicaid-ize all of AIDS services with major, major help from the Social Security Administration, which decided the diagnosis of AIDS was prima facia evidence of disability.

SMITH: But that's AIDS, right? Not HIV?

VLADECK: No. And they still have not done that with HIV-positive stuff. But in those days we were talking about diagnosed AIDS. And the state built a very comprehensive service system, a little behind the curve, but all Medicaid financed.

And we were involved—in the United Hospital Fund we were involved particularly in the planning and development of the first special-purpose AIDS nursing home and the first special-purpose AIDS hospice program, the first special-purpose AIDS medical day care program. And there were..., you know. We didn't spend a lot of time on financial feasibility.

And then I went on the board of the Health and Hospitals Corporation sometime in the mid-'80s. And of course Medicaid is essentially the revenue source for the Health and Hospitals Corporation. Then I was fired from the board of Health and Hospitals by Koch and I was reappointed by Dinkins. And it was during the Dinkins Administration that we did the first financing of HHC on its own credit, not on the city general revenue financing. And the way in which that was done was development of a mechanism that I was sure—I still am—was a direct violation of the—the fraud and abuse amendments.

But they had people sign off on it. There is actually a separate trustee created under the terms of the bond issue that has first claim on all Medicaid funds payable to HHC. And it pays off the bond holders and then remits the rest of the money to HHC or maintains the reserve funds in the trust. And I think that's—I still think that is inconsistent with the antifactoring provisions of fraud and abuse amendments—but somehow they got a waiver from HCFA and the OIG and that mechanism has since been used by other institutions in New York City, and probably elsewhere as well, including Mount Sinai-NYU Health. So maybe they changed the law. That I don't know about.

But—so we were looking at Medicaid from a variety of reimbursement points of view all the time in those days and I was paying somewhat closer attention. And then one other—where I got that, the one other Medicaid

thing that pops to mind, and I am sure I'm missing things, but—is when the White House counsel was reviewing my financial disclosure, and at the time I didn't have any money but I had—our total liquid assets were something like $80,000, $100,000 in one of these cash management accounts which was flipped between a money market and four mutual funds...

And one of the mutual funds was a tax-exempt bond fund which had maybe $15,000, $12,000 in it—something like that. And the guy at the White House Council's office told me I would have to divest my holdings. And I said, "Why?"

And he said, "Well, the fund invests mostly in state obligations, right?"

And I said, "Yeah."

And he said, "You know, both general obligations and, you know, special purpose obligations like school bonds and sewage bonds and all that kind of stuff."

And I said, "Yes."

And he said, "You are going to be in charge of the Medicaid program."

And I said, "Yes."

And he said, "You know, decisions about the Medicaid program have a major effect on state finance..."

And I said, "Yes."

"And therefore on the creditworthiness of state issuances."

And I said, "Don't you guys have a de minimis rule somewhere in all this? It's $12,000. It's spread over like 30 issuing entities, you know. My financial stake in any one can't be more than about $100."

And he said, "No, no, no." So I had to sell all those funds anyway when we bought a house. But it was unbelievable.

SMITH: What brought you to Washington? How did you get to Washington?

VLADECK: I flew.

SMITH: I figured. I take rail, generally.

VLADECK: I wanted to work with Judy Moore.

SMITH: Well, that's a good reason.

VLADECK: And that was the best opportunity. Somebody else asked me that. I'm trying to think who. I have a new sort of—it's not quite a one-liner, but a new shtick about how I got to be administrator.

What I told the person—trying to remember who it was—was that during the '92 campaign there were probably 25 or 30 of us sort of health policy-nics around the country who were identifiable Democrats and most of whom had some connection with a group that Bruce Fried chaired in—in Washington..

And which I was invited to be a member and accepted and then never went to any of the meetings. But that was, excluding the Congressional staff who felt compromised participating in that, and then...by Clinton anyway, that was sort of the Democratic health policy crowd pretty much. It was a group of people who knew one another, and so on and so forth. And my new one-liner is: After the election, all the rest of them went off to do health reform.

And that left me to take care of HCFA. So that's one way of looking at it.

SMITH: But when you get to '95 and Medicaid is very much on the line—it doesn't take very long for some of you people to come back together and start working.

VLADECK: No, we were together all the time.

SMITH: Did you continue to be involved? Were you involved during health care reform?

VLADECK: Oh, yeah. And, you know, the amazing thing is everybody else in '93, when everybody else was busy doing health care reform, I was doing Medicaid. I probably spent—oh, I certainly spent more time on Medicaid issues the first year or so I was at HCFA than on anything else.

And the only thing else would be someone out doing health reform and Medicare stuff, some general agency stuff. And—but the time eaters were Medicaid.

SMITH: When you first went there, you're working heavily on Medicaid. Why—was there a particular reason for that?

VLADECK: Yeah, well the Governors had a big backlog agenda that they laid on... And as I like to remind people before the first—I think before the first formal meeting post-inauguration of the health reform task force, the President met with the National Governors' Association.

And the agenda was Medicaid and a number of longstanding policy priorities, Medicaid policy priorities of NGA, most of which Clinton had been involved in as a member of the NGA and as a former chairman of the health committee, and so forth.

So before I got there to Washington in April, there was already a list of stuff that the President promised the Governors. It had been sort of general policy terms. And then there were a whole bunch of specific issues. There's one—the first actual issue I had to deal with, which was before I was appointed although I was sort of consulted and eventually got stuck in the final stages of it.

I wasn't a decision-maker. I couldn't be a decision-maker, I hadn't even been nominated. But I had dinner with the HCFA transition team in Washington in late February or early March. And the issue before them that they were asking what to do about was a $400 million claim on New Jersey that resulted from overpayments to hospitals under their Medicaid waiver—which put Brenda Bacon, who was chair of the transition committee, in a very awkward position.

And so who else was in that group? I don't even remember. They asked me what I thought they should do and I said they obviously can't go get it back but, you know, put them on a 20-year repayment schedule.
But they rolled on the Medicaid piece of that on direct instructions from the White House right at the—you know, early, early. And then I got stuck with the Medicare piece which we eventually forgave all of as well.

MOORE: Specifically, that first year you had lots of time on Medicaid.

VLADECK: Well, the first thing that we had was to rewrite the tax and donation rules. That was the first big plan. I got started on that when I was still a consultant. And we published revisions to those regs like incredibly fast. By June, I think, which, as you know, is incredibly fast.

And then we immediately went from there to negotiating new policies on 1115 waivers, which also produced a Federal Register notice that summer.

SMITH: What were you doing particularly with 1115 waivers?

VLADECK: We were simplifying the process. We were encouraging big statewide programs. We were publishing Federal Register—no, the public notice came later. We were letting states use other states' waivers for applications as templates—which is directly contrary to the spirit of the statute. Also, the welfare reform folks worked with us on that because we had a whole bunch of welfare reform waivers under 1115 as well. That also moved real fast. And then Tenncare wasn't the first. The first was still hanging around when I got there. It was Oregon, which was left over from the first Bush Administration. And that was basically done by the time I actually got there. But I was in some of the latter discussions.

SMITH: But so then Tenncare wouldn't be the next.

VLADECK: Was Tenncare the next? I'm trying to think the order in which the states came in.

SMITH: I thought Oregon came in, too.

VLADECK: Hawaii was in early. Oregon was definitely first. Hawaii was in early....was relatively early. Trying to think if I'm missing... I guess not. I guess it was Tenncare.

SMITH: And these are big statewide waivers. Was there any particular problem with big statewide waivers? Were you happy with that?

VLADECK: First of all, it was clearly, you know, a Presidential agenda. The second thing was that—it wasn't day one, but at some point relatively early we figured out that all the states were going to take all the Medicaid benes they could and dump them into managed care and that it was better if they would use the savings gained thereby to expand coverage rather than just pocketing them—because they clearly had the legal opportunity just to pocket the savings. And some of the original proposals...Hawaii really came

very close to universal coverage with their proposal. Rhode Island's, I think to this day, is an excellent program.

And as—you know, it's very difficult disentangling all the pieces of TennCare, including how difficult it was to deal with those people. But I think in the big picture TennCare has been really a good thing. I think a whole lot of people got covered who otherwise wouldn't have, reasonably well, without doing much damage, if any, to the existing beneficiary base. I give those folks a lot of credit. I mean, a lot of it was smoke and mirrors. A lot of it was under-the-table deals of one kind or another or sheer intimidation. But it held together for six or seven years, which in this day and age is good. Massachusetts did some good things but I think they would have done them anyway.

MOORE: Minnesota. Well, all the usual suspects...

VLADECK: Yeah, all the usual suspects. Minnesota, yeah.

SMITH: Incidentally, what was to be the role of Medicaid under health care reform?

VLADECK: It was going to go away.

SMITH: Yeah. So then you pick up on Medicaid after that, I guess, when you have the House revolution and Gingrich comes in and we have—

VLADECK: I never got away. I mean, you have to realize the other thing that is going on at this time. You probably need to get some additional perspective.

But sometime in 1993, or maybe it was really after the demise of the health reform, the leadership of the Public Health Service and many of its component agencies figured out that with the demise of health reform they had nothing to do and that all the health policy action was taking place in the Medicaid waiver sector.

And they also decided that all their constituencies were involved in and to some extent at risk from the depredations of all these state governments trying to get Medicaid dollars to do whatever they wanted to do. And so they mobilized.

And for a variety of reasons, given the structure of HHS and the proclivities of the Secretary, they were encouraged to do so. And so I spent the better part of 1994 being harassed by various people from PHS as were my colleagues and staff. It was unbelievable. There were more people working on Medicaid waivers in some of the PHS agencies than there were in HCFA.

And there were some really important policy questions that got resolved and they got resolved by the White House. And we carried out the policy directives we got. And the PHS people never accepted that. The one that particularly drove me crazy was, there was a requirement in 1915(b) that in the absence of a contract between a managed care plan and a federally-qualified health center, the managed care plan had to pay the federally-qualified health center on a cost basis.

For a variety of reasons, in the panic over managed care in 1993 and 1994, many community health centers around the country signed contracts with Medicaid managed care plans to take less than the cost-based reimbursement. And then, when they decided they didn't like it, they lobbied the Bureau of Community Health Services in HRSA to insist to us that we require under 1115 waivers that managed care plans pay cost-based rates.

And I went to the White House with that issue at least three times and was told go away. And I kept, you know, telling the folks. They didn't care. I probably spent several dozen hours on that issue. And I can only imagine what people did who were actually running the 1115 waiver process. The major difference between being in the federal government and my experience in the state government or in city government is the extent to which I spent my time being harassed by my colleagues.

I don’t know if you were—where you were, Judy, when we were doing the Utah waiver. Remember the Utah waiver and the tribes?

MOORE: No.

VLADECK: ...after your time. This is as late as '96, maybe,... The state of Utah had an 1115 waiver. It was very modest. It wasn't a very good project. We didn't like it very much, but it was okay. And it wasn't very large. But there were two executive orders in the Clinton Administration concerning Native Americans and with the tribes. And the second one, which I think was early '96, required any federal agency that was taking any policy action that affected the tribes to consult with them.

So we're reviewing this Utah waiver...making its way through...and there were weekly meetings in HHS, waiver meetings which would be chaired by the deputy secretary, the chief of staff, and to which all the various chiefs and CDC used to come to these meetings for Christ sakes, all the various little PHS agency directors would come to harass us and the—you know, assistant secretary of management and budget and the office of legislation and so on and so forth. And they were mostly—I mean, the basic dynamics of clearance inflicted upon HCFA.

But somehow there were 42 Indians affected by this Medicaid waiver. And so the people from the Indian Health Service said, "Well, have they consulted with the tribes yet?" And I said—you know—we said, we don't know. They said, "Well, under the executive order, this affects the tribes." We said okay.

So when our people call the state people and say, you know, this is a problem... and they say “Okay. There's a big room, have big meetings with state government people and all the tribes—dah, dah, dah, dah—and we'll put this on the agenda. We'll talk...”

Fine. So two weeks later we check in. Yeah, we had the meeting. It went very well. We told them what we were planning to do. We asked them if they had any comments. They had a few. We may accept some, we may not accept the others. But—so we started moving and take it back next meeting. Well, you can't move this ahead. There's been no consultation with the tribes yet. Yes, there has. Yeah, there was a meeting at such and such date and the state people talked to the tribes. Well, the tribes don't consider that consultation. That's a very sort of bureaucratic notion of consultation. It's not a real Native American form of consultation. So we said as far as we can tell the executive order doesn't specify which it has to be. It was just—you know, like that.

SMITH: Maddening.

VLADECK: And we did 20-some odd of these between '93 and '96, I think. And of course the great white whale, which I refused to have anything to do with, which was the New York 1115. As soon as they came in, which was Saint Patrick's Day in 1995, I disqualified myself. I recused myself from any involvement in a waiver that ate up thousands of hours...

SMITH: It was two years, wasn't it? Something like that?
VLADECK: Took about two years. Thousands of hours of time.

MOORE: There was a lot after it was granted, too.

VLADECK: But it wasn't. What happened—the thing was 90 percent of the way done and was finally getting done and then Dennis Rivera figured out that the state was going to save $500 million over four years even with the coverage expansion. And he decided there was no reason the state should keep it, he should get it. And he had more leverage at the White House at the time than George Pataki did. So...another two or three months at the back end of that process.

MOORE: Talk about the block grant proposal in '95 and '96.

VLADECK: Well,...

MOORE: Well, it came out of the Contract with America, I guess.

VLADECK: I don't know. Was it in the Contract? I don't know when it first hit us, when they first...

SMITH: I think they said they were going to—they're going to take that on later but—

MOORE: It came out of welfare reform then.

VLADECK: I don't remember when. I mean, I don't remember when it first popped up. But in all fairness, the thing to say about the fight against the block grant, there was a team that worked on it on a day-by-day basis.

And the team—I mean, and the people who really—I'm missing one person. I can visualize that damn conference room at OEOB where they always met. I'm missing a person. The heart of the team was Jack Ebeler..., Alan Weil, who we drafted from Governor Lamm's office, and...

SMITH: Judy Feder?

VLADECK: No, Judy was gone by then.

MOORE: Was it a state person?

VLADECK: No, no, no. It was another—it was Jack Ebeler and Gary Claxton and somebody from the—no, no, no. Jack and Alan, I mean, and

then somebody from the White House, I think. And then there was sort of the second team that was me and Chris Jennings and Nancy Ann Min-DeParle which became a team on everything. That's part of my government service, was the evolution of that. Jean Lambrew. Jean was with Jack and Alan. And much of the work—I mean, there was a hell of lot of work of all kinds done. But that team focused its efforts. And then there were other people who played a very important role. John Monahan played a central, central role.

And I don't know whether it was John Hart in White House intergovernmental affairs or someone else, but the key for us, the key political issue—there were two political issues. One was the Governor's Association Task Force, keeping that from getting out of hand. And Alan and John Monahan and John Hart were involved in that.

Then after the president vetoed the bill in July or August, negotiations began about some kind of deal. And part of the deal is the creation of this NGA Task Force. And these guys worked that task force continuously. And we were very close but we weren't troops the way they were.

And then the other piece of it was the sort of P.R. political campaign which started after the House passed the Gingrich bill, the budget bill. It started in the Senate because they made an incredible mistake.

I think they really weren't paying attention but they included the repeal of the OBRA '87 nursing home reforms in the House bill. And that was like, you know, a softball right over the middle of the plate.

We mobilized...and I took the lead on that piece of the politics. We did figure out, and I'm not even sure who the "we" is now. There are lots of folks playing in it.

But we figured out even while the bill was still in the House, I think, the argument that Medicaid for all the perception of moms and kids and everything is the middle class safety net. And we were able to mobilize some very good P.R. people and obviously all the constituent groups and so forth.

And Shalala did a lot of that, I mean, personally. But, you know, we all worked with her. She probably had as much to do on the P.R. public side of it as anyone except for the narrower issue of the nursing home stuff which I sort of took the lead on.

If I remember correctly, that actually got killed in the Senate. I mean, the Senate knocked that out of the bill.

SMITH: I thought it was they got it back in but practically over Chafee's dead body and it took forever and ever.

VLADECK: Okay, well, there was a big fight in the Senate, I know. Anyway, the NGA Task Force—I'm jumping around, I know—the NGA Task Force didn't actually finish its work till December-January, December '95, January '96. And then the whole fight was for the President. And we were all scared to death by their report.

And I remember very vividly for a whole variety of reasons—before the end of the Administration I asked Chris Jennings if he could find the photographs, which he was unable to do.

There was a meeting in the Cabinet Room on the day after the Washington's Birthday holiday in '96. And I remember it particularly vividly because, among other things, my daughter's Bat Mitzvah was that weekend. And there had been a terrible snowstorm.

And Clinton came into the meeting. Sometime before the meeting with us, he had met with some people from New Orleans. And it was Mardi Gras and they had brought him a krewe necklace, you know, all those beads, which he was wearing in this meeting. Which is why I particularly wanted the photograph.

It was a small meeting. It was the kind that they usually held in the Roosevelt Room. But they were doing some media thing or something or other, so we had the Cabinet Room.

And there were only about seven or eight of us. Must have been me and I guess Shalala. I don't even remember. Maybe somebody else from HHS. And Chris Jennings and Nancy Ann Min and Jack Ebeler were there, I'm pretty sure. And a couple other White House people.
...somebody else from OMB. Who would have been director at the time? Maybe Alice Rivlin. I don't remember. But we walked in that meeting and we didn't know for sure what the President was going to say.

And, you know, after five minutes of teasing us which, you know, was part of his style, he came out very strong about why this was unacceptable. And

as usual, at the risk of sounding like an apologist,...as usual he got the issues dead on.

The big sticking point at that stage was the question of federal court jurisdiction over enforcement of beneficiary rights, which we believed, and I guess the President believed, was the boundary between whether or not Medicaid eligibility really was an entitlement or not.

And he just went on for about 10 or 15 minutes and people asked a couple questions or said a couple things. And there were a few questions about getting the word out and what the next steps were in strategy and so forth; and that was it. But it was really an extraordinary—

SMITH: It was a dramatic moment.

VLADECK: —sort of high point, yeah. And he was—he couldn't have been...stronger.

SMITH: How much of that do you think was tactical in a way? That is, people were running a big bluff at this point and who was going to back down first.

I remember all sorts of people saying, "We didn't know until the last moment what he was going to do." There were some who said, "Oh, we knew all along he was going to say this." But a good many who said they didn't—

VLADECK: Still, I don't know. I really think by then the tide had turned on the Gingrich revolution and the Contract With America. The government shut down. It was sort of the second shutdown, and all that kind of stuff. You could feel—the contrast between February '95 and February '96 was so dramatic.

February '95 I really was just in a total funk. The Administration was just in total funk.

And a year later the world was looking up again. And I think it was right around then. The budget deal had been—there had been a handshake on the budget deal. I don't know if it had been passed yet but the negotiations had been concluded. The work had begun on the BBA. You know, it's another year but it was a different world.

SMITH: In ’96 we had this big thing about—it's not very long after this that you had this big thing about what are we going to do about welfare and Medicaid.

VLADECK: Right.

SMITH: And they decide to, in a sense, disentitle this program.

VLADECK: Right.

SMITH: And then people pretty well back off and don't talk about block granting Medicaid. What was your feeling about welfare: some people, of course, resigned over it.

VLADECK: Yeah, I was really glad, not to be tied into welfare, though I thought that the welfare legislation was terrible. But again, you know, the sort of line in the sand for us was the Medicaid entitlement. And the process was so clear about that. And then I made a big mistake after that. We met with the Medicaid directors. We must have been part of that that fall, after welfare reform, to talk about what to do about eligibility determination in the TANF world.

And my instinct, which wasn't very informed or very well thought out—I don't want to exaggerate my impressions here—was that with the separation and with the growing number of little Waxman kids and everything and the growing number of people who already were non-cash recipients who were now eligible for Medicaid, the time had come to split the eligibility determination system.

And we thought that all the state Medicaid people would want to do that. And that was sort of the naive part, with not enough homework. And so we walked into this meeting. The quarterly meeting with the executive committee of the Medicaid Directors Association, and said, "Well, what do you guys think? You know, we think it's time to set up new eligibility processes."

And everyone said, "No, no, no, we can't disentangle ourselves from the current relationship. Too expensive, too complicated. Now would be the worst of all times to do it." And that was a—we should have—we should have forced them to do it. The world was fluid enough and there were enough...and the states were happy enough about all the extra money they

got under welfare reform—in year one of that we could have gotten away with it. That was a mistake, I think. Hindsight is a wonderful thing.

SMITH: Is there anything else on the Medicaid history that we want to cover?

MOORE: The only other thing I wanted you to talk about a little bit is relations with the States.

Several state Medicaid Directors have said to me that they never had a better or a closer relationship with HCFA than they did when you were Administrator, which I guess is an irony in one sense since Republicans are always talking about state rights and state flexibility.

And yet, there are a number of both Republican and Democratically aligned Medicaid Directors who really feel they had a better relationship with the Clinton Administration and with you than they had with other people. And I just wondered what your comment would be on that.

VLADECK: Well, it's interesting. I am reminded—and this is a weird way of approaching it—of another Medicaid story. It's about 1990 or 1991, just when taxes and donations are taking off like crazy. And I am at some crazy conference, one of the early conversion foundations sponsored at the Broadmoor in Colorado Springs.

And I don't even remember the topic that I was supposed to be talking about. So I gave my talk and other people gave their talks and then there was like a panel. And Gail Wilensky was on the panel.

I don't know if she was still—I think she was still at HCFA, and hadn't moved over to the White House yet. Somebody asked her a question about taxes and donations and she makes this five-minute speech. And she is livid. She is really agitated.

I mean, Gail is generally pretty good about keeping her cool. This obviously has really gotten her going. And she talked about it's a scandal and it's fraudulent and so on and so forth. And I'm sort of listening to this.
And so finally, the moderator says, you know, "Anybody else on the panel want to say anything about this?" I sort of—I can't resist. And I said, "Well, let me first say that I think I agree with everything Gail has said. This is a fraud. This is a scam. And it's a charade, it's a sham, it's a manipulation.

"However," I said, "given the indifference of the last 10 years of the executive branch to the needs of the states and their Medicaid populations and their absolute unwillingness to be helpful in substantive areas, I think it serves them right."

Actually, I just remembered some other Medicaid history of mine. It's clearly the case that the Reagan and Bush people cared about Medicaid only insofar as a budgetary issue. And, you know, to a limited extent, other things, if they became a source of embarrassing public relations. But that was about it.

What I forgot was—in the first Reagan budget when they tried to cap Medicaid, right? And actually succeeded slightly, for a couple years. There was an exemption for the rate-setting states, the states that did hospital rate-setting. I was running the New Jersey waivered program.

So we worked very, very closely with the other four states involved. And our allies at the time, our major non-governmental allies—really, our only non-governmental ally in state hospital rate-setting—was the Health Insurance Association of America, which was the biggest supporter of state rate-setting you ever saw.

In the olden days. As that played out, I also got involved in—I really am very proud of this. It's one of my little scratches on the hieroglyphic of history that in '82, when they were writing 1915(c), the home and community-based waiver provisions, somehow Brian Biles ended up consulting me about it. He was still on Commerce, I think, before he went to Ways and Means. And I remember I was in his office and he showed me a list of services that states could offer under 1915(c). And I said, "You got to do one thing."

He said, "What's that?"

I said, "You have got to add ‘and such others as they may think appropriate’," because the whole point of home and community-based waivers is to get away from this service by service mentality. And they did; and it's still in there.

Also in '82 in response to some of the sequellae of the Reagan budget, and an offhand remark by Reagan or somebody in his administration, the people decided to take seriously the idea of a swap. The NGA actually had a task force to look at the swap. And I was a member of it. And at the time the

swap was that the feds would take the moms and kids and the states would have the long-term care. The disabled stuff wasn't nearly as big a deal then. And to my surprise, when I went to the first meeting of this task force, because everything knew—I mean, every policy wonk knew that that was a bad deal from the states' perspective, while the state people wanted to take it in principle because they thought they could manage the long-term care.

They could run community-based services. They could deinstitutionalize nursing homes. They could run it more cost-effectively and all this kind of stuff. And then we spent a lot of time trying to figure out what protections we would need. You know, what kind of growth factors and what kind of thises and that's. And it was clear after about six months into this process that the state people were really gung-ho and really interested. And the Administration had totally lost interest. They weren't paying attention anymore. They didn't care. There was nobody to talk to. It just had fallen off their radar screen.

So back to Judy's question. One of the real problems, institutional problems, at HCFA that is more severe on the Medicaid side than the Medicare side because the culture in Medicare was so different, is that the people around the agency thought that their primary client was OMB. There was a lot of confusion on the part of the Medicare people on who their client was, but there wasn't that much confusion on the part of the OMB. But I think the notion that the role of HCFA relative to the Medicaid program was to assist beneficiaries, you know, actually struck a responsive chord with a lot of the old-timers buried around the place.

Actually, it was a pleasant surprise for the Medicaid Directors who are much more interested in that than people give them credit for. And who spend all of their lives fighting off their budget directors and trying to protect the program. And the other thing that I was very conscious of and I think I conveyed a little bit, of course, I had worked in state government. So I have been on the other side of that equation. And maybe, some of it may be that a certain sort of New Yorker's cynicism is helpful. I mean, people take political positions in the executive branch of the federal government and after some period of time they are astonished to learn that the state people are trying to steal them blind.

And they are offended and, you know, hurt. And so I sort of was going in not taking that assumption with me. So I would never have the psychological baggage associated with that.

That was the other stuff. We spent time, my God. Do you remember administrative cost claiming? And Anna Eshoo?

MOORE: Uh-huh.

VLADECK: It started off with like $150 million or $200 million for an L.A. county claim for Medicaid and...

MOORE: About 200, I think.

VLADECK: And they had these consultants who went through every item of the L.A. county budget and decided what costs could be allocated to Medicaid administrative costs. It was an order of magnitude increase from one quarter to the next in their administrative costs. And when we really started getting down into it, my favorite of all, they were charging—essentially the whole juvenile justice system to Medicaid...

But the one I like the most, the single most outrageous to me was the DARE program, you know, with DARE, when they send the cops out to the schools to lecture kids about drugs being bad for them. Well, the L.A. county DARE program is run by the sheriff's department. These consultants figured out the cost of sending the sheriff's deputies out to schools. And then they figured, based on demographic data, the proportion of the kids in the schools who were Medicaid enrolled.

And then they multiplied the cost of the DARE programs by the...kids who were Medicaid enrolled and put that down as beneficiary education.

SMITH: That's pretty rich.

VLADECK: But anyway—that reminds me of this. A lot of the counties in California got—and the state also got into this. Most of them did not but a few of them did. And L.A. county wasn't the only one.
And one of those that got into it was—oh, what the hell is it? San Mateo county. Which is the richest county in the world.

It's like...Silicon Valley and everything. And, I mean, they had like four Medicaid beneficiaries in East Palo Alto. That was Medicaid in San Mateo county. Very rich. But they tried some games and they weren't nearly as bad as what L.A. county did; but we were sort of cutting down... Well, Anna Eshoo had been a member of the county board of supervisors when they did this, and then she went to Congress. And she would not get off my case on

the disallowances. I must have spent several hours being yelled at by her on the telephone, let alone all the other hours of meetings and reviewing.

And, I mean, they had done these ridiculous things. But we haven't talked at all about my two greatest time eaters in the latter part of my tenure in Medicaid, the famous L.A. county waiver. Which resulted, among other things, in the only helicopter ride in my life. (But they didn't throw me out.) And the California Two Plan program, county by county, practically beneficiary by beneficiary. L.A. county was particularly complicated.

SMITH: Tom Scully was reported as saying that he sort of thought when he came to Medicaid that he would be doing administration of the program. But he said he has found all of his time was spent on waivers. I think it was not quite that bad but—

VLADECK: No, it was. It was, pretty much. We didn't do very much. Well, you know, we did the legislative stuff. And the disallowance meetings with Congress people. The other thing we did was—there's actually—there's more Medicaid stuff in the Balanced Budget Act than people generally recognize, in part because we finally sort of gave into the NGA agenda, but got some stuff back.

And the beneficiary protection stuff that they just gutted the rules that poor Tim Westmoreland killed himself getting out at the end of the Clinton Administration and Scully gutted, which were based on the BBA provisions, were really wonderful. I mean, they are about the best patients' bill of rights stuff anywhere.

But the other thing that was most amusing in these days was I spent a lot of time personally in working with some of our staff trying to find a formula or a benchmark with which to judge the adequacy of states' capitation rates to Medicaid HMOs.

The old 1915(b) had said something about actuarial adequacy or something like that, which we had litigation over in California, and it turned out to be entirely useless as an operational concept because if your actuary said the rates were too low, the state would hire its own actuaries and they would say they were fine.

And then the judge would say, "I'm not getting in the middle of a fight between actuaries." So we spent a lot of time with our actuaries, with our managed care people, trying to come up with some definition of adequacy in

payment rates and got nowhere. And it was an interesting lesson to me in managed care pricing. What a wilderness...

SMITH: Well, do you think that anything in particular should be done to fix the...situation or—

VLADECK: Yeah, I do think there is something to be said to the notion that Medicaid as it is now constituted is sort of, you know, like the British and the Irish.

After five or six generations, you are so busy fighting the 8th epicycle of the 14th last war that it's time to sort of start all over again.
I used to talk all the time about how in the course of my lifetime we used to have formal mechanisms for federal-state communications about policy issues. And we had an Advisory Committee on Inter-governmental Relations.

SMITH: I like that suggestion of yours very much.

VLADECK: And we don't anymore. And it's a real problem. And obviously it's a real problem with Medicaid.

SMITH: I associate you particularly with that suggestion for an advisory panel. One other thing about that meeting we all attended was where you talked about the future of Medicaid...and trying to do something about the disabled populations. Have you thought about what the next step should be? I mean, once we say this is on the agenda, where should we try to head with it.

VLADECK: So much of the problem is wrapped up in the duals and the Medicare interactions, too. I don't know if with each passing year it becomes a less and less or a more and more reasonable position.

I mean, I continue to have this sense that in the chicken-and-egg situation where we have been on services to all these populations over the last gazillion years, that there's more opportunity in the short run, taking new steps in service delivery, than there is in public policy and that we just ought to find a chunk of a couple hundred million dollars and have some kind of competition and, pick the 20 best proposals, each of which will promise to enroll a thousand people.

SMITH: Sounds, among other things, as though you would like to see us move a little bit more back toward a classic of innovation in service delivery.

VLADECK: On this stuff, yeah.

SMITH: Yeah.

VLADECK: I mean, it's really amazing when you stop and think about it, but in 1975, what was then the Bureau of Health Insurance issued an RFP to the states: develop alternative hospital reimbursement methodologies. And they let like seven contracts. And it worked.

SMITH: Pretty well. And we are still running on it, to some extent...

VLADECK: Yeah, to a very large extent. And we haven't made very much progress since. And Rich Feather has houses on four continents. But, you know, so it's really—to me that's—that's the first part. I mean, that's the critical part.

And then—well, if we still have a Medicare program 10 years from now, I really do think that cleaning up sort of the Medicare drug benefit, and the Medicare SNF benefit, and the Medicare home [health] benefit, is a precondition, if not the critical precondition to rebuilding the Medicaid side of financing the service delivery system.

In a sense, it's easier. It's more expensive, but it's almost easier from a policy point of view to start there because you've got one program.

SMITH: Yeah.

VLADECK: For the time being. So if you could do that, if you wrote the terms appropriately, then I would be ready for sort of the swap kind of thing. Because it sort of shows to me the ultimate ridiculousness of the policy enterprise that the populations for whom capitation is the only intelligent payment system are the most disabled and the most expensive.

And it really doesn't matter, you know, if you are talking $100 PMPM for well child care, how you pay the damn..., you know. And you can pay them fee for service. It's not going to cost you an extra nickel. But when you have people on the PACE program with the total capitation of $7-8,000 a month, which makes people cringe. You've got to capitate them. You can't

rationally run a service system otherwise. And you've got to have a single funnel.

SMITH: And for that you've almost got to redesign managed care.

VLADECK: Well, you can't take conventional managed care. That's for sure. And conventional managed care wants no part of it. But what you've got to do—you've got to have effective local control and you've got to have effective state level oversight to revise it, because it's too complicated.

SMITH: Well, I find that an interesting observation, because one of the pieces of legislation that impressed me, looking at its history and what they were trying to achieve, was the old Mental Health System set back in 1980. One thing it did, that has seldom been done, was to try to work through the problem at the local level, but then to get into the question of what did the state, exercising its sovereign capacity and its taxing jurisdiction, and its power to allocate funds, what did it do about making this system work? Because— we do operate with three layers of government.

VLADECK: And dipping my toes very lightly into this mental health financing service question the last six months, (a) you run into the—it's not a paradox, it's just a frustration—that all of the really successful delivery systems are very locally rooted. And (b), the overwhelming majority of localities have failed to deliver, to develop even a halfway decent delivery system. So it's, you know, it's an analogy to my losing it every time people mention Jack Wennberg these days, you know.

I tell people that the only way to make use of all the variations data that Wennberg keeps publishing, from Medicare's point of view, was to move all the Medicare beneficiaries in Miami to Minnesota. But, you know, it's like the way to get everybody in the United States good community mental health care is move them all to Madison, Wisconsin. Because they do a really good job in Madison and about 10 other places or 12 other places, or whatever it is. Out of 230 SMSAs in the United States.

So, we have to look at these things a different way. I just saw somewhere—I was looking at, you know, this general stuff and our health economy in the United States is so big. And we spend so much money that in fact—I read this through the first time—the percent of GDP going to tax-supported health services in the United States—okay?—is as high as it is in Germany or in France or in Japan. It's just that it's only 45 percent of the total cost of health services in the United States.

But—so it's the same thing. I mean, when we look at the Netherlands or at Sweden and say these people know how to do community mental health services, these people know how to run a humane, progressive, effective system of care for seriously disabled people.

If we said to ourselves there are probably 12 metropolitan areas in the Netherlands where they have good systems of care for the...there aren't 12 metropolitan areas in the Netherlands. There are like four.

So we can do it in four, too. We just have 230 others. That's just a different perspective on looking at it.

SMITH: As one friend of mine said, "Don't throw Sweden up to me. It's not even the size of a major HMO."

VLADECK: Yeah, right.
Canada is for Canadians. And we do real well, relatively, for the Chinese.

SMITH: And not relative to Singapore. But well, thank you so much.

VLADECK: It's a pleasure. It's always good to see you.

SMITH: Great fun. It's great to see you again.

VLADECK: Thanks for coming up.

INTERVIEW WITH HENRY A. WAXMAN
JUDY MOORE AND DAVID SMITH – JANUARY 25, 2005

SMITH: This is Judy Moore and David Smith interviewing Congressman Henry Waxman and his health staff aide, Karen Nelson. And we would like to start by asking you how you happened to get interested in health, as opposed to various other things.

WAXMAN: I made a decision when I first got elected to office in the California State Assembly that I wanted to concentrate on health policy issues. I looked at a lot of issues like welfare reform or education and I had some ambivalence as to whether I really could become an expert in those areas or make a difference in those areas.
But I was representing a district, and I am still representing a district, with a large number of seniors. And it just became apparent to me that no one could argue against the importance of the government involvement in health issues.

Here on the national level we deal not only with the health care systems of Medicare and Medicaid but we have the essential research and sponsor the National Institutes of Health, Food and Drug Administration approval and pharmaceuticals, all the public health aspects, the Centers for Disease Control.

So health became my interest. But when I got elected to Congress in 1974, which was right at the time of the energy crisis, people were backed up in their cars waiting to get to the gas pumps because we had a fuel shortage. New members of Congress wanted to get on the commerce committee because of the energy legislation jurisdiction.

But I wanted to get on because this was the premier committee dealing with health policy. I went right on to the subcommittee on health and the environment, then chaired by Congressman Paul Rogers from Florida, who was a very able chairman. He retired four years later.

And since there was a vacancy for that chairmanship I decided to request that my Democratic colleagues their support, even though I wasn't next in line in seniority to take over that subcommittee. And I was able to do that and became the chairman of the health and environment subcommittee in my third term.

SMITH: Now, when you were working in the Assembly you were Chairman of the health committee?

WAXMAN: I was Chairman of the health committee in the California Assembly.

SMITH: And people have said that you learned a good bit of your craft there, that it was good for learning how to negotiate with people and how to put together legislation and so forth.

WAXMAN: I'm always learning.

SMITH: Were you involved in your time with the Assembly with the health plan—

WAXMAN: Yes.

SMITH: —issue.

WAXMAN: We had something of a scandal in California at the time under then-Governor Ronald Reagan, who decided that the best way to hold down the cost of MediCal, which is what the Medicaid program is called in California, was to try to get people to volunteer to sign up in prepaid health plans.

But in signing up for these prepaid health plans, a lot of people were being conned into joining a plan that really was not able to give them their health care services. But once they had signed into the plan, the government responsibility was limited financially. And the fact that these people didn't have any care that they could access wasn't a major concern of the then-Reagan administration.

So I was involved in holding hearings on that subject and authoring legislation with Assemblyman Gordon Duffy, who was a Republican, to try to make these prepaid plans more transparent and accountable and to meet certain standards.

SMITH: Is the Waxman-Duffy bill still on the books? Is the Act still on the books?

WAXMAN: I think so, but I have lost track because there have been lots of different legislative changes in California. California adopted a patients' bill

of rights, which the Congress still has not done. Unfortunately, in California it only applies to those health insurance policies that can be regulated by the state and not all the ERISA policies that have to have federal oversight.
But for California, that patient bill of rights law may or may not have superseded some of the Waxman-Duffy Act. But I just haven't kept up with it.

SMITH: Right. Well, a large part of our story starts with President Reagan and David Stockman and OBRA of '81. And one of the first questions I wanted to ask you is a little bit about your perspective of that rather astounding performance in that first few months.

Did it seem like a tsunami or did it seem as though, they were going to have trouble down the road when they tried to cash in on these reconciliation assignments?

WAXMAN: When President Reagan won in 1980, he carried a large part of the country, including districts of many members of the Democratic party in the House and Senate. And that was a big pressure on some of these members to want to go along with the newly-elected president, with his proposals to cut taxes and as well as to cut spending at the federal level.

So he had strong bipartisan support. He had a few Democrats that came out early, such as Phil Gramm, who became so enamored of the Reagan policies that he later became a Republican. But he had some Democrats who co-sponsored the legislation with Republicans.

I don't think that he would have been successful in some of that legislation if he had not faced an assassination attempt. I think then there was an enormous amount of sympathy for him.

And even though the Democrats controlled the House and the Senate, the Republican unity, as well as a peeling off of a large number of Democrats, gave President Reagan a working majority of the Congress and he was able to get his proposals through.

SMITH: Were you calling them boll weevils then or did they...?

WAXMAN: Yeah, we called them boll weevils, among other things.

SMITH: Right.

SMITH: Well, you know, there is this enormous kind of massing of political power and they put this through first—they called it a reconciliation bill.

WAXMAN: Yes.

SMITH: But then when they start trying to get these committees to actually deliver on what they were assigned to do it doesn't work very well. And did you foresee that kind of problem? Because Stockman himself said that the thing really kind of collapsed after that first enormous effort.

WAXMAN: In the Senate they had the very able leadership of Senator Bob Dole. He was chairman of the Senate Finance Committee. He helped them get their tax bill through. And when it came to other issues in the jurisdiction of the Senate Finance Committee, particularly Medicaid, he got through what the administration wanted.

SMITH: Yes.

WAXMAN: And that passed the Senate. In the House, the—John Dingell, was he Chairman? Yes, he was Chairman.

NELSON: Yes.

WAXMAN: In the House, Chairman John Dingell was able to successfully bring together a majority of the committee to back a different version of reconciliation, particularly because of the strong desire of Southern Democrats to have changes of the natural gas law.

SMITH: Uh-huh.

WAXMAN: They wanted that more than anything. That was on their top wish list. And when they got those changes they were locked into an agreement for the rest of the reconciliation committee. So our committee passed out a reconciliation bill—I think overwhelmingly, as I recall. But I'm not sure anymore—where we had our version.

And when it got to the House floor the Republicans in the administration—Dave Stockman particularly, who had been a member of our committee—became very nervous about changing the reconciliation proposal with regard to the commerce committee. He just thought that they needed to get this whole bill through as fast as they could.

And so he ended up rewriting the bill on reconciliation even up to the point where it was brought to the House floor. There was a lot of mockery at the time of writing on the margins of legislation and putting in different provisions in a rather incoherent way.

But they left intact the commerce committee provisions, so that we went into the conference with the Senate with our original provisions from commerce, including—and especially—an alternative to the proposal to cap Medicaid, which is what...

SMITH: Right, right. We want to get into that just a little bit. But the negotiation that took place there, was that largely between Stockman and Dingell or were you involved in that? Because as Stockman portrays that, he was kind of desperately trying to get this thing together.

WAXMAN: Right. And I was definitely involved on the health issues.

SMITH: And some people, like perhaps in the commerce committee, had an awful lot of leverage in that situation. I mean, because as is well known, you have got an alternative to the Medicaid cap passed and you have also got a version that you could live with on the block grant proposal.

WAXMAN: That's right. Well, we had compromise provisions. We were conceding ground in the House bill. But what Dave Stockman certainly had to have in his mind at the time was that he didn't want the whole thing to flounder.

SMITH: Yeah, uh-huh.

WAXMAN: Because the overall bill was so significant for what they had to accomplish and what they wanted was to implement their budget proposal overall. So while he perhaps didn't want to have our version into conference he thought, well, better get our version into conference and deal with it in conference than to jeopardize the whole thing...

There were members, I think Phil Gramm among them as a Democrat, who was a very good friend and very close to Dave Stockman. And Phil Gramm made the deal in committee on the natural gas provisions and I think was standing by the deal. So I think Dave Stockman got a good sense, having come from our committee, that he better not rock that boat—

SMITH: The particular numbers, you got a declining percentage of cuts as an alternative to capping the Medicaid program.

WAXMAN: Right.

SMITH: Were those numbers calculated to meet the reconciliation?

WAXMAN: Yes. So we met the reconciliation targets without changing the fundamental structure of Medicaid in a permanent way except with some minor exceptions.

SMITH: But then the Senate raised the percentages on you and then the economy took a bad turn so it really turned out that what you thought was pretty much going to disappear was a fairly onerous cut, was it not?

WAXMAN: Well, we didn't think it was onerous, considering the alternative of capping the program. It wasn't...

SMITH: Not what you came out with, but what—when you put together the final version of the bill with what happened in the economy it was pretty hard on the Medicaid program, wasn't it?

WAXMAN: Yes. And the irony of it was that this developed an enormous amount of support for the Medicaid program which helped us throughout the '80s in expanding Medicaid.

SMITH: Uh-huh. People felt that the OBRA 81 had overdone things.

WAXMAN: Absolutely. People were quite horrified. And even Southern governors were coming to us and urging that we start mandating some of these Medicaid proposals so that they could get their federal dollars and get their states to go along with drawing down the federal dollars for a lot of health care for pregnant women and infants.

SMITH: An awful lot of what subsequently happened, so it does seem to turn one way and another on this OBRA 81. I mean, this started a lot of things going, for example. I mean, I just wondered did you perceive it that way? Was it a kind of a big watershed or a great triggering event?

WAXMAN: I don't know that I was thinking through what was going to happen 5, 10, 20 years down the road.

SMITH: Right, right.

WAXMAN: I was just trying to hold onto the Medicaid program being an entitlement without any caps or limits on it at the federal level because that would have been such a fundamental change that would have made it impossible for states to pick up the slack.

SMITH: Uh-huh. Uh-huh.

WAXMAN: And it would have left even the people covered under Medicaid at that time with a difficult situation to get their care.

SMITH: Right, right. The block grant proposal, now there was a proposal—

WAXMAN: Before we finish Medicaid, do you want to go into the conference a little bit because the conference, I was then dealing with Senator Dole and I think he had a lot of sympathy for the Medicaid program. He didn't want to permanently cripple it but he certainly wanted to achieve targets of reductions in spending that he was obligated to achieve.

And I went to him at one point and just said there is no way in the world I would ever agree to sign onto a conference report that capped the Medicaid program. I told him that's just something we would not do. And I think—I'm sure he passed that message to David Stockman and others in the administration.

I think Senator Dole also wanted them to understand that the whole thing could come tumbling down if they pushed too hard and I don't think he personally wanted to push that hard to get the block grant, have Medicaid become a block grant. So that was—I give him an enormous amount of credit for the result.

Now, certainly it was more of a cut than I would have liked and maybe more of a cut than he would have liked. But that was the situation we were dealing with at the time.

SMITH: Well, then on this block grant proposal, you came up with a very different grouping of—

WAXMAN: Of the public health programs.

SMITH: Yes, very different grouping of which were going to be in which category. And I'm just wondering what sort of governed the kind of groups you put them in. Was there a political logic to it? Was there a programmatic logic?

WAXMAN: Well, certainly a programmatic logic. There were some programs we just felt very strongly had to be categorical programs from the federal level, such as family planning and community health centers. We gave way on the preventive health programs because the states pretty much run the public health services. And so I think we came in with—I don't know that it was politically thought through, but given my able staff it probably was and I wasn't aware of it. We applied programmatic sense to design some block grants but to draw the line on others.

SMITH: Right. When did you first—when did this kind of swell of interest in children's health develop?

WAXMAN: Before we leave that do you want to talk about this—complete the conference on those issues?

SMITH: Oh, sure. I'm sorry.

WAXMAN: Because it was interesting.

SMITH: Yes.

WAXMAN: It was interesting. I think Senator Pete Dominici has to get an enormous amount of credit for the survival of the community health centers program. He understood those programs because of his experience in his own state with how they picked up the slack for people who had no insurance.

And he didn't want to make it a block grant where the program might get hurt. So we came up with some kind of hybrid block grant, but in effect still allowed it to be a federal categorical program.

So that was that piece of it. On the family planning program there was an enormous amount of ideological concern swirling about that because of President Reagan's victory being so tied to the anti-abortion movement.
And to my amazement even today, people who are so strongly against abortion are very hostile to family planning, which you would think they would want to support—

SMITH: Yeah.

WAXMAN: —because it stops unwanted pregnancies which lead to abortion. But they had this ideological sense that the people who run family planning programs also believe in abortion as an option, which of course is the law of the land.

And a group like Planned Parenthood would have a wing of its own facility where they used their own money for abortion services. So they wanted a block grant family planning program in order to start eliminating federal support for it.

At the same time, there was a senator named Jeremiah Denton who had the idea of a chastity program and he wanted to make that a federal categorical program so the federal government would start putting money to the states to run these chastity programs.

In addition, one of the outstanding issues of the time was whether C. Everett Koop would be allowed to become surgeon general of the United States. He was older than the law allowed for him to join the U.S. Commission Corps.

WAXMAN: —Commission Corps. And so he needed legislation to change the law to allow him to become a member of the Commission Corps so that he could be the surgeon general.
The Senate, of course, had to confirm him and we had no role in that. But I asked that he come and appear before the House committee because he wanted that legislative change. He was told by the administration not to come before our committee and therefore we held up the legislation that would allow him to join the Corps.

I was very suspicious of him when he was appointed because his previous experience was as an excellent pediatric surgeon but a forceful lecturer against abortion. And it was for that reason that I think he was appointed, the work he had done against abortions around the country.

But in order to save the family planning program and to work out the overall proposal on block grants and categorical programs we threw the legislation the surgeon general needed into the mix and agreed to give the legislation final approval. And it had earlier passed the Senate, but not the House, but I think what was one the best moves that I made inadvertently in my career...

SMITH: Yes. It turned out well.

WAXMAN: ...he was an outstanding surgeon general. And he became a good friend of mine and he told me that at the time he really disliked me intensely. But he was surprised in later years that he changed his mind about me as well.

But that was my recollection of the kind of mix of legislation we were dealing with. Senator Hatch had just become the chairman of the health and human services committee over in the Senate because the Republicans now had control. And that was a committee that had been chaired by Senator Kennedy. And Senator Hatch was very reluctant to agree to some of these changes. He just felt very insecure about it.

And while we worked out all these things at one point, we had a meeting where even Sen. Dan Quayle was a participant and a bunch of other Republicans who finally said, "..., let's go with the deal." And Sen. Hatch finally came around. He was a tough negotiator and had to be brought around finally at the very end. But he was out there fighting for the best he could get.

SMITH: Yes.

WAXMAN: And he did reasonably well.

SMITH: While we are on the subject of conferences, on these OBRAs it was pretty much the case, wasn't it, that the Medicaid issues were settled in conference finally?

WAXMAN: Yes. Yes, because Medicaid and Medicare became very much the important key to the budget proposals each year. Usually what they wanted was to go to the Medicare piggy bank and take money out of that to try to pass their other proposals. And the savings were supposed to come out of Medicare because the future spending of Medicare was geared to rise with the medical inflation...

SMITH: So that was kind of the Willie Sutton principle—– go where the money is.

WAXMAN: Yes.

SMITH: There was a kind of a rumor going around that somehow they would go through these reconciliation processes and Medicaid wouldn't get whacked very much but Medicare would get whacked quite a lot. But of course Medicare had a lot more money involved at that point.

WAXMAN: Yeah, it was absolutely the Willie Sutton principle. That's where they wanted to get the money. I remember the irony. It was in 19—we had a proposal called CHAP that came out of the Carter Administration to cover poor kids under Medicaid. And we couldn't get anywhere with it, but finally we negotiated with David Stockman. What year was it, Karen?

NELSON: I think it was '84.

WAXMAN: And this was to just take the first step of that CHAP program.

SMITH: Yes.

WAXMAN: Requiring the states to cover children up to age five meeting the AFDC income and resource standards and first-time pregnant women. And the big breakthrough was when we met with David Stockman, who of course had been a member of my subcommittee when he was in the House. And what he wanted—what he wanted was to put for the first time price controls on doctors. He wanted to put a cap on doctors' fees under Medicare.

SMITH: Uh-huh.

WAXMAN: And I had the ironic situation of suggesting that that really wasn't a good idea, that price controls was not the way to go. And I couldn't convince this very strong fiscal conservative that it was a mistake to put price controls on doctors because he so desperately wanted the money out of what otherwise had been the physician fee increases.

SMITH: Yes.

WAXMAN: So I had a great time after that everywhere I went talking to doctor groups particularly saying how David Stockman was the one who in this Republican administration was the one who wanted to put the ceiling on doctors' fees.

SMITH: Well, now—

WAXMAN: And we used the money to get some of our Medicaid expenditures.

SMITH: Right. You were mentioning CHAP which came in the Carter Administration and then you introduced a bill which you said really didn't get anywhere, as I remember.

WAXMAN: Yes.

SMITH: And I was kind of wondering if that was about the time or how it came about that you began thinking that, well, the way to go is reconciliation on these matters. Was that something that was obvious to you or it is something...

WAXMAN: Well, it was the only time we could deal with legislation on Medicaid.

SMITH: That's the only way you could get stuff through.

WAXMAN: Yeah.

MOORE: We have had people tell us that Medicaid was always the last thing taken up with the least attention given to it. And I wondered what your reaction to that would be.

WAXMAN: Often that was the case. There were many years when everybody was ready to leave Congress and the last bill up was the Medicaid piece of the budget reconciliation proposal. And we were a last issue to be resolved in that proposal.

And sometimes on the House floor we were the only ones there because everything else had been passed and we were trying to make sure that we had our Medicaid piece worked out the way we wanted it.

But what we saw were opportunities in the '80s to use the budget reconciliation process to try to build on the Medicaid program, which we—in my first opportunity as chairman of the subcommittee I had to preside over cuts to that program.

But we were able to, with bipartisan support and support of many governors to expand programs for women and children. I remember Congressman

Henry Hyde being quite supportive of the idea of prenatal care for women, which is of course strongly consistent with his pro-life position—

SMITH: Yes.

WAXMAN: —and viewpoint. And all these things had to have bipartisan support because we had a Republican president. It wasn't what the Republicans would have pushed because it wasn't high on their agenda. But it was certainly high on our agenda. But because we had a majority in the House we were able to set that agenda.

Now we have a situation with the Republicans in control of the Congress, both Houses, the presidency and the courts, so you don't hear a lot of talk about expanding public or private programs to get the uninsured covered who are hovering around the poverty line and many of whom are working at jobs—sometimes two or three jobs—but have no health insurance coverage in most jobs.

SMITH: Right, right. How important were things like the Southern Governors Conference in providing support or even maybe some of the initiative for the children's programs?

WAXMAN: They were very supportive. I remember Governor Riley, South Carolina, particularly. But the Southern governors were tremendously helpful in pushing for this. A big part of their economy in some of these states was health care under the Medicaid program. And this was a large amount of federal dollars that they could use to cover people.

SMITH: Uh-huh.

WAXMAN: Especially women and children.

SMITH: But now you said they were highly supportive and I have a little bit of a sense that the children's health initiative was going on fairly strongly within Congress as well before those governors got there. The proposals had a large element of popular support, some very important political support. But it wasn't as though this was an idea that had only occurred to them and then Congress got on board, was it?

WAXMAN: No. It wasn't initiated by them.

SMITH: Right.

WAXMAN: But they were strongly supportive of it.

SMITH: And Senator Bentsen had made an effort earlier in this respect, hadn't he? I think you were maybe first in '83?
Didn't you try a bill, kind of a stand-alone bill that didn't go and Senator Bentsen in '84 and then in DEFRA '84 you had the first kind of major installment?

WAXMAN: We had CHAP as a stand-alone bill.

SMITH: But that didn't pass.

NELSON: No.

SMITH: And then you had what has become known as the Waxman two-step.

WAXMAN: Well, we often introduced legislation that we intended to put into reconciliations. And sometimes we would put that bill out there. I can't remember the details.

SMITH: Right.

WAXMAN: So many years ago. But I know that we were champion of the cause. And the first time expanded children's legislation was passed, it was passed in the House. Senator Bentsen shared our concern about this issue and was very helpful in making sure that we could expand it, as was Senator Chaffee.

SMITH: Right.

WAXMAN: And the Senate Finance Committee as well. So we had a lot of people concerned and interested in trying to take an opportunity that was there.

SMITH: And at what point did you think about moving on and doing the same kind of thing with the elderly and disabled? That is where you—eventually you get expansions for the dual eligibles out of this but there was an effort made I think in this direction in COBRA.

WAXMAN: Yes.

SMITH: And then later it comes about with the Catastrophic Act.

WAXMAN: The—

SMITH: The repeal of—well, the Catastrophic Act and the repeal of it.

WAXMAN: Yeah, well, I'm trying to remember and Karen's going to refresh my memory if I'm wrong. But it seemed to me there was a fight in a conference, one of these reconciliation conferences, about how high the Part B premium would be increased under Medicare.

SMITH: Yes.

WAXMAN: And Speaker Jim Wright decided to go with the 25 percent of premium to cost to be passed on to the Medicare recipient, which we thought was going to be too big a jump. And then we came in with a proposal, since we had lost that fight, to say let's at least have a QMB program, what became known as the QMB program, to cover some of the cost sharing that was now going to be shifted onto the very poor elderly.

So that became part of it, part of a reconciliation bill. And then one of the changes that we made in '81, by the way, which was a big change—it wasn't as big as block granting but it was a big change because we said to the states they didn't have to pay hospitals or nursing homes in a way that reasonably related to cost—

WAXMAN: We took away the standard for an adequate rate.

SMITH: Uh-huh.

WAXMAN: That was a big change. And we weren't happy with it but we had to go along with it. So we did allow a special payment for DSH -– hospitals that served lots of poor people. That was an effort to give them access to higher payments even if the rest of the reimbursements to hospitals were low.

SMITH: You put the DSH in, and that was in part of the OBRA of '81.

NELSON: Right.

WAXMAN: Right. And that was a significant change. But then we—later in the '80s because we saw that I guess it was in the Medicare Catastrophic

bill, and we saw that a lot of the low-income seniors weren't going to get enough help in the Medicare Catastrophic bill. And so we wanted to then expand assistance in Medicaid to pay for the Medicare premiums and cost-sharing for people below poverty.

SMITH: Yes.

WAXMAN: And we also enacted the spousal impoverishment protections.

SMITH: Right.

WAXMAN: Both related to that issue but also related to the fact that low-income seniors were facing a difficult time in nursing homes.

SMITH: Yeah.

WAXMAN: And the nursing homes were finding it difficult to provide services for them. So even when the Catastrophic or I guess I'll say so-called Catastrophic bill was repealed these provisions in Medicaid stayed in.

SMITH: Well, one of the things I note, part of the thinking it seems to me, there was one sense in which Medicaid was going to help out with the seniors that were hurting on Medicare and were not...for their co-pays and things like that.

But another piece of it was that Medicare was going to help out Medicaid because there was going to be a pharmaceutical benefit. And that would have taken quite a bit of a load off of the Medicaid program. But then as things turned out what was left behind was pretty much this one part.

WAXMAN: Right.

SMITH: And there are various interpretations of what happened there. One is that people overloaded the Christmas tree. There were just more and more things that got into the bill. But the other was that almost from the beginning it was kind of doomed to fail because of this Reagan requirement that it had to be paid for by the beneficiaries.

WAXMAN: Well, that was the big problem with the legislation and that's what the National Committee to Preserve Social Security and Medicare hit on the most. There was a national effort by them to point out to the seniors how unfair they were being treated because they had to pay for all of this.

And actually, they had to start paying before they got any benefits.

And why should they have to pay for all of it, especially with an income-related premium that meant if they had more income they had to pay a higher premium for the Medicare program. They thought they were paying more than the new benefit was worth. So that was what became so controversial and doomed that Medicare catastrophic bill.

SMITH: When did you do the nursing home standards?

NELSON: The nursing home standards came I think—

SMITH: They were '87, weren't they?

NELSON: Yes.

WAXMAN: See, that was another issue that came up because of the Institute of Medicine having conducted a study about nursing home standards and how the states were not doing the kind of job they needed to do to make sure that the nursing homes were meeting decent quality standards for their residents.

And when it became clear we couldn't rely on the states, because some were doing a decent job and others were not, we needed to set up a federal standard. We came up with that proposal. It was a pretty long, complicated proposal.

SMITH: Yes, it was.

WAXMAN: And I remember Andy Schneider sitting down and negotiating it with Senator George Mitchell.

SMITH: Interesting.

WAXMAN: Both of whom, of course, wanted to do the right thing and came out with a proposal that passed into law.

SMITH: Well, as you know, it was 1989 and it was just at the time of the repeal of Catastrophic act two years earlier there had been these nursing home standards.

And then there was quite a bit of addition to Medicaid eligibility. And then in 1989 the National Governors Association comes out with this declaration of no more mandates. I don't think they used the language unfunded mandates because they were funded. But no more mandates.

And do you sense that there is a point where you could say that we were kind of getting to a tipping point, that resistance was building up and trouble was ahead?

WAXMAN: We were aware that the states were feeling that there was a lot being required of them in terms of putting up money for their share of the Medicaid [match].

SMITH: Yes.

WAXMAN: We argued for the QMB and the SLMB to be fully federally funded.

SMITH: Okay.

WAXMAN: I think Senator Bentsen wouldn't allow us to do that, as I recall, in the conference when that came up. And that was, I think, a serious mistake.

SMITH: Right.

WAXMAN: Because the states really didn't have—still never had a strong incentive to want to get seniors to sign up for Medicaid who are eligible because the states would have to pay that money.

SMITH: Uh-huh.

WAXMAN: The first part of the health coverage expansion for low income children and pregnant women below the poverty line, the states were willing to accept a mandate on that. But then we provided each year some options for the states.

SMITH: Uh-huh.

WAXMAN: And states were happy to have the option because they could do it or not do it and then get federal dollars if they decided to do it. But by

1990 we had the big budget compromise with President George Herbert Walker Bush.

And that was a time for us to revisit these issues and make a big step in covering all children below poverty born after 1983. That's when we go the so-called Waxman Kids. Does anybody else but us call them the Waxman Kids?

NELSON: Yes, absolutely.

MOORE: Everybody calls them the Waxman Kids.

SMITH: Yes.

WAXMAN: It's nice to hear.
(Laughter).

WAXMAN: And then we also included Medicaid coverage of Medicare premiums but not cost sharing for people between 100 and 120 percent of poverty. So we were doing what we could to help low income people. And then we went into the pharmaceutical area and adopted the best price drug rebate program to achieve significant savings in Medicaid at the same time.

MOORE: Did you package those that way, the drug rebate with the expansions or were you just,—I think you had been having hearings on drug prices and so forth.

WAXMAN: Yes, we had been holding hearings on drug prices. And the argument at that time was: Why should some people or institutions pay the best price for drugs but the government shouldn't get the best price for the poor in the publicly-funded health program? And so we then went into figuring out primarily, because the Senate had a provision on it as well, how to work out the best price rebate system so that we could hold down the costs when Medicaid bought drugs.

SMITH: I am interested in one thing you said. You said, "We would try to work out this or that." And I'm a little bit interested in how you and your aides worked together. I mean, would you sit down at the beginning of the year and kind of survey it and say, "It looks like we might want to try this or that"? Or would you pretty
much—

WAXMAN: Somewhere along in the year Karen Nelson and Andy Schneider and others on that staff would come in and tell me that these are some of the things we think we could do.

SMITH: Uh-huh.

WAXMAN: And I would say, "Let's go for it. Let's do it."

SMITH: You know, I think that's one reason that you have been known for being able to keep a very good staff.

WAXMAN: Absolutely.

SMITH: One of the things I was wondering about is: How do you manage to do all of these things in the face of your own budget committee and the kind of concerns they would have and what OMB would say about some of this and obstacles that come along the way like Gramm-Rudman-Hollings and then the Budget Reform Act? Where do you get the money? And how did you handle that sort of a problem?

WAXMAN: Well, there were lots of obstacles. The Gramm-Rudman-Hollings Act exempted Medicaid after we got in there and fought like tigers to make sure that they did.

SMITH: Yes.

WAXMAN: That wasn't in the original proposal. And our own Democratic budget chairman, Leon Panetta, was always pushing back.

SMITH: Yes.

WAXMAN: I remember being called into a meeting with Dick Gephardt, Leon Panetta, assorted other people, in 1990 particularly, where they told me you just can't—you can't get these things that you want. They didn't know that Senator Bentsen wanted it as much as I did. They thought I had to settle for less.

And I said I wasn't willing to settle for less. We had to do what we could and I thought we had a chance and they should just leave me alone, let me negotiate and see what we can get. But they didn't want to spend a lot of money...

SMITH: Yes.

WAXMAN: They wanted to spend some but they didn't want to spend as much as we wanted and certainly not as much as was needed. But we thought we could push the envelope further. Now, I think again throughout this whole period of time people always worried about those reconciliation bills coming crashing down.

SMITH: Right.

WAXMAN: So it gave it some leverage that we didn't otherwise have. But I think we were also just persistent.

SMITH: Uh-huh.

WAXMAN: And sometimes people just wanted to get rid of me or Karen.

SMITH: Well, I'll tell you one small joke that is legendary around the Hill. People will say that Congressman Waxman never has to go to the bathroom. Well, various people—did you go sort of early in the season as the budget cycle was cranking up and kind of talk this out with Leon Panetta?

WAXMAN: Well, we would testify before the budget committee, outline proposals that we wanted to advance.

SMITH: But you didn't have any kind of special relationship here.

WAXMAN: No, we had a cordial, friendly relationship with him and the other Budget Chairmen who presided during that period of time.

NELSON: I think in addition, you know, as we probably talked about when we talked before, when the budget process got set up a program like Medicare was in the jurisdiction of the tax committee. That's why if they had some things they wanted to spend money on they had a lot of ways to raise it without being explicit about it. But partly because Medicaid was on the jurisdiction of a committee that had no place to raise funds, we had to press the issue with them every time to say, you've got to allow us some money. Otherwise, there is no possibility of expansion.

SMITH: Uh-huh.

NELSON: There is just no way to get the money for it.

SMITH: So you would go to Ways and Means and—

NELSON: No, not Ways and Means.

WAXMAN: No, we would go to the Budget Committee.

SMITH: Oh, you would go to the Budget?

NELSON: So we were recognized in the budget—

WAXMAN: Right.

NELSON: So Medicaid started to consistently be one of the few areas where you would actually see among all the rest of the cuts some specific allowance for spending...

WAXMAN: So when you ask about the relationship with the Budget Committee—committees during those years, they were trying to be helpful. They certainly saw the need, and especially when the economy had a difficult time, it was straining under the pressure. And Medicaid is like a lot of other programs, a kind of cyclical program.

SMITH: Right, right.

WAXMAN: So when the economy was having difficulty it just made the Medicaid program more needed than ever before. Well, Leon Panetta, for example, didn't want to go as far as we did under some cases. He certainly wanted us to get some of these expansions and improvements. He wasn't an adversary. I remember OMB—OMB of course, under Reagan and Bush were—they were obstacles. They had to be dealt with. But Senator Bentsen was a good ally in these negotiations, in these efforts.

SMITH: Well, of course, he was in a position to get money in the Senate, wasn't he?

WAXMAN: Sure. He was Chairman of the Senate Finance Committee, which could figure out how to raise money for taxes, how to make the cuts in Medicare. And they had money then they could put into Medicaid, which was one of their committee's programs.

SMITH: And then could this help you in conference or things like that?

WAXMAN: Sure.

SMITH: Yeah.

WAXMAN: And I don't remember how many times they actually—they never had anything that cost more than what we had.

NELSON: I don't think so.

WAXMAN: They certainly had the ability had they wanted to do what we did. They could have done that and more. But they had the ability to help us put it all together. They had members that were sympathetic.

SMITH: And how about your relations in all this with OMB or with the Administration? One of the things that is surprising is that they—well, Stockman says pretty much this in his own book.

But we were also talking with Don Moran and he said that we could really try to hit Medicaid hard during pretty much the rest of the Reagan Administration. We would take a kind of a symbolic billion or so each year out.

But—and I don't quite understand why this was so. I mean, in other words, why didn't the Administration give you more trouble than they did, particularly in an Administration that was kind of hostile to entitlements anyway?

WAXMAN: I think they didn't—they saw there was a lot of political problems for them if they did.

SMITH: Yeah.

WAXMAN:...with the governors and the states, with sympathetic Republicans in both the House and the Senate and I think they were trying to limit the image that would come across if they were trying to cut women and children and seniors.

SMITH: Was there any of a kind of a sense that they understood that it was more grief than they would like to deal with?

WAXMAN: I'll give them the benefit of that doubt.

SMITH: Yeah, yeah.

WAXMAN: That's right.

NELSON: But I think the point made right at the start, they had a big backlash on the big cuts that they took out of Medicaid and they felt that and they knew that they had somebody here who was going to make them feel it if they continued to push that. But we also don't remember that they were that easy to get along with, do we?

WAXMAN: They were not easy to get along with and they only came around most of the time very grudgingly because they had too much invested in the whole bill by that point. That's why Medicaid was often the last thing to be resolved.

SMITH: Back just briefly to—

WAXMAN: But it is again that irony of what they did in '81 that caused them to be fearful to go after Medicaid. It wasn't until the Republicans took power here in the House in 1994 that they thought they could try to come back with a block grant for Medicaid. But in that time between, most Republicans realized it wasn't worth it.

SMITH: Back just briefly to OBRA 81, one of the big changes of course it made was to put in the 1915(b) and (c) waivers.

NELSON: Home and community based.

SMITH: The home and community based and the so-called freedom of choice waivers.

WAXMAN: Oh, yes.

SMITH: And again—this is from reading Stockman and some other people back in this period, it sounded to me as though they were quite willing in exchange for some cuts to give a great deal of freedom to the governors to rearrange these programs.

And someplace I read that it was largely at your initiative that these became not just simply a statement of do what you want with these programs, but that you are going to have to do it with waivers if you do it, and that you were largely responsible.

I mean, that's not the way things are generally perceived, but the waivers were actually a way of setting some limits on what might have otherwise happened.

WAXMAN: Sure.

SMITH: And you were a big supporter, actually, of these waivers.

WAXMAN: And we wanted these waivers because, for example, in the nursing home area we didn't want people put into nursing homes if they could get community services. And we put limits on it that [it] couldn't cost more than it would cost if they were in a nursing home and they had to be eligible to go into a nursing home. We put limits because the Republicans wanted to be sure this wouldn't mean a lot more people got covered, and a lot more money spent.

WAXMAN: —they worried more people would be eligible for community care. But we wanted to start moving away from just paying for nursing homes. And in doing that we didn't want states to come in and have the complete flexibility to take away the entitlement from people who had. This is, of course, what the Republicans have always wanted to eliminate that entitlement. If you give them just a chance to eliminate the entitlement through a waiver, they would come in and ask for waivers. I ended up fighting the Oregon waiver, for example. They wanted to be able to avoid the entitlement program in order to rearrange the money to cover more people, additional people, but with less services. And I just thought that was a very bad trend. And we're seeing that trend elsewhere, or at least the attempt elsewhere by governors to avoid the essential requirements of Medicaid, which is the entitlement.

SMITH: Uh-huh. One of the things I wanted to ask you a little bit about was the whole AIDS controversy. And of course, certainly if there was anybody out on the West Coast that really stepped up to the plate and did something, you are certainly seen as that person. There were separate initiatives on the East Coast.

What do you think kind of turned things around on AIDS? For a long time we weren't getting anywhere at all. And then comes a time when there is a kind of a breaking and things begin to happen.

WAXMAN: We had the first hearing on what we now know to be AIDS—we didn't have a name for it at that time—in 1981 in Los Angeles because the

first cases were emerging at UCLA Medical Center of gay men coming down with Kaposi's sarcoma, which is a rare cancer.

And it was multiplying very fast in L.A., San Francisco, New York, other places around the country. The Centers for Disease Control was tracking it. So we went, held the first hearing on it. The first of many, many hearings were held here in Washington about this disease.

It was interesting that the public initially thought of this as only a gay plague and it didn't get a lot of attention to it. We held hearings. People within the Reagan Administration at the Department of Health and Human Services understood that this was a serious health matter.And they wanted to put more money into research, to find out what was happening and to try to deal with the epidemic in a clear, sensible, public health way, acknowledging the fact that this was a population that was first afflicted by AIDS that needed to have some assurances of privacy and confidentiality in order for them to come in and get tests and respond to care.

We had very strong support from Dr. Ed Brandt, Assistant Secretary of Health, and Dr. C. Everett Koop particularly, who emerged as a real giant in this whole controversy. At the same time, ironically enough, the ranking Republican on our Committee for a period of time was Representative Bill Dannemeyer and he became monomaniacal about this issue because he was so strongly against homosexuality.

SMITH: Yes.

WAXMAN: He wanted to take people who had AIDS and isolate them. He wanted to have a list of everybody who had AIDS. And he wanted to make sure that we incarcerated them so they wouldn't infect anybody else. It was very punitive, a very punitive approach, one that all the public health experts said would—could be counter-productive.

SMITH: Uh-huh.

WAXMAN: And we had to deal with him because every single hearing he raised the same issue: Why aren't we keeping a list of everybody? Why aren't we making it public? We aren't we dealing with this on a law-enforcement basis?

But we held hearings, we tried to get legislation through for years. And at one point we did get a bill through. Senator Hatch was now chairman over

at the Senate side and he and I agreed to legislation. I think this is accurate.

And then Senator Helms, Jesse Helms just said he would filibuster it and put a hold on the bill; and it died. I am still so angry about it. Not only was he against it but the fellow at the Reagan White House on domestic policy was Gary Bauer.

SMITH: Oh, yeah.

WAXMAN: And he is very much tied into the religious right. He was against this issue because of the homosexual population being involved. I don't know who advised President Reagan. I expect it was Gary Bauer. But President Reagan wouldn't even mention the word AIDS for years, even though this epidemic was expanding...

SMITH: That's right. It's interesting here. I don't know whether this little historical detail will mean anything to you but you might find it interesting. I did interview Ed Brandt and he said that Reagan really wasn't quite the ogre that people thought that he was.

He said several times Reagan had actually approached him or approached other people in Public Health Service and said, "Should I make a statement about this?"

And they said, "Well, we are trying to keep it as uncontroversial as we can and kind of low-profile it. And we were afraid that if you make a statement it will produce such an uproar that it might set things back." Now, that may not make sense but anyway—

WAXMAN: Well, if that were the case I think he got bad advice.

SMITH: Possibly so.

WAXMAN: The country certainly needed leadership. The turning point in the AIDS issue was when Rock Hudson had AIDS. And I remember that I was invited to go on a Sunday television interview show with the caveat that if it turned out—because they were going to announce the next day or so whether Rock Hudson had AIDS or not—that if he didn't have AIDS they didn't want me on to talk about the AIDS issue.

They only wanted to cover it if Rock Hudson had AIDS because then there would be a lot of attention paid to it. Well, that certainly increased the public awareness of AIDS. But I think Elizabeth Taylor made a huge difference in getting President Reagan to come to a dinner of AMFAR here in Washington. I don't know if it was the last year he was in town, I think.

And he finally talked about AIDS and his concern about doing something to stop this epidemic.
We didn't get the Ryan White bill through until Bush was president, right?

NELSON: I think that's right, 1990.

WAXMAN: And the person who deserves an enormous amount of credit on this issue is Tim Westmoreland. He was on my staff throughout this whole period of time and was in very close contact with the medical community here dealing with AIDS: Dr. Faucci at NIH, the gay organizations.

One of the remarkable things to me was the way that groups like Act-Up, which were really rattling the cages of FDA, ended up being so impressive, because they ended up learning the FDA law so that they could lecture the FDA as to how they could get drugs out to people who desperately needed and couldn't wait for final approval.

SMITH: Well, that was an extraordinary performance, I mean, the efforts made by the gay community in this whole business.

WAXMAN: Right, yeah.

SMITH: Let’s segue rather quickly to a few other questions. One is, I did want to ask you one kind of technical point. Did the budget reform act of 1990—did that—was that a big obstacle in your path when they said that you had to offset expenditures with savings within this entitlement? If you're spending for this entitlement you have to find a way to offset it within this entitlement.

WAXMAN: Within the entitlement itself?

SMITH: Yeah. Or from the entitlements, maybe from the entitlement part of the budget. But the question narrowly was: Did the budget reform act of 1990, did that become a big obstacle to you?

NELSON: I don't really remember it simply because we always had to have either a savings or an acknowledgement of being able to spend in a program like Medicaid.

SMITH: The pay go element.

WAXMAN: Yes.

SMITH: And one person said they had to put the pay go in as a way of trying to hold down Congressman Waxman.

WAXMAN: By 1993 we had President Clinton in.

SMITH: This was 1990.

WAXMAN: In 1993 and we're dealing with a reconciliation there with a friendly administration and a Democratic Congress, but nevertheless a budget that barely passed in both houses.

SMITH: Yeah.

WAXMAN: Was it the budget or the reconciliation that barely passed? I guess it was the reconciliation that became the difficult item. We ended up getting money out of Medicaid and through some limitations governing the transfer of assets—

SMITH: Uh-huh.

WAXMAN: ...in order to pay for some of the improvements that we made. And we covered more people in Puerto Rico. And what else did we do at that time?

SMITH: Okay. Well, could we just ask you one brief one, Mr. Waxman? And that is: What do you think we should be doing about Medicaid now?

WAXMAN: Well, the first thing is, don't do any harm by block granting the program.

SMITH: Right.

WAXMAN: This is a very, very bad idea and this administration has been trying to entice the states into a Faustian bargain to give them a little bit

more money up front and then to doom the program for the future. That would be a terrible decision and I think we are going to have to fight that one back again this year.

I think we have to help the states by giving them some flexibility where it makes sense and—most importantly—more money.

SMITH: Yes.

WAXMAN: That seems to me the choices that we have if we are going to have a viable program, to not increase the number of uninsured by throwing people off Medicaid and making them part of a long list of the millions that are already uninsured.

SMITH: Right.

WAXMAN: If we had not had these Medicaid expansions there are millions and millions more that would be uninsured. And right now we are still looking at 45 million or thereabouts.

SMITH: Well, I want to thank you very much. Very kind of you to take your time with us.

INTERVIEW WITH ALAN WEIL
JUDY MOORE AND DAVID SMITH – JULY 2, 2003

SMITH: This is an interview with Alan Weil by Judy Moore and David Smith and the date is July 2, 2003. One of the first things that we'd like to ask is a little bit about your background and how you happened to get into Medicaid and Health Policy.

WEIL: I came into Health Policy by accident. I have always been interested in social policy: welfare, employment, social supports for low-income people. I graduated from Harvard Law School and the Kennedy School of Government and thought I would do public interest law. The market at the time was abysmal and even finding a public interest job was almost impossible.

SMITH: When did you graduate from law school?

WEIL: 1989. I spent about a year doing computer programming to buy some time until I could find something that fit my training and ended up in an unusual position at the Massachusetts Department of Medical Security. DMS, as we were known, was created in the Dukakis administration to implement universal health insurance in Massachusetts, which was a major policy initiative of Governor Dukakis.

We were a small agency. I would guess we were in the twenties in terms of numbers at our peak. But we were trying to do something extremely innovative, which was figure out, based on legislation that had been passed, how to structure what was called a "pay or play system," where employers had to either provide health insurance or pay a tax that would be used to enable the state to provide people with health insurance.

The mandate—although we avoided that term for reasons of federal law which prohibited states from imposing mandates—the mandate was never implemented. But the so-called mini-mandate, which was one percent of the big mandate, did create funding for people who were collecting unemployment compensation to obtain subsidies for coverage.

We also had a mandate that students be covered. We administered the states' uncompensated care pool, which transferred dollars from hospitals that provided a small amount of charity and bad-debt care to those hospitals

that provided much larger amounts. So we did a lot that was geared toward preparing a state for universal coverage, although it never got there.

SMITH: It's also good training for Medicaid.

WEIL: It's good training for Medicaid. I was in a position that, because it was such a small agency, I sort of got to learn a little bit of everything. The agenda was health although my position was part legal, because I was trained as a lawyer, and part computer programmer, because that's what I had been employed to do.

I got to see the range of policy-making. So—a long answer to your question. But I took sort of a general interest in social policy, and my first job ended up in a health care position, and I found it so fascinating, I have stayed in that field.

SMITH: Well, from the word go you had to worry about putting numbers and institutions together which is not a common skill.

WEIL: Well, you know, the Uncompensated Care Pool is a remnant of the days of rate-setting, Massachusetts being one—at the time I think we were down to four states in the country that had rate-setting systems. A completely different model of cost containment than the dominant model today—which is all about competition.

In a rate-setting system, the state establishes what different payers have to pay and can explicitly create margins that some payers have to subsidize to cover the cost of other payers. It's an explicit form of reallocating the resources.

When you move to a competitive system you leave all that to the market and the market squeezes out margins. So the notion of the government being responsible for cross-subsidies to make it possible for poor people to get health care, even if they don't have health insurance was sort of something we thought of as normal at the time, although today it would be quite abnormal.

SMITH: Then what about the next phase, your Colorado experience?

WEIL: I was actually only in Massachusetts state government for I think about a year and a half. There was a new administration. Governor Dukakis had run for president quite unsuccessfully. There was a new administration.

Both the Democratic and Republican candidates for Governor had run on a platform that included repealing the Employer Finance Pay or Play System. So it almost didn't matter from a health policy perspective who was elected. But in the end it was the Republican, Bill Weld. He brought in a new commissioner and part of the agenda was to dismantle or at least wind down what we had been gearing up to do. So it was a big transition for us.
I moved to Colorado and first went to work for a small non-profit called the Colorado Children's Campaign that did advocacy on children's issues. But within about six months I moved in to Governor Romer's office. Now, Governor Romer was about to become the chair of the National Governors' Association.

And just to place the context, which I think is the most important part of any of these stories, U.S. Senate candidate Harris Wofford had been elected on a platform of if the government guarantees criminals a lawyer, why don't we guarantee sick people a doctor? He said it more artfully than I just did. But he demonstrated the political power of universal access to health care as a political issue.

Bill Clinton had not yet been elected when I started working for Governor Romer, but he subsequently was and then made health care a major agenda item. Governor Romer saw the ascendancy of the health issue. And you have to understand, Colorado state government is not like the well-resourced governments of, for example, Massachusetts that I had come from.

He had a very small policy staff and so to dedicate an entire position to health care was quite unusual. But he created a position for someone to focus just on health care and I came into his office to fill that role.
Now it gets fun because Governor Romer becomes chair of the National Governors' Association. States start talking in very ambitious terms about coverage. Bill Clinton is elected and talks about universal coverage at the national level. And we have what at the time seems like a tremendous opportunity to move health policy forward dramatically.

Colorado is not a state one thinks of as being at the vanguard of social programs. It certainly is at the vanguard of some things, but it is a low spending state. It's a politically conservative state. We were talking about universal health insurance and we were doing it along with states like Minnesota and Washington and Massachusetts—well, Massachusetts sort of peaked a little early on that discussion.

But we were a leadership state in this policy area. So it was a very exciting time at the state level. Meanwhile, the national discussion is heating up, and so this is a very exciting time to be in health care.

SMITH: Well, I guess we can kind of move forward from that. We all know about the huge debacle with the Clinton health proposal. And then you get the new Congress and generally an assault on entitlements and the block grant controversy. Maybe you could say something about that.

WEIL: Yes, I certainly won't do the story of the Clinton plan; it has been told. But I think it's important if one is going to talk about the Medicaid block grant effort to recall that it was in the wake of this major effort of expansion.

And just two years into the Clinton Presidency you have a new Congress coming to town with a new Republican majority in the House and the Senate. Is that right? You have it in the Senate for two years and then they lost it again I think—and then returned. You also for the first time in a long time had a majority of Republican governors—just a bare majority, but you did have a majority. In fact, the Republican Governors' Association changed their letterhead after the election to say the Nation's Majority or something like that to make it clear that they were—but also I would have to look at the records here to get it right.

There was a point there where nine of the ten largest states had Republican governors. So this was not just a Midwest phenomenon, this was a major shift, a major political shift.

So I will tell the block grant story from my perspective. And I know I have told it to some people who don't share that perspective but all I can do is give you mine.

SMITH: All right.

MOORE: Okay.

WEIL: The new Congress came in. Now I need some help here. This is 1994. The 104th Congress.

MOORE: It would have started in January of 1995.

WEIL: January of '95.

SMITH: Right.

WEIL: And there's the "Contract With America," which includes as a major plank balancing the budget. We had decades of deficits and the Congress looks at the budget and says the only way to bring it into balance is to reduce the rate of growth in the major entitlement programs that are growing faster than our revenues are growing. And Medicaid is really on that list.

Now, the problem is, you can count on two hands the number of members of Congress who know much about Medicaid. And at the time you can count on less than one hand the number of Republican members of the House who know anything about Medicaid. This is not meant as a partisan jab, it's simply a reflection of the relative policy priorities of the different parties.

Medicaid had grown while no one was looking or very few people were looking. It was no longer just a poor people's program and a welfare program. It was not at the heart of the Republican constituency. Most of the changes to the program had been led by a very small number of Democrats who were paying attention.

And suddenly you've got Congress trying to make major changes to this program and they don't have a lot of institutional knowledge to draw upon. So they have to turn to the Governors because after all, the states are the ones who actually run the program.

Unfortunately, the Governors don't have a whole lot more understanding of this program than the members of Congress. Medicaid, at the state level just like at the national level, had grown without people really focusing on it.

They knew it was costing a lot of money but the expertise about how the program was run far fell short of the share of budgets that it commanded. And you could look at any other area of the state budgets that came close or had a fraction of the size of the budget and the amount of the state legislative committees, the administrative staffing, the attention in the Governor's office would have been much, much higher. So this was really a program that not a lot of people knew very much about.

So Congress, the Republican leadership of Congress, turns to the Republican majority of Governors and says, in order to balance this budget we need to make major cuts in the rate of growth of this program. And at the time, the budgeting horizons were ten years. And by the tenth year, in order to meet

the balanced budget target, Medicaid had to be one-third smaller than was projected under law at the time. Over the period of ten years, it needed to be about a quarter smaller but by the tenth year we were looking at a program that was one-third smaller. Well, Medicaid cannot be run for two-thirds of its current budget without major changes either in who it covers primarily or what it covers.

All the talk of efficiency and streamlining, you know, maybe can get you some percents here and there. And when you're talking about a program this big, a few percent is a lot of money, let's not kid ourselves. But if you're trying to save a quarter or a third of the budget you can't just do that at the margins.

And so when the Congressional leadership went to the Republican Governors, the Governors said, if you need budget targets this low, you are going to have to just give us the money and let us do the best we can with it. Now, we think we can do pretty well with this and we're actually kind of excited about the flexibility and the opportunity it would create.

SMITH: Was this certain leadership states? Because some states—it seems might look at that and say, no, we can't, but other states which are more powerful and can move around their institutions and raise money.

WEIL: Well, I would like to think that the response was sort of that orderly, but I don't think it was.

SMITH: Right.

WEIL: First of all, the grants were heavily front- loaded so in the early years many states expected to have more money than they would have under current law.

SMITH: Under the proposal.

WEIL: In addition, because after all, the goal is to balance the budget seven or eight years out, so it didn't matter how much you spent two years from now. We knew we would be in deficit two years from now. Of course, it turned out we weren't because the economy got better so fast. But the thinking was, you know, spend the money now and then on the back end it will be okay. In addition, the Congressional Budget office which was responsible for giving the gold seal of approval on the notion that this

budget was going to be balanced seven or ten years from now, was anticipating a rate of growth in Medicaid.

I can't remember the exact number but it was in the nine-percent range. And if you went to the states, most of them thought their programs were going to be growing around six percent. So in fact you could take a lot of money out of this program and states thought they could afford it. We really had a gap between what the national government thought the program's growth rate was going to be and what the states thought. So that gave states a lot of confidence that they could manage the program with this budget. But fundamentally, I think we have to see this as a combination of ideology and budget politics. I mean, there was a sense that the states were the right place to make these decisions. The states are closer to the people.

The Governors didn't like seeing this program grow and use up the dollars that they wanted to spend on transportation and building prisons and building highways. They were frustrated with this program and even if maybe in the back of their minds they had some nervousness about what the program would look like if the federal government wasn't continuing to put money into it at the same rate, they just saw states as the right place for the decisions to be made. And I have to say, I think the level of understanding of how the program actually operated was very low. And so the Congress for the first time was coming to the governors and saying, "You tell us what you need to make this work."

I mean in the past it was always the Democratic leadership of Congress saying we're going to tell you how this program is going to run. And now we had a Republican majority saying, "Governors, tell us what you need to make this program work." And it's very hard to walk away from that.

SMITH: Right, right.

WEIL: And particularly the Republican governors, who saw this as part of a national movement, wanted to be helpful and supportive. So there was a whole political ideological side here that was extremely compelling to the Republican Governors, but also pretty compelling to the Democratic Governors. And that context, I think, is critical to understanding what happened.

From my perspective, the partisan aspects of this are critical. There were early conversations between the Republican leadership and Congress and

the Republican governors and the staff to the Republican governors. And they were very involved in the crafting of the initial legislation. The Democratic staff were not. And I can say that with a great deal of confidence—having been one of them. It was only when the National Governors' Association decided that they were going to get involved and attempt to build the bipartisan consensus that the Democratic staff were involved in these conversations. And then the Democratic Governors were involved in those conversations.

There were spreadsheets that had allocations of dollars by state that were created by the Republican staff that the Democrats never saw. And, yes, the initial drafts of the legislation were built with the input of Governors, but only Republican governors. I can state that with a great deal of confidence.

What I can't say off the top of my head is exactly—as we were just discussing—whether the first bill that included block grants had been passed and vetoed by President Clinton before or after the NGA got involved in the process. But at a certain point it became clear when President Clinton basically said, "I'm not, you know, into these block grants."

MOORE: For Medicaid.

WEIL: For Medicaid, that the only way that anything really was going to change with Medicaid was if there was a bipartisan effort that included a bipartisan team of Governors. And a task force of six Governors, three Democrats and three Republicans, was created to try to develop a compromise position on Medicaid.

I was staffing Governor Romer at the time. He was one of the three Democratic members. We—and I mean the principals, the Governors themselves—met an incredible number of times for well into the hundreds of hours trying to craft a compromise. I think there was a genuine desire to do so despite the fact that there were some genuine differences between the Republican and Democratic Governors in their views.

MOORE: What Governors were involved in this?

WEIL: On the Republican side it was the current [HHS] Secretary, Tommy Thompson. It was the Governor of Michigan John Engler and it was the Governor of Utah Mike Leavitt. On the Democratic side it was my boss, Governor Romer. It was Lawton Chiles of Florida and it was Bob Miller of Nevada.

Miller and Thompson, I believe, at the time were chair and vice chair of the NGA. Romer—and I can't remember now whether it was Leavitt or Engler, were the chairs of the health group that was a residue of the time of the Clinton Health Plan. The other two Governors were brought in.

I've forgotten exactly what their reason for inclusion was. The fundamental challenge was to come up with something the bipartisan NGA could endorse. You have to understand, the Governors like block grants at least in the early years because there are relatively few strings and there is a lot of money.

They know that over time there will be less money and there will be more strings but they don't know how long it will be before that happens.
And so the Governors came into this process really thinking we can work this out. Meanwhile, the Democrats in Congress and in the Administration were trying to figure out what's an alternative approach that can get some budget savings that isn't a block grant. They came up with something called per-capita caps.

SMITH: Yes.

WEIL: The concept behind the per-capita cap was you get so much money per person in the program so that at least if we have an economic downturn or a new disease that brings people in, the money will follow the people. Now, setting the inflation rate for how much you should get per person is very hard.

Deciding what the right number is by state is very hard. Figuring out what to do with disproportionate share hospital programs that have nothing to do with individual enrollees is very hard. There are a lot of tough issues with per-capita caps but that was the alternative model that was being floated. And what the Governors essentially tried to do was compromise between block grants and per capita caps. And what they tried valiantly, I believe, to design was something that in essence gave them a solid base of funding with a solid commitment to the federal government of a population they would cover and what they would cover them with, with a protective formula on top to make sure that if enrollment went up too high there would be additional federal matching funds available.

My boss Governor Romer talked about it as an umbrella of coverage, sort of the federal government in essence almost insuring the states against this risk. Now marrying a block grant base with a per-capita insurance policy on

top involves a level of complexity not far short of the Clinton Health Plan, without the benefit of providing universal coverage.

Conceptually, it kind of makes sense. I wouldn't want to bless it with too much logic. Politically it was, I think, an honest legitimate effort, a compromise. How you would actually do it I think would be very, very difficult if we ever tried to do it in practice.

Now comes the fun part. The Governors come out with their consensus and actually achieve, as I recall, unanimous agreement at the NGA meeting among all 50 Governors endorsing this proposal.

MOORE: But how detailed was the proposal? Was it written out? I mean, was it two pages or 22 pages or what?

WEIL: I was going to say I remember something like four pages. It was not 22 pages. And, you know, what ends up happening is the Governors adopt policy.

MOORE: Right.

WEIL: And that's really the only formal statement the Governors can make. And the NGA policy is certainly a matter of public record. There were documents behind it that go into more detail. But, no, it was a fairly general statement. Now the document or the policy sets in motion a very tense political process.

The Congressional leadership introduces a bill and holds a hearing on their bill. The title of the hearing is, "Hearing on the Governors Bipartisan Medicaid Proposal." But the bill that they introduced was the same block grant proposal they had introduced before.

As I recall, they had passed and President Clinton had vetoed, in part launching the Governors' bipartisan process. So the Congress is [not exactly] taking the Governors' efforts here. We then are faced with this tremendous political challenge which is: How do you tell someone that what they are doing—when they are telling everyone they are doing what you want—isn't really what you want?

And after all, from the Republican Governors' perspective it was exactly what they want. So they were happy to follow along. Meanwhile the President

and some of the Democratic leadership in Congress are saying to the Democratic governors, "You're hanging us out to dry."

You signed on to this thing that is now being presented as what you agreed to. I, the President, stood out there and said, we won't live with this. You now have agreed to it and you are going to undercut us politically in a way that is very damaging. And the stakes here are tremendous, politically and substantively. Well, to make a long or at least a painful, complicated story short, we—and in this sense I mean, we the Democratic staff and Democratic Governors—went through the legislation and tried very hard to compare its provisions with what we felt we had agreed to in this process and found tremendous differences.

Now, to someone who isn't expert in Medicaid it probably looked like nit-picking, but given what was at stake, the budget, the scale of the budget, this whole—I mean basically, the proposal did not include the umbrella. It sort of had a little hand waving at this umbrella, but there was no open-ended commitment by the federal government to participate, if the cost of meeting the needs was greater than what the state resources were.

And the three Democratic Governors—and this will sound very familiar with what just happened in the last few months here in 2003—the Democratic Governors ended up sending a letter to the leadership detailing the ways in which the proposed legislation did not meet the agreement the Governors had entered into.

And it led to some pretty partisan sniping and the Republican Governors saying that the Democrats were backing away. The members of Congress not necessarily being expert in Medicaid, not even understanding necessarily why what looked like small issues were really deal breakers—and slowly, I think the Democratic Governors were able to make clear that what had been proposed was not what they had agreed to. Congress still ultimately passed a Medicaid block grant bill.

My recollection is that Clinton twice vetoed bills that had been passed that included welfare reform and Medicaid block grants. And the third time Congress sent him a welfare reform bill without a Medicaid provision and he signed the welfare bill. So my recollection is that there were two vetoes of Medicaid block grants.

SMITH: Well, he vetoed the CR and then he vetoed the Balanced Budget Act.

WEIL: So he only vetoed that once and there was never a—

SMITH: He only vetoed the BBA one time but he vetoed a CR earlier.

WEIL: Yeah, but the CR wouldn't have included presumably a Medicaid block grant or welfare reform.

SMITH: It would have backed him into a position strategically where he would have been much weaker than otherwise I think.

WEIL: Okay, but substantively it didn't include the block grant.

MOORE: In talking about this, you've talked about the hearing and the negotiations and so forth and it sounds like you are talking more about things happening in the House with the House leadership. Was the Senate as engaged in this as the House was, in your memory?

WEIL: Well, the block grant legislation was drafted by Howard Cohen and he was a staff member on the House side. Speaker Gingrich was, you know, the force behind much of this. And so I think it's fair to say that the leadership on this issue came out of the House side.

Now, the Senate, of course, was involved. But I think, you know, when you're talking about the Balanced Budget Act, of course both chambers were involved. But that included changes to so many programs that I think it's fair to say that the Medicaid provisions were primarily influenced on the House side. Let me add two personal stories. One, is I recall sitting in a meeting where the Governors, bipartisan Governors, met with House Republican leadership and were basically told, "You can do whatever you want with this program so long as you meet our budget."

The direction was really very clear. There was no—and I want to emphasize this—there was no substantive interest in this program.

SMITH: Right.

WEIL: There was only the question of how changes to the program could feed into a balanced budget which would have been and was a huge triumph for the new Congress coming into power. And the notion that really —the rewriting of the Medicaid statute was left entirely to the Governors, or at least the leadership said they were willing to leave that rewriting entirely to the Governors, is in my mind astonishing, and a little terrifying.

And although I think Governors—I've worked closely for one and I have interacted with many, and I hold those I have interacted with in very high regard. Governors are not the only interested party when it comes to a Medicaid program. And so to say that you are going to turn that over to them, particularly when their budgets are so much at stake, I think was a very telling statement.

Now just to share the joy of the process, I should also say that the Democratic Governors were publicly rebuked by the late Senator Moynihan when they came to the Senate Finance Committee and said, "This proposal does not match what we agreed to in our negotiating process."

And Senator Moynihan as much as said, "You've just got cold feet. You entered into this. You made your own bed here and now you're trying to tell us that this isn't what you agreed to? I know these programs. I read your policy. This looks a whole lot like what you agreed to."

And the Democratic governors had to work very hard to convince even the leader of their own party that they really had agreed to something else. And I think Senator Moynihan had a point. The Democratic Governors actually agreed to a policy that very fundamentally changed the Medicaid program and a fair reading of the proposed legislation would suggest that Congress did do about 90 percent of what the Governors had agreed to.

And then when the political heat got high the Democratic Governors made a whole lot of hay out of the 10 percent. And the 10 percent was real but it was only 10 percent.

And I think anyone who is looking back on this needs to acknowledge that the Democratic Governors got way out ahead of their party and their President and agreed to fundamentally redoing this program and then had to say, "Oops. Gulp. We might actually get what we asked for or at least very close to it," and had to make a lot out of the pieces that were missing.

SMITH: Yes, so it was about then that the AHA had a big campaign on to try to save traditional Medicaid. And according to their reports they were getting a lot of noise from Governors from the states.

Some of them saying, this thing may not be as good as it looked. And I'm hearing from a lot of my constituents down here that they don't want to see these programs threatened. So there was a campaign that might have changed a few minds in there.

WEIL: Well, again, I think the Governors started this process having historically paid a relatively small amount of attention to this program. And one of the things you learn the longer you work on Medicaid is, you know, there are tens of millions of people who rely on this program.
And when they think it's threatened—including some politically powerful constituencies, not very weak constituencies but very compelling stories—and when the program is threatened they made their voice heard.

I would feel remiss if I didn't add one more piece to the story. I feel very confident in my presentation, that the impetus came from the desire to balance the budget.

But I would being doing a disservice to the Republican Governors who put so much energy into this if I did not acknowledge that while the debate began as a budgetary issue, it very quickly became an ideological substantive interest to the Republican Governors along the lines of welfare reform, where—although they probably hadn't been thinking about Medicaid block grants just a year earlier, when the budget situation forced them to think about changes and then they started thinking about block grants—they got kind of excited about them.

And a lot of Democratic Governors did as well. So what I want to be clear on is that the sustained gubernatorial interest in converting this program to a block grant, or something very close to it, was a genuine reflection of substantive and ideological positions that Governors held, long after the budget motivator for the discussion went away.

SMITH: Well, that's kind of a good introduction to another question that I wanted to ask you. Here you've got the situation in '95 and spilling over a bit into '96 and even beyond.

How would you explain some of the differences in the Governors' response in 2002 and 2003, where they came out with a proposal, then the Administration adopts it or adopts it with some changes, and now they are not so enthusiastic?

WEIL: Well, I don't agree with your characterization but I actually think that the process and the outcome are surprisingly similar between these two eras.

SMITH: Yes.

WEIL: The governors had a proposal a while back but the fundamental glue that held that proposal together was a huge federal infusion of money into the program.

SMITH: Yes.

WEIL: Enhanced matching rate for different services. A federal assumption of financial responsibility for dual eligibles. Depending on how you read it, multiple tens of billions of dollars of money to the states. If the President had proposed that, I think he would still have the governors behind it.

But he didn't and Congress didn't. In fact, to the contrary, they made it quite clear that they weren't even the least bit interested in that aspect of the proposal and you can't call the proposal similar if there is 40 billion fewer dollars on the table.

SMITH: Yes.

WEIL: And when I say 40 billion I'm talking about a year, not over ten.

SMITH: Right.

WEIL: What the governors really proposed was a fundamental change in the fiscal responsibility for this program—a change, by the way, that I endorse. And two colleagues of mine and I in two weeks will have an article in Health Affairs taking that very same position. But that is not at all what the President proposed.

What the president proposed was something that was budget-neutral and an optional block grant. But I think that the Governors' recent process was surprisingly similar with the one exception: that the Democrats in Congress were more ready for it this time.

And so they started telling their Democratic Governor colleagues right away, this is not a path we want you to be on, whereas last time around it took a Presidential veto and a little learning before that happened. But the positions of the Republican and Democratic Governors in this process don't sound too different to me from the positions of Republican and Democratic Governors a while ago.

If you can structure this in a way that gives us flexibility and enough money, we're for it. The Republican Governors are willing to accept a cap on the federal appropriations for this program and the Democratic Governors are not.

The Republican Governors are willing to accept a fairly substantial rollback in the federal government's commitment in terms of who will be covered and what will be covered. I think many of those Governors are willing to accept a smaller Medicaid program even understanding that it means fewer people covered or fewer services covered.

Meanwhile, the Democratic Governors are less willing to be a part of something that says the federal government's decisions about who will be covered and what will be covered will be rolled back. So I think the positions are fairly similar to the ones taken in the past.

And in fact to me the primary difference is, that the Governors felt apparently enough pressure to reach consensus back in the mid-'90s that they did, even papering over some differences, but then re-emerged when it got to the point of legislative language. This time the Governors, for whatever reasons, were willing to call it a day when they didn't get there.

And I'm sure both sides point the finger at the other. I wasn't part of this recent process at all so I don't really know. I'm not sure. When negotiations break down you really can't point fingers here. If they couldn't agree, they couldn't agree.

SMITH: Right. We were talking with Howard Cohen a little bit earlier and he didn't particularly mention the chunk of money that was available in the proposal, although the budget-neutral aspect was a strong item.
But he also seemed to think that amongst the Governors there was more of an attitude that we're a little bit more aware of what the entitlement aspect of this thing means. I was struck by one Governor, Ed Rendell, saying,

"Well, it looks pretty good until you get down toward the end and of course the end of this will be after I'm out of office." But that doesn't really seem to be the way a governor ought to behave.

So can institutions learn? Do you think there was any kind of learning on the part of the Governors, that they maybe saw the Medicaid program with a little more understanding of some of the things? You'd like to think so.

WEIL: Look, the huge difference between the mid-'90s and the latest run is that in the mid-'90s Medicaid block grants were proposed with a 25- to 33-percent cut against baseline.

SMITH: Yes.

WEIL: And the block grants that were proposed this time had no cut. They were budget-neutral. They added a little front loading and then it was taken back at the end. That fundamentally changes how you start thinking about the program. I think that in '95, after a couple of years of 20- plus percent annual rates of growth in this program, Governors thought this program is out of control.

Governors said, “I am a manager. I run other programs in my state. Don't tell me I can't do this better. The only way that this program could be growing so fast is if it is completely out of control. And I know how to control a program.”

Now, what the Governors didn't quite understand at the time was that a lot of the reason—a lot of why the program was growing—was because their staffs or departments were making conscious decisions to convert what had historically been state-only programs into Medicaid programs, and thereby obtaining a federal match.

The disproportionate share hospital program was growing rapidly. Yes, there was a new mandate of coverage. But if you look at the numbers and the people, that does not account for double-digit growth. There was also, of course, growth in the health care sector as a whole at that time.

Now, what I don't know is what has changed between then and now. But I think the rates of growth in the prior years had been so dramatic that the Governors just took it as an article of faith almost that they could run this program for less.

SMITH: Right.

WEIL: Now, you come to a period where, okay, Medicaid growth now is back into double digits for two years but we went through a period of very low single digits and then moderately low single digits. The Medicaid program did not look out of control.

States were expanding Medicaid. They have the SCHIP program that they are using. They have waivers under HIFA that they looking at. This program is not viewed as an out-of-control program. It's viewed as an expensive program.

SMITH: Right.

WEIL: State budgets are in crisis now, not because of Medicaid growth, but because of revenues falling off. And I'm sorry, changing Medicaid isn't going to reverse your loss of revenue.

SMITH: Right.

WEIL: So you just can't look at it and say, oh, this is a no-brainer.

SMITH: Right, right.

WEIL: Governors said, "I could do better." Now is that learning? I don't think so. We're talking about different Governors. We're talking about different people.

SMITH: Right, right.

WEIL: This doesn't look like learning to me. This looks like a different environment.

SMITH: Right. Well, I read your piece on why block grants are not a good remedy for Medicaid and it seemed to me it was very, very persuasive. And it particularly underscores exactly what you were saying here that changing Medicaid is not going to be an answer to your problem, that is, changing Medicaid in the form of trying to squeeze money out of it.

WEIL: Well it all depends on your objectives.

SMITH: Right.

WEIL: I believe, and I state this without hesitation, that we ought to have universal coverage in this country, and that if we are serious about it the federal government is going to have to play a major financing role. I'm open to lots of models for the structure of such a system.

I'm open to lots of models for the roles of state and local government, and individuals, and businesses, and all of the other actors that are necessary to make it happen. But I do not believe that this is going to happen without a strong federal role.

The Medicaid matching design is an expansionary design. It's inherently expansionary and we should not pretend otherwise. You tell states the marginal cost of an expansion is 30 cents or 40 cents and they are more likely to do it than when the marginal cost is a dollar.

SMITH: Right.

WEIL: This is not complex economic theory that we're talking about here. This is kind of basic. I believe that we should have systems that build those kinds of positive incentives in. But if you don't share that goal, the first thing you ought to do is get rid of those expansionary incentives and have contractionary incentives.

You want a good contractionary incentive, eliminate the matching structure. It will do wonders for shrinking the size of the Medicaid program. It will also as a byproduct solve some of these fiscal games. Now, I would rather solve them directly. I'd rather look at DSH and upper payment limit, intergovernmental transfers, and change or potentially even eliminate those opportunities and redirect the dollars to something that I think is more productive.

But there is an ideological view that underlies the notion of the matching structure, which says we want to make it easier for states to expand. And if you don't want that, then it is pretty smart to get rid of the matching.

SMITH: In one of your articles you talked about Medicaid as a workhorse, and that seems to me that's more useful as a metaphor than talking about the orphaned child, or the afterthought, and things of that sort. There is also a sense, which I've been kind of struggling with a bit, that Medicaid is kind of as American as apple pie or cherry pie, whichever you wish.

But it's a remarkable program that enables us to take advantage of some of the good impulses that we occasionally have but also protects us from some of the more vicious impulses: it has a nice ratchet effect in it. You do something good and then it's a little bit difficult sometimes to take it back. And maybe we almost need something like that, given the nature of the American political system—and it's a system that is institutionally weak in

terms of leadership. And it's a system which often makes a mess of public/private ventures so that Medicaid could also be viewed as a happy kind of compromise, given the nature of the American political character.

WEIL: Well, I agree. And let's divide Medicaid into two programs and tell two very different stories about the essential role that Medicaid plays. So the first story is of course, as students of Medicaid know, that the large majority of spending in the program is for the elderly population and people with disabilities.

And what even students of Medicaid often forget is that we are approaching the point where 50 percent of spending on services is for people with disabilities, which is a phenomenal statement. Now, what would we do without Medicaid for that population? Who are we talking about here? We are talking about the chronically mentally ill, the seriously mentally ill. We're talking about people with AIDS. We're talking about people who have experienced traumatic brain injuries, who are in wheelchairs fully functioning intellectually, but not physically.

We're talking about people with developmental disabilities, what we used to call mental retardation, who are going to live lives as long as the rest of us but are not going to function at the same level as the population as a whole. We're talking about people with degenerative diseases: multiple sclerosis, muscular dystrophy.

We're talking about such an incredible range of ailments and increasingly chronic conditions where, to be blunt, we are talking about people who 30 years ago and 50 years ago would be dead.
But because of the advances in health care and because of the move away from institutionalization for some populations, we are looking at people who are very much alive and we have to pay for those services that these folks use. And the services they need are outside the budget of any normal family.

And then we can look at the elderly, they get so much attention I don't even want to waste time talking about. Again, a consistent—not a growing portion of the Medicaid program—but growing budget expenditure, because the costs per person are going up, but the number of elderly in nursing homes is not growing, contrary to, I think, public perception.
Oh, the aging population. Well, the average age of entering a nursing home is 85. The baby boom is not yet 85. We are not seeing rapid growth in the elderly population in Medicaid. Medicaid is social insurance against the worst

things that can befall you either in terms of illness or disease or accident at a younger age, or the need to go into a nursing home at an older age.

It is the quintessential insurance policy. And when I hear people say Medicaid isn't insurance they just don't know what they are talking about. Medicaid is the perfect model of social insurance for the most serious things that can happen to an American. And it is there for people of a broad range of incomes; and then we treat you like dirt.

Once you're on, we don't pay providers well. We make you run the gauntlet. We tell you, you know, we don't help you through the system because after all, it's welfare.

So, yes, is Medicaid as American as apple pie? Absolutely. We are compassionate to a point. We will make sure that you get something, but we'll do it on the cheap because we don't want to pay more than we have to, and that is the American way.

SMITH: Right.

WEIL: We are suspicious of people who are needy, but we are also compassionate towards people who are needy. So that is one half or more than half of the Medicaid program. The other half is coverage for moms and kids—inexpensive, millions, tens of millions, and without Medicaid the number of uninsured in the country would be ten or 20 or 30 million more.

Now, in a country that is willing to tolerate 40 million uninsured, it's not obvious that we couldn't tolerate 70 million uninsured. I mean there is nothing magic about 40 million but the pressure on the overall health care system would be greater. And so Medicaid in essence becomes a financing stream to prevent us from falling off the bottom of having a large number of people who are uninsured.

And basically a lot of providers simply take the dollars that they are able to obtain from the Medicaid population, and reshuffle them to try to also cover some needy services for the other 40 million or so uninsured.

We do know that the health outcomes for people who have a Medicaid card are better than the uninsured, so it's not just a financing mechanism for the safety net, but it does that. And here I would simply argue that, you know, this is the typical American welfare program. Again, we are compassionate, but we are suspicious.

We don't want to make it too generous so people like it. We don't want to pay the people who benefit from it very much, but we do want to make sure that people don't fall off the bottom. And I do think that if we had 70 million uninsured the pressures on the mainstream provider system would begin to be so traumatic that other people would stand up and notice, even if they weren't uninsured.

Now, you know, the only way you make Medicaid unnecessary is to adopt a national policy of insurance coverage and a national policy of long-term care coverage. Once you do that you don't need the Medicaid program.

SMITH: Right.

WEIL: But we haven't done that. You may have noticed.

SMITH: Right.

WEIL: And so you need the Medicaid program and you can't take it away. You can't eliminate it. You can't pretend the needs away and there are people like me who will fight really hard against converting it into a block grant because the question is: Are we going to make the commitment to meet those very basic needs?

SMITH: Right, right.

WEIL: To me the answer is obvious. The answer is yes. And I think most people would answer yes. As long as we kid ourselves, or there are people who are willing to kid themselves, that the efficiencies gained from block-granting and getting rid of the federal oversight are so large that there would actually be no consequences to real people for converting this into block grants, then we will have to keep having this debate.

And as long as there are people who don't want to raise the revenue, the taxes necessary to pay for meeting these needs, we will also have this debate. But until we make either half of the Medicaid program unnecessary by broader policies that really integrate the needs of Medicaid beneficiaries with the broader needs of society, then, you know, you need this program.

SMITH: Well, now I'd like to come back to another theme here because when I read this piece of yours in Health Affairs on the nature of Medicaid, I was really struck by the degree to which to me it suggested an awareness of

a healthy tension between federal and state impulses that, in a way, it's good we have the states because it's one way of decentralizing discontent.

But it's also good that the feds are in there because if you leave the states alone, we soon won't like the result. And also related to this, though I don't think you got into this particularly in the article, the sense I get that it is also a good thing in this country if you have a fairly creative tension between the public and the private.

I think of states like Minnesota where you've got strong private institutions, you've got very strong public institutions, and you get a kind of progressive politics that is pretty healthy. And at times when Medicaid is at its best, they get some of that kind of result.

Now, that to me would suggest that for the system to go along with some of these tensions that it currently has might be a good thing, unless we get to national health insurance. And that's going to be another ball game. That's where I'd like to get, too.

You were saying that you were getting ready to publish a piece in Health Affairs in which you talked about some major new departures. So I think we would like to hear a little bit about that.

WEIL: Well, I'll tell you about that but I don't want to gloss over the public/private.

SMITH: Yes.

WEIL: Because in the piece that's coming out—one of the critiques that we got from a reviewer was that we talked about federal/states, but not much time talking about public/private.

The problem for me in talking about public/private is the only serious conversation you can have about public/private is when you look at the whole system. We have a voluntary private employer-based system. It achieves certain things, but when it gets unhappy, it gets up and walks away. That's the system that we've set up.

As long as that is the cornerstone—and it is—of coverage for most Americans, certainly Americans under 65, and as long as it is the normal way people think about health insurance, you can't discuss the allocation between public and private when one side of the discussion is by formal

American public policy empowered to simply expand or contract as it sees fit.

Now I'm not saying that that is the wrong way to do it. Look how much coverage we have based on the system we do have. But it is a very different discussion than a discussion about relative roles of federal/state where we have mostly agreed on what together we want to accomplish and the question is: Who is going to take responsibility?

If you ask me the question in a universal coverage system, "What should the relative roles of public and private be?" I have opinions on that. I'd be happy to talk about them. I won't talk about them now because I don't think they are particularly relevant.

That's, I think, an interesting and important discussion but that's a very different discussion and so that's why I think my colleagues and I, when we focus on Medicaid, tend not to get into the issues of public v. private because it feels odd.Now, what we propose in the paper that is going to come out in two weeks—

SMITH: Who by the way is "we?" You and—

WEIL: "We" is John Holahan, who is the director of the Health Policy Center here at the Urban Institute, Josh Weiner who just left the Urban Institute last week to go to RTI, and I. We are editors of a book called Federalism and Health Policy, which will be published by the Urban Institute Press in three weeks. And in two weeks we will have a paper that draws upon the book, in Health Affairs. First of all, I should say the proposals, although I think they will get some attention, are in my mind less the contribution than the review of the evidence.

And a review of the evidence—and we spent a lot of time reviewing the evidence—is as follows: The current allocation between federal and state has achieved a great deal. We have the Medicaid and SCHIP program that cover millions of people. They have accomplished a lot in terms of reducing the burden of illness and disease in this country.

We have the flexibility that states have. It gives us some degree of experimentation due to variation. But the system falls short in a number of respects from our perspective. One is the variability across the country. You know, you are three times as likely to be uninsured as a poor child in

Texas as you are in Minnesota. What can justify that difference? I can't find a rationale for that kind of difference.

The amounts states spend varies dramatically and in fact in an ironic way: higher income states even though they have a lower match rate in Medicaid, still spend more on Medicaid because they are willing to spend or they are able to spend more. We have tremendous gaps in coverage.

We have 40 million-plus uninsured. The question is: Does the federal/state allocation solve the social problems that we are confronted with?

And I think the answer here is: It has made a big dent but, no, it hasn't solved the problems. Meanwhile, in our looking at the fiscal side we conclude, and history will only tell us whether we're right or wrong, that under the current system, probably the late 1990s were the high watermark for coverage in this country under the system—a local high watermark, not, you know, a global one.

But it's hard to imagine looking in the next five or ten years thinking that we're going to have higher rates of coverage than we had in the late '90s. The distrust between the states and the federal government makes Medicaid hard to build upon, even though in my view it has tremendous strengths, but the fiscal tension is tremendous and destructive.

And the experimentation we get is on the delivery side and it is modest. We have a lot of variability, but variability is not the same as experimentation. Experiment means you learn something from it and you take the learning and you funnel it back into public policy. One chapter in our book focuses exclusively on Medicaid managed care, which we think is a good solid example of experimentation, both the strengths and the weaknesses. States ultimately learned a great deal from each other but they also started so fast, for political reasons, that they were out of the box before they knew what they were doing. And that's the plus and the minus.

But in our analysis state variability is getting us less in the way of true experimentation and learning than it ought to, and the financing side of state variability is really just variability. It's not experimentation. There is no social benefit. Maybe that's too strong but we don't find that defensible, the kind of variability that exists now.

SMITH: It's a useful distinction. It really is.

WEIL: So we are left with a sense that you really need to fundamentally change relations between the states and the federal government. We propose in our paper two options, either of which we think is better than the current. And these proposals are designed to illustrate, not to answer all questions.

We propose a federal floor of coverage of 200 percent of poverty for kids and 100 percent of poverty for adults regardless of family structure. And we propose a 15-percent increase in the federal match rate for all of those populations and allow states to have optional coverage both for populations and benefits beyond that and also get the enhanced match on that.

So we propose basically a federal buyout of the acute care side of the dual eligibles. We basically propose a major increase in the federal share of the program and an increase in the match rate to try to offset some of the state fiscal constraints.

We have no illusions. This is new federal dollars. A lot of those new federal dollars are budget relief for states, but not all of them. There is new money in this proposal, without question. But in our minds, it addresses the variability that we don't think is defensible.

There would still be variability at higher income levels, but that feels to us more justifiable than variability when we are talking about at 40 percent of poverty, where it's kind of hard for anyone to make the argument that people aren't in need.

The second option we propose is to have the federal government take over the program for again, those same poor populations up to 200 percent for kids and 100 percent for adults. Run it kind of like Medicare. If states want to do something on top of that they can but they do it entirely with their own money. But they would have a lot of new money because the federal government just came in and eliminated the acute care side of the Medicaid program. Unfortunately, we didn't really get into the long-term care side of the program. We have some modest initiatives at that level but I think restructuring the long-term care system, again, is just bigger than we can get into in this discussion.

SMITH: What would be the effect of taking over—buying out, you said buying out the dual eligible acute care. Now you buy that out, how? You just simply say we'll pay for that but you leave standards up to the individual states? Or is it like Medicare?

WEIL: No, it would be like Medicaid. It would be run by the states with a full match or, you know, very close to full if you want to keep a little state money in the picture. The point being to provide some real fiscal relief and to change the way we think about the role of Medicaid with respect to the population, of the dual eligible population.

The goal in these proposals is not that we think they should or could be enacted tomorrow but to simply raise the notion of what are we getting from how the state is so much at financial risk for this population. It's kind of hard to see it. The first proposal, the first option, the states still have a major administrative role.

SMITH: Right.

WEIL: And so we gain the benefits of that. I'll say I'm more interested in the first option than the second. Having been close to the Medicaid program, the notion of the federal government coming in and running Medicaid like they do Medicare does not grab me the same way the first option does.

At the same time, Marilyn Moon wrote a chapter in the book describing some of the benefits of the Medicare system and those benefits are real, particularly around equity. And the inequities we have in the system right now are so large, that I'm willing to make some sacrifices to try to improve the equity of the system.

So, you know, if I were given the choice, I would move more towards option one. But I think part of why we include those options in the book, or at least why I was willing to endorse both of them is, I think either one of them is better than where we are now.

SMITH: Well, on your option one, one of the questions that certainly interests me is: Do you think there is really a positive benefit from, say a political standpoint, in leaving more in the states for program development? I mean, one is certainly struck by the innovative record of some of the leadership states. In your first proposal what kind of political benefits might be there?

WEIL: Well, I think we primarily propose it for the substantive benefits which are the notion that state innovation is important. I mean, think of things like risk adjustment, the current innovations getting a lot of play, the patient-directed care and cash and counseling model, the whole home and

community based process and the services covered under that, the primary care case management evolution, the disease management, the pharmacy, and the pharmacy benefit design.

I mean, these are things that came out of the states one by one, two by two, that couldn't happen otherwise. I mean, even the current debate over Medicare prescription drugs. You would think, given the kind of debate, that nobody knows that half the states have already put in place prescription drug benefits to wrap around Medicare. And given the substantive design of how Congress is approaching it you certainly wouldn't know that states have done it, given that we have more than 20 experiments and Congress has decided to reject the findings from all of them, which I think is an interesting political statement in and of itself.

The political benefits? Well, one is the shared fiscal vision. I do think there are political benefits there. I'm a big fan of state government. I worked in it for years and have been studying it and I don't want to see the entire debate about who and what taking place at the national level. I don't think that's healthy.

SMITH: Right, right. That was one of the concerns that I certainly had. I noticed you gave tax credits a pretty negative reading. And could you say a little bit about why you feel that way?

And also, what do you think might be some of the prospects for some of these premium subsidy schemes that many of the states are experimenting with? Because it certainly seems like one way you could expand eligibility.

WEIL: I'll try to answer these quickly.

SMITH: Right.

WEIL: They are so complex. First of all, in our paper we propose that it is certainly possible that you could layer tax credits on top of either of these options. I'm not opposed to tax credits if we have a solid federal floor. What I don't like—and I said this at a conference in Austin, Texas a couple of months ago—if we are going to experiment with something that may or may not work, and that's I think the nicest thing I can say about tax credits, let's experiment with people at 200 to 300 percent of poverty who actually might get some recourse if it doesn't work, rather than people from zero to 100 or 100 to 200 percent of poverty, where if it doesn't work no one is going to pay them any mind.

My reaction to the block grant proposal that the Bush Administration put out in Medicaid is—why don't you give states a block grant for the 200 to 300 percenters. Let them decide whether they want to do tax credits or public program expansions.

And while we're talking about federalism, we might take some learning from the fact that no state has adopted tax credits as the approach they have chosen with their own dollars to try to expand coverage.

Whereas, at least a handful of states—Minnesota, Washington, Massachusetts—have expanded coverage even before they have matching funds available; so this is a level playing field. Before they had matching funds available, states spent their own taxpayer dollars on program expansions, not tax credits.

Now, if you are a believer in the states and states' rights and states as laboratories, why don't you look out on the horizon and discover that no state thinks tax credits work? Or at least they don't think it enough to put their money in there.

Are we going to actually acknowledge that states have learned what does and doesn't work here, or are we going to pretend to know nothing and go out wildly into the blue with something untested and unproven. I mean, we ought to be honest about what we do and don't know.

Okay, so I'm not against tax credits. I don't think that they work for low-income people. And it's low-income people who are uninsured so we'll just leave it at that. Premium support. I believe that the greatest risk to the future of the Medicaid program is premium support. Let me tell you the story. Even among poor, or particularly if you take people below 200 percent of poverty where most of the uninsured are, there are still tens of millions of people with private health insurance.

If we turn Medicaid into a premium support program we are inviting, and in some instances explicitly making the argument or the claim that what we are going to do is, we are going to take those tens of millions of people who are currently privately insured and instead of the employer and the employee contributing to the coverage, it's going to be the employer, the employee and the federal government.
And what we are in essence doing is shifting a huge current private financing stream into the Medicaid program.

Now, these are poor people and often small businesses that could use some relief. But when we open the Medicaid door to just being a form of financial subsidy to a traditional commercial insurance plan we are opening the door to Medicaid going from covering 40 million people to covering 80 million people. That will blow up the program politically. Talk about crowd out.

And this is where I go back to the relationship between public and private.

If we want to make a statement as a country that small firms or firms with low wages or poor people or working people with low wages ought to get a subsidy from the federal government in order to help them afford health insurance, fine.

Let's debate that and figure out its merits and how to design that. If you want to run that through the Medicaid program, you're crazy. It so fundamentally alters the nature of the program that it will make the current talk about budget growth and the program being out of control seem timid. Well, you made it out of control. You changed what the program does. So I think we have to be very, very careful.

Now, the problem is, if you sit in a room and have this conversation it goes like this. There are a lot of employers out there who can't afford to provide coverage and their employees can't. But if the employer just had to put in $50.00 a month and the employee had to put in $50.00 a month, then we could run it through the Medicaid program and get a match. We'd cover all these people who don't have health insurance right now. That sounds totally logical but it ignores the fact that there are twice as many people—depending on where you set the income cutoffs, it could be three times as many people—who are already covered by employers and individuals who are struggling to afford the bill.

And you can't build a wall between those two. So as I say, if we want to move to a public policy that says we are going to subsidize low-wage workers or low-wage firms, I am happy to have that discussion. But don't pretend that that's what the current Medicaid program is or you are going to sink it.

SMITH: I can see that. Well, I must say I certainly look forward to seeing this book as well as your Health Affairs article.
WEIL: Well, thank you, I hope you enjoy it.

INTERVIEW WITH MARINA WEISS
JUDY MOORE AND DAVID SMITH – MAY 2, 2003

SMITH: We are especially interested in your work with Senator Bentsen and in his work on the Finance Committee. But maybe we could start with a time-line on your career.

WEISS: I started working with Sen. Bentsen in late 1979 or early 1980. At that time, Carter was in the White House and Democrats made up a majority of both the Senate and the House. In the 1980 election, Republicans gained a majority in the Senate. Sen. Bentsen was first appointed to the Finance Committee in the mid-seventies, so he was second or third in seniority behind Senators Long and Harry Byrd. In other [words], he was in an important position to influence the deliberations of the committee.

Senator Bentsen was personally very close to Sen. Long, the ranking member of the committee. Their friendship was due partly to the geographic proximity of the states they represented, but also they just had a very warm, cordial relationship. For example, when a number of committee members asked that subcommittees with legislative authority be created so as to parallel the sub-committees in the House Ways and Means, Senator Long asked Senator Bentsen to head up the project. Senator Long was not favorably disposed toward creating such subcommittees, but Senator Bentsen worked out a compromise wherein sub-committees were created, but only for the purpose of holding hearings, not for the legislating—and even the hearing topics were (and are) subject to the approval of the full committee chairman, and of course all the committee staff report to the chairman. I use this example as an illustration of how well Senators Bentsen and Long worked together.

The early 1980's was the era of Gramm-Latta and federal budget cutting efforts. Still Sen. Bentsen worked aggressively to improve Medicare and Medicaid, although Medicaid was not a hot topic in the Senate. In fact, during debate over the 1980-budget resolution—in the Senate, there was much more activity surrounding the maternal and child health [MCH] block grant than there was on Medicaid. The Reagan Administration was proposing to do a couple of things to modify MCH. They wanted to block grant the program and cut its funding by about thirty percent. In addition, they proposed to reorganize responsibility for the program. As you may know, the Senate handles jurisdiction over MCH differently from the House. Sen. Long had worked long and hard to assure that everything related to

Social Security stayed with the Finance committee--and neither he nor other members of Finance wanted jurisdiction to parallel the jurisdictional structure in the House.

The debate over the maternal and child health block grant turned out to be quite a tempest in a teapot in the Senate. There was talk about combining it with other kinds of aid to states in some sort of unified block grant—moving jurisdiction over MCH to the Labor Committee or setting up a shared jurisdiction arrangement. The Finance Committee addressed the structural issue by insisting that MCH remain a part of the Social Security Act, in other words, separate from the public health service programs with which the Administration had proposed it be combined. By taking this position, they moved to protect the committee's jurisdiction, but in exchange the Members lost ground on program funding. The Senators' thinking was that it would probably be relatively easy to restore funding in conference and the structure could be better protected if they didn't have to overcome a bad vote in the Senate. This example of work to protect jurisdiction as well as MCH program integrity is an illustration of the strategic way in which Senators Long and Bentsen thought and acted. In this case, they were willing to trade away a budget cut in exchange for maintaining jurisdiction and program integrity, and in the end, they were also able to restore some funding during conference with the House.

SMITH: You said that Medicaid had low visibility in the Committee. Was it partly thinking in the Senate that those guys down there [in the House] do the heavy lifting, at least initially?

WEISS: No, no, no. The Senate never thinks that way about the House. No, their view was pretty much what I said, that there were some rather dramatic changes proposed to the Medicaid program, and that if they attempted to work on those changes with the new majority in the Senate they might lose, and then have a proposal they didn't much care for go to conference where it would be incumbent upon Senate conferees to support the policy position approved by a slim vote in the Senate. In other words, if they had tried to vote down the administration's proposal and lost, they would have been in a difficult—if not impossible—situation in conference. Finance Committee Democrats made a very strategic decision to avoid pressing for votes on which they risked losing.

I can't ever remember in fifteen years of working in the Senate anybody saying the House did the "heavy lifting." Of course, the House thinks that. [LAUGHTER]

So l980-198l were complicated by the fact that there was a new majority and complicated further because the new majority was working hard to deliver for the President.

There were some interesting hearings, OMB Director Stockman, for example. The typical M.O. with a new administration is for agency representatives to appear before congressional committees supported by rows and rows of aides, with mounds of briefing books. Typically, they make a formal statement and then take some questions—on the most difficult questions they often promise to follow up in writing. When David Stockman testified on the President's budget before the Finance Committee, not only did he appear alone—or virtually alone, he had one or two aides—but he pushed aside the briefing books, threw his prepared statement on the table, and said, "Mr. Chairman, this statement is submitted for the record. Why don't we just set it aside and go right to the questions." He just opened the hearing right up—which was just extraordinary, extraordinary. It was a wonderful hearing. And on that day, Sen. Moynihan was in rare form, saying that what the Administration was proposing in its budget was to reduce the size of government by "starving the beast," as he said. By taking needed resources from government programs, those programs would fail. Stockman had baby sat for Sen. Moynihan's children when he was a student at Harvard, and I understand that he actually lived in the Moynihans' house. The exchange between the two was so professional, but also very personal and very warm, very warm—but also sharp.

The committee went along for a while with the new President sending up legislative proposals and Sen. Dole holding hearings to allow the Administration to present its ideas to the committee. We'd hold a hearing and someone would say "Mr. Chairman" and Russell Long would answer, and Senator Dole would just sit there. And then someone would say, "Senator Dole, you're the new Chairman. And Sen. Long would apologize for responding—Senator Long had been Chairman for fourteen years and for many of those years, Senator Dole had been a senior member of the Committee. Both men were accustomed to Democrats being in the majority, and with the change in Senate and committee majority, both took a little time to get used to their new roles as Chair and Ranking member.

So where do you want to go from here?

MOORE: Could we pick up in 1983-84?

WEISS: Well, the first time Senator Bentsen offered a Medicare or Medicaid amendment that had not been 'greased'—or guaranteed to pass—was in 1984. I discussed the amendment with Sen. Dole's staffer ahead of time, but it seemed the staff was not particularly warmly disposed toward what Senator Bentsen wanted to do. The Senator had what might be referred to as a "Moms and Kids" amendment he was hell bent for leather intending to offer. And let me give you a little bit of background so that you'll understand what he was proposing—I'll tell you a couple of anecdotes about the genesis of the amendment.

At that time, the Aid to Families with Dependent Children Program (AFDC) in Texas was paying about $33 a month per child in welfare benefits. Texas had one of the least generous programs in the country, if not the least. Nevertheless, working to improve welfare payments was extremely difficult for members of Congress who represented that part of the country, as it was very hard to defend pro-welfare proposals back home. Having said that, Sen. Bentsen grew up in what is called "The Valley" of Texas. There's no valley there at all—the topography is absolutely flat; but that is the name given to the area just across the Mexican border—it's one of the poorest areas in the state. Typically the jobless rate runs around thirty to forty per cent. Senator Bentsen had been a county judge down there, which is what you would call a county administrator, and so he knew the area very well.

He understood that, as an elected official, it was not a good idea to be too visible in working to expand public welfare, but he found other ways to help low income constituents. At that time, Texas was one of twelve states in the country that required individuals to be enrolled in AFDC in order to qualify for Medicaid coverage—so-called "categorical eligibility." But, if a fifteen year old girl was pregnant for the first time, she couldn't get Medicaid coverage because, technically, she wasn't enrolled in AFDC. She could enroll in AFDC—and thereby qualify for Medicaid—only if she already had a child. But if she was pregnant for the first time, and therefore not enrolled in AFDC, she was barred from Medicaid's prenatal coverage. The Senator viewed this as a 'Catch-22' situation, and one that was detrimental both to the teen mother and to her child. The state had the ability to rectify the problem by allowing her to enroll in Medicaid if she met the income eligibility threshold, but Texas had not elected that option. Senator Bentsen found the policy appalling and vowed to try to change it. At the time, Bill Hobby (Oveta Culp Hobby's son) was lieutenant governor of Texas. Because of the structure of state government in Texas, the lieutenant governor has a great deal of legislative power, yet Lt. Gov. Hobby had not been able to garner the votes needed to change the Medicaid rules to allow for coverage of first time

pregnancies. Bill Hobby was a very pro-active, hard-charging lieutenant governor and one who worked very closely with Senator Bentsen on many issues important to the state. Well, Senator Bentsen called Lt. Gov. Hobby and said "I find this appalling, my son Lance—who is doing some volunteer work with the Houston school district—tells me there are girls in the state who are going without any prenatal care and even when there are problems with their pregnancy can't get care, and I just can't believe that the state of Texas won't extend Medicaid coverage for maternity care to these girls." And between them they agreed that the Senator would offer an amendment to the federal statute that would require states to extend Medicaid coverage to income eligible women who were pregnant for the first time.

And so the committee mark-up was under way—and I'll tell you a funny side-bar story—the senator was called out of the hearing room right at the point at which he was supposed to offer the amendment—I'll never forget this. The hearing room was packed. Sara Rosenbaum, with whom I had been talking about the amendment, was standing at the back of the room. She couldn't believe that fiscal conservative Lloyd Bentsen was going to offer a Medicaid expansion amendment—if it was enacted, he would have slapped a Medicaid mandate on his own state, and he would have done so in a very visible way. So, the Senator gets up and leaves. Chairman Dole was in the chair and, as you know, Senator Dole is not given to letting things slip by—his was a very organized way of running committee meetings—he carefully followed an agenda and when he was done, he would adjourn. So with Senator Bentsen out of the room and the time for the mark-up winding down, I had to go to Ranking Member Sen. Long and ask him to offer the Bentsen amendment. He said "yes, he would handle it." So it was Sen. Long who offered the amendment. As originally drafted, the amendment was meant to be a permanent change in the federal law, but Sen. Dole asked whether a two-year sunset would be acceptable. Sen. Long turned to me and asked if Sen. Bentsen would agree to a sunset, and I said I couldn't imagine he would. Senator Long then turned around and told Chairman Dole, "We'll take it." Sen. Bentsen returned from his phone call in the Exec. Room and he and Senators Long and Dole conferred and finally agreed on a two-year sunset. The provision was then approved by the committee as part of the larger reconciliation bill. When the bill got to conference, of course, we got rid of the sunset.

Now back to the story unfolding in Texas. On the very same day that this amendment was being passed in the Senate Finance Committee –the lieutenant governor had gotten a resolution passed [in both the House and the Senate of the Texas state legislature] commending Sen. Bentsen and

Speaker Wright for "all that they do in Washington for mothers and children in Texas." In other words, while Congress was slapping a mandate on the state, the state legislature was approving a resolution commending the Junior Senator and Speaker for their federal efforts on behalf of Texas' mothers and children. Ray Sheppach, (who's still Director of the National Governors Association), pulled me aside and said, "I don't get this, why would Senator Bentsen want to impose this new requirement on the state?" Well, that was our first foray into Medicaid mandates on states.

SMITH: Was that the first one of those mandates?

WEISS: Yes

SMITH: That pre-dated Waxman?

WEISS: Yes. Now the reason it was important for Senator Bentsen or someone on the Finance Committee to bring into conference material on Medicaid is that it was very easy for conferees to say, since there's nothing on Medicaid in the Senate bill, there is no need to include Medicaid amendments in the final conference agreement. House Members interested in Medicaid provisions would be told, "Well, there's nothing in this bill from the Senate on Medicaid, so we'll delay working on Medicaid issues until the end of the conference" and, not surprisingly, the Medicaid provision approved by the House would not make it into the final conference agreement. That was a very easy way to knock out House initiated Medicaid provisions. Conferees would simply say "We don't have time." Another way of saying this is that it was important that the Senate include in its version of the reconciliation bill provisions that made Medicaid relevant to the conference. That way, House and Senate members interested in Medicaid could insist that Energy and Commerce Committee conferees ought to be conferees for the entire period of negotiation. If Energy and Commerce Committee members were involved from the outset, it made it easier for staff to work on Medicaid provisions, just as we did on Medicare. Inclusion of the Energy and Commerce members and staff was feasible because when the Senate Finance committee goes to conference, they confer with two House committees—Ways and Means and Energy and Commerce. Although Medicare Part B requires that all three committees be together, the absence of Medicaid provisions in the Senate bill generally meant that Ways and Means and Finance would work first on Medicare Part A (over which Ways and Means has exclusive jurisdiction in the House) and serious negotiations involving Energy and Commerce would be deferred until late in the conference, with no time to finish work on Medicaid.

Now the other thing of which you should be aware is that until the House Budget Committee Chairman started working out arrangements with Energy and Commerce Committee Chairman Dingell about permitting new spending for programs under the Energy and Commerce Committee's jurisdiction, the bias—I'll just put it that way—of the Ways and Means Committee was that they really didn't want Energy and Commerce programs expanded in the context of reconciliation bills, because Ways and Means would have to foot the bill for the expansions. If Finance brought program improvement proposals into conference, we would also include provisions to pay for those expansions. That became very, very important in the period 1981 to 1986 when the Senate conference team was dominated by Republicans who didn't want to approve lots of programmatic expansions. It was less of an issue later on, when Sen. Bentsen was chair of the Committee. Although it is true that there were some conferences between l986 and 1993 (notably in l990), where the White House and the Republican minority in the House and Senate attempted to control the content of the final bill by controlling the process in such a way as to keep Medicaid expansions out of the negotiations and conference agreement.

In my judgment the untold and extraordinary story here—if you really want to know—is that while Lloyd Bentsen worked to advance his own agenda of programmatic initiatives he also did something important but much less obvious—he opened the door for others to bring forward their initiatives and he brought money to the table to finance his proposals as well as those developed by other Members. When Senator Bentsen proposed Medicaid expansions in the Senate, he insisted they be paid for—Energy and Commerce couldn't always do that, because the committee has only a moderate amount of jurisdiction over fees and other funding sources. By and large, when the House takes up Medicaid program expansions, it really requires that Ways and Means raise the necessary funds to offset the cost of the expansion. This split between program improvement and funding was always a difficult part of the dynamics in the House.

SMITH: Ways and Means would have to raise the money for what Commerce was doing? But Finance would pay for they wanted to do?

WEISS: Yes. Let me see if I can explain more clearly. During the period when Sen. Bentsen was chairman of Finance, I can think of no instance when the committee reported a bill that didn't include offsets to pay for whatever expansions had been approved by the members. And I mean revenue losses as well as program expansions. On the House side, Chairman Rostenkowski was not particularly keen on having to raise revenue

for things that other committees wanted to do, especially if the expansion was for a program such as Medicaid where even small changes are expensive. In the early years of my work for Senator Bentsen, initiatives to expand programs faced very tough sledding. Later on, particularly when Leon Panetta was Budget chairman, there would be a deal cut that included the Ways and Means and Energy and Commerce committees as well as the House leadership and called for one or more expansions in Medicaid. With this arrangment, the Energy and Commerce committee would not have to ask the Ways and Means committee for funding. Instead, the full House would have voted for the expansion when it approved the budget resolution. So Ways and Means would have to cover the cost of program improvements and Chairman Rostenkowski would have bought in to raising the necessary revenue.

SMITH: Andy Schneider was telling us about this, that Waxman would get an initial allowance from the Budget Committee.

WEISS: And initially, in the early part of the 1980's he wasn't having much luck—there wasn't much traction there. That's why it became so important that Sen. Bentsen not only opened up the conference to Medicaid issues, but also put money on the table. You know, if you had say a $100 program improvement you wanted to enact, and there was already $40 on the table, you were in a good position to add to that which was already there. It's much much harder to make a credible case when there is no offset to begin with.

SMITH: What was the Senator's motivation here? Was he being a good citizen? Was he a health liberal?

WEISS: I believe so, yes. But that's a hard question to answer if you think in the traditional way about how Members work. Let me explain. One of the things that always perplexed Andy [Schneider] and I think Mr. Waxman as well was that Senator Bentsen never wanted publicity. And the reason that he didn't was that it was a negative at home. It isn't that he was any less proud or that he didn't have an ego—it was just that it was more complicated for him to go home and talk about what he was doing for low-income people than it was for members from other states or districts. So he was fine with the fact that Mr. Waxman got a lot of the public credit while he did not. In fact, it was cute. There were times the staff would tease me and I would say it's just that he's not particularly concerned about getting credit. But there was a real reason for it.

Having said that, it's important in understanding how the Senator thought about Medicaid to know that, before he was elected to the Senate, Sen. Bentsen owned an insurance company—not health insurance, it was life insurance—but he understood how insurance worked and thought it very important to be insured. You didn't have to explain to him how adverse selection works, for example. Also, he had some family history of children with severe problems. He lost a grandchild who was a patient at Texas Children's Hospital during many, many months of illness. He also has two other grandchildren with significant health problems. Part of his belief in the importance of health insurance was that he understood the financial burden on families. This is a person who believed to his core [that] everyone should have health insurance. In my view, he really thought he was doing the right thing. But he did not think it made sense to spend much time debating whether health insurance should be privately purchased or publicly supported. He was quite content to live with the dichotomy that exists in the US health system today. He was willing to expand publicly funded programs, but he was also willing to use the tax code to drive behavior. For example, he was one of the early proponents of 100% deductibility for health care in the business world. He thought that would encourage employers to make health insurance more readily available. And he was fine with the notion of using tax credits where they made sense, for example, in helping small businesses provide insurance. And he was very supportive of the Medicare program and thought we should improve benefits offered by Medicare and Medicaid as well. And he didn't see inconsistencies between those two positions. So the dichotomy that is part of the today's debate—public vs. private coverage—where you're either in the public camp or the private camp—he had it perfectly resolved in his own mind. He believed both approaches have salience and ours is a mixed system, so he reasoned that his role was to work to make the system we have even better.

SMITH: One of the things that was a surprise to me—I think it was Lisa [Potetz] who first told me--was that the "T" in EPSDT is pretty much Bentsen's creation.

WEISS: Well I don't know about that…

SMITH: I don't mean the legislation as such, but that you did the diagnosis and then whatever turned up, you had to treat.

WEISS: That's true. At the staff level we were hearing of an increasing number of cases where, after having been diagnosed through Medicaid screening, children weren't getting the treatment they needed. We also

knew that the screening program was under-enrolled. In other words, there were cases where, a child was diagnosed, but that was the end of the road. Failure to treat was particularly difficult for families where the cases were very severe -—kids with chronic problems that required ongoing care. So we raised the issue with him and he was flabbergasted. "You mean they are diagnosed and no one is doing anything about it? So who pays for the treatment? A child has a life-long condition, they have to go to the physician or to the hospital but Medicaid doesn't pay for their care? What do the families do in such cases?" So I think he just set out to fix the problem. He thought it was just a ridiculous program operations decision at the state level. So, in 1989, a provision requiring treatment for conditions found through the Early and Periodic, Screening, and Diagnostic program was added to the Senate reconciliation bill.

SMITH: He did that at the conference level, didn't he?

WEISS: Well, yes and no. The original version of the provision went into the Senate Finance committee bill. However, 1989 was the year that the committee's bill was "stripped" on the Senate floor. Here's how it played out. The members approved a bill in committee, and it had a number of provisions, among them an initial version of the amendment. We did the spending side first and the committee staff and legislative counsel went off to draft the final bill language. We were writing the legislative language and getting revised cost estimates and so on while the members and the tax staff started work on the revenue side of the bill. But things spun out of control that night. There were meetings in the exec. room that lasted well past two o'clock in the morning and many provisions were added to the bill. The following day, a couple of the members were unhappy at what had happened and they went to the press and said the bill was chock full of "special interest" provisions and that they were going to oppose it when the full Senate took it up on the floor. Over the next couple of days there was a great deal of discord. Members started going to the floor and making statements to the effect that what the revenue provisions they had approved were excessive and that they regretted what they had done. It was clear that we were losing votes and that there was going to be difficulty on the floor. And Majority Leader Mitchell, who was a member of the Senate Finance Committee, called for a caucus. Most of the discussion at the caucus centered on the revenue provisions. However, late in the meeting, Sen. Gore got up to discuss a Medicaid provision in the bill known as the "Oregon waiver.. I had argued against approving the waiver as part of the reconciliation bill when the members had been working on the spending provisions. However, Senator Packwood argued for it and won. So, the bill

included a provision granting Oregon permission to redesign its program, including elimination of some benefits. Senator Gore stood up in the Democratic caucus and said, “There is in this bill a reprehensible provision granting Oregon the authority to deny Medicaid coverage for organ transplants. I find this provision so objectionable, I will fight this bill on the floor until it is removed.” And then other people started getting up and saying, “Well, I don’t like this provision or that provision”, and so on. So it was obvious that we had a problem on our hands. Chairman Bentsen called the staff to his office and told us that after caucus, Senator Robert Byrd had indicated that he too was unhappy with the bill because he believed it contained too many provisions that were not essential to what was supposed to be a deficit reduction bill. At that point the Chairman said, “All right—what we are going to do is strip this bill. I want the bill stripped. I don’t want anything in the bill that doesn’t raise revenue or cut spending.” So we went back to the committee offices and within three hours had stripped the bill to a core set of provisions. A bill that had taken us a week to put together was radically altered in just under three hours.

There were a couple of collateral issues I should mention here. One was the American Hospital Association was flabbergasted at how much their payment rate update had been reduced in order to pay for other things in the bill. Rick Pollock called to say “Wow, thank you for restoring the full update.” The second sidebar issue had to do with a package of Medicare provisions designed to benefit rural hospitals. Senator Phil Gramm (who was one of the architects of Gramm-Latta and several other budget cutting initiatives) went to the Senate floor to criticize the committee bill on the basis that it included provisions that increased federal spending. I was standing to the left of Sen. Bentsen who was managing the stripped down version of the bill when Senator Gramm walked over to ask if the Chairman wouldn’t consider adding back the rural hospital provisions. Sen. Bentsen said, “No. I don’t believe it equitable to add back provisions important to some members while leaving out provisions important to others. We will debate the committee approved bill or every provision that does not reduce the deficit will be stripped.”

So, we went to conference with a bill that was as spartan as anything you could imagine. But, of course, many provisions had been approved in Committee as part of the original bill. Finance had approved the EPSDT provision initially, but because it was part of the larger exercise over “bill stripping”, it had been deleted on the floor of the Senate. When we got to the conference with the House, Chairman Bentsen, Chairman Rostenkowski, and Chairman Dingell met and agreed that legislative provisions approved by

the committee (but stripped out of the bill on the Senate floor) would be treated as though they had been approved by the full Senate. At the staff level, we thought that was great.

SMITH: Couldn't that have been challenged on the floor?

WEISS: Of course, but the more important question is whether the challenge would have been successful. One could always argue that the provisions approved by the Finance committee were outside the scope of the conference. But the problem with that argument is that, in this particular case the House had brought some Medicaid provisions to conference, so it was hard to argue that EPSDT was non-germane. And, as you well know, whether a provision is in or out of the scope of the conference is a judgment call made by the conferees.

Well, anyway, by the time we began conference with the House, Sen. Gore's caucus remarks about the Oregon waiver had been made public. We also had some anecdotal evidence that kids who lived in states with limited or no specialty care available were being taken to academic medical centers in adjacent states where their care was not being compensated. The question was, if the committee is serious about the EPSDT program, how can we be sure needed treatment for these very sick children is both available and reimbursed? That's how we got to where we are with EPSDT now. If a child who relies on Medicaid for his coverage is a resident of Montana, but liver transplants are not done in Montana, so the child is taken to Washington state for transplant surgery, shouldn't Washington state expect to be reimbursed for the cost of that care? As a result of the work done by these conferees, if a child is diagnosed through an EPSD screen, Medicaid will cover the cost of 'medically necessary' treatment for the condition or disease identified—regardless of whether the state plan includes said treatment. Sen. Gore was exercised about the Oregon waiver precisely because it would have made it possible for the state to exclude organ transplants from its Medicaid scope of services. And that point was lost on none of the conferees.

SMITH: One point I have wondered about Sen. Bentsen is how he worked with others and how he was regarded. For instance, was he a coalition builder?

WEISS: Yes, absolutely. Senator Bentsen is by nature a consensus builder. As you know, the style used by a committee chairman greatly influences the work of the committee. Chairman Bentsen was not and is not a very

gregarious person, he's a serious and thoughtful individual whose friendships run deep and who is trusted by his colleagues. And while he had wonderful personal relations with others in Congress, Senator Bentsen was a very serious and very effective legislator. He worked hard, was always extremely well prepared, and made it a point to help members of the committee obtain support for initiatives important to them at home. He did everything he could to help them, and I want to be clear that his help was offered and provided in a bipartisan way. For example: we would build a bill very differently than the way it is done today. The Chairman would have committee staff set up meetings with staff from each senator's office, Democratic and Republican members alike. We would run through the issues of interest to that particular senator. Senators and their aides learned to trust the process enough so that they would tell us, "We have a list of 5 items of interest, but only items one and two on the list are critical…for the rest, the Senator will make a few remarks at mark-up, but we can come back later." Or staff might say, "My boss will be insisting on this provision; if the provision isn't in the chairman's mark, I can tell you that you will not have my senator's vote." Members and staff were very candid with the Chairman and with the committee staff. Once we had a comprehensive list of member items, we would sit down at the staff level and figure out which provisions were absolutely necessary and where we needed to make changes that would satisfy the requestor while making the provision a little more palatable to other committee members. And keep in mind that the Chairman insisted we work with Senators from both parties.

Once we had a draft list of items for inclusion in the committee bill, we would sit down with the Chairman and draw up a game plan. We'd know how much we believed we had resolved at the staff level, as well as what would require his hands-on involvement with the interested Senator. We would also recommend ways to resolve differences between members over key issues. So, the first step was always for the staff to do a bit of reconnaissance and put together a draft from which he could work. And he would take it from there. But this negotiating was always done privately and never in a way that could embarrass a member, ever. That was an absolute requirement. And, to the best of my knowledge, staff never violated those confidences.

Once we had developed an outline for the Chairman's mark, I would go to the exec room and run through the provisions of the bill for the staff and later for the members. We always reserved the right to adjust the provisions slightly to ensure that the committee bill was within scoring parameters provided by the Congressional Budget Office. Since members

and staff knew the architecture of the bill before we ever held a public session, even if slight adjustments had been made to accommodate member concerns and/or CBO, every office could easily recognize the provisions which they initiated. Senators and staff also knew which provisions Chairman Bentsen would want included as his portion of the bill. By the time we went into a public mark-up to approve and report a bill, members knew what they had won, Chairman Bentsen knew what members had to have in the bill in order to support it, and he also knew who would vote for and who would vote against the final measure. His was a very deliberate, formal and effective process, with great care given to the protection of relationships among Members of the committee.

Senator Bentsen's style as a Chairman was very different from that of his mentor, Senator Long. Russell Long would hold multi-day mark-ups where dozens of amendments would be offered. His staff once told me he did that in order to "get a sense of where he thought committee members were on multiple issues." When he was satisfied that he understood where members stood, he would move to put a final mark before the committee.

So, your question was about coalition building — Chairman Bentsen built and nurtured relationships; and he believed that trust between Members was the coin of the realm. He drew on his relationships with other Members—in the Senate and in the House—to move legislation.

SMITH: Now, you have all these Medicaid provisions coming though—mandates if you will—and along about l988 or 1989, the governors are beginning to get restive and they are talking about "No more unfunded mandates" and DSH scams are beginning to come in; and then there's catastrophic and dual eligibles and so forth. How was the Senator viewing all of this? As far as I know, he never seemed to object.

WEISS: Did he realize that we were building mandates? Yes. Did he think there would be a major push-back from the governors? I don't think he thought the governors were doing anything other than what they had always done. That is, I think he would have been surprised if the governors hadn't been opposed to the Federal government telling them how to spend dollars or run programs that were partially funded by the Federal government. Likewise, he thought it was his obligation to see to it that taxes his committee was responsible for raising for a particular purpose were spent for that purpose.

This may sound a little simplistic. But I believe that he thought that everyone who was involved in these negotiations and discussions would play the roles that they were supposed to play. If the Medicaid program was largely funded by the Feds, he believed that the Feds should have something to say about how the money was spent. And he would also expect that the governors to resist that idea because they would like to have the maximum amount of flexibility to structure and run programs as they thought best.

SMITH: At the very end of the decade, when states were beginning to develop provider taxes, DSH scams, and so forth, was that setting off any alarm bells for him?

WEISS: I think that would just reaffirm for him that there should be some rules that the Federal government puts in place for how these funds should be used. I mean, if the funds had been raised at the state level, he would not have thought that he had any role at all. But if the funds were raised by the Federal government as a result of action taken by his committee, then he thought he had an obligation to the taxpayers of America to be able to say to them that their money is being well spent and that if problems were found with inappropriate use of funds, his committee would be looking into it and taking care of it.

SMITH: It is Federal money.

WEISS: It is money raised through federal taxes. Really, that's how he saw it. If you were to say to him today that fifty or sixty per cent of the money being spent is Federally raised, he would say that people who are serving in the Federal government, whether they are the President or a member of the Cabinet or a member of the Congress have an obligation to see that the funds are properly spent. And beyond that, let me remind you that something on the order of fifty percent or more of the Medicaid program is flexible to the state. It's not a program about which the Federal government makes all decisions, but there is a core of Federal requirements and he was perfectly comfortable with that.

SMITH: We did touch on catastrophic and in particular…

WEISS: That's going to be on my tombstone. [LAUGHTER]

SMITH: Well, the part I was particularly interested in was that with its repeal and their continued responsibility for dual eligibles that many of the states had a sense of grievance.

WEISS: Be careful what you ask for. So, what would you like to know about that? Of course, well informed health policy experts like you would know this. But people who aren't focused on Medicaid come to me and say, "Oh, it must have been terrible to have that entire bill repealed." Well, it wasn't all repealed. There was a substantial portion left; and I'm so glad that it was.

The Medicare Catastrophic Coverage Act began in 1984 in the Joint Economic Committee (JEC) and not in the Finance Committee. Senator Bentsen was chairman of the JEC in 1984—the chairmanship rotates back and forth between the House and Senate, and he was Chairman in that year. He scheduled some hearings on some of the deficiencies in the Medicare program and George Tyler of JEC and I staffed those hearings. What the Senator was trying to figure out was whether Medicare provided adequate coverage for seniors—going back to the core of his beliefs that everyone ought to have health insurance and it ought to cover the expensive stuff. So, he was quite taken aback to learn that beneficiaries were liable for an infinite number of hospital deductibles—that there was no annual cap on the number of deductibles, that there were large gaps in what could be covered under the category of home care, that skilled nursing care benefits were structured to limit the number of days of inpatient skilled care. And he began to work on these problems in the way he always did, which was to take an existing program and try to make it better. So there were a handful of program features that he wanted to address, to fill the gaps---that's how we got going. Later on, other issues and agendas came into play.

Turning now to the innovative and very controversial financing structure of the bill. The financing structure was set up to accommodate President Reagan's concern—communicated through Secretary of HHS, Dr. Otis Bowen, that he would not sign a bill unless it was paid for by those who would benefit from it. Well, when that parameter became part of the discussion, we were working with members such as Senators Mitchell and Bradley who strongly supported progressive taxation—sharing the burden in a way that was related to the individual's ability to pay. So, because of the need for a financing mechanism that drew from those who would benefit, coupled with the desire that the financing be progressive, we wound up with what we called a 'basic premium' to be paid by all beneficiaries and a 'supplemental premium' to be paid by those with higher incomes. The program improvements would be funded by a combination of these two revenue streams. When we began discussion of a mark-up proposal with other members of the Finance committee, there were two pretty expensive

add-ons that Senators wanted to include, and then a third add-on that first came up in committee and reappeared in conference. Senator Matsunaga wanted to include a mental health benefit which the staff recommended be taken up on a subsequent bill. The Senator agreed to wait and, on a later bill the committee approved and the President signed into law the mental health coverage that remains part of Medicare today. The second major amendment was to add pharmaceutical coverage and was authored by a foursome including, Senators John Heinz, John Chafee, George Mitchell, and Jay Rockefeller. Senator Bentsen was eager to report the bill out of committee and because this amendment surfaced late and was a fairly controversial new start, he suggested that the sponsors agree to "….report out the bill with the promise that I will work with you on a floor amendment." And they agreed. The third amendment was a proposal by Senator Bradley for respite care coverage. Senator Dole was adamant in his opposition —I don't know why, but he was. The issue came up again in conference from the House side—Senator Bradley had been unable to add his amendment to the Senate bill. When the issue resurfaced in conference, Senator Dole read aloud a letter from someone within the Administration—it might have been the Director of OMB. Secretary Bowen was at the conference table in the Ways and Means hearing room and, when he was asked whether he agreed with the content of the letter, the Secretary responded that he thought it might be possible to find a way to add the respite care provision to the bill. And Senator Dole was so irritated that he threw the letter down, got up and walked away from his seat at the dais. I thought Sheila Burke, his health staffer, was going to pass out. Well, anyway, those were the three most difficult amendments. What else would you like to know?

SMITH: One question would be whether there was any concern or discussion about how the states might react to this.

WEISS: Sure, there was discussion with representatives of the states. In fact, there were various provisions included in the bill that were added to address issues raised by the states.

SMITH: You probably weren't thinking at this time that the statute would get repealed and what would be left behind would be the dual eligibles.

WEISS: We were very surprised it was repealed. And the dual eligible issue didn't really surface until late in the game when it was brought to the table by the House. Now, if I remember correctly, Senator Rockefeller was

working closely with Congressman Waxman on the exact language of the provisions, but the initiative was developed by Mr. Waxman and his staff. To the extent that the overall bill generated some savings for the states, Members thought it was reasonable to share some of those savings with beneficiaries who really couldn't handle the co-pays, it was a way to ensure that low income enrollees could benefit from the expansions.

MOORE: Do you think we can continue to build on Medicaid?

WEISS: In my usual way, I am probably going against the grain. But I honestly think we accomplished much of what we set out to do. And that was to take Medicaid, a program that was something of a backwater in the Department, a program that nobody could explain very well, a program that varied greatly from state to state and we improved it. In some states Medicaid was being run extremely well, reaching the populations Members of Congress intended for it to reach. But Members thought other states weren't doing what they ought to have been doing with respect to low income elderly and disabled individuals. So I believe the Members decided that a rising tide could lift all boats—that what this program needed to make it really work was expanded eligibility to more middle class income levels. That would, first of all, stabilize benefits at the state level, it would make Medicaid a more visible part of the landscape and add a group of articulate advocates to the program. Beyond that, the improvements would make available some very good health benefits that many consumers didn't have as part of their regular coverage.

So I think these members accomplished what they set out to do. The pushback that just occurred in response to President George W. Bush's most recent budget initiative makes my point. For the first time in my memory it wasn't just Medicare that was getting top billing in the press, Medicaid was there too. Medicaid has become an important source of health coverage for millions of seniors, disabled individuals and working families. Today in this town, there are many, be they physicians, association representatives, advocates for consumers and others who can talk very knowledgeably about the importance of Medicaid to their constituencies. I can tell you, here at the March of Dimes, that we are keenly interested in the program. Nearly 40 percent of hospital based deliveries in this country are reimbursed through Medicaid. And the current level of interest in this important program is due, in some measure, to the expansion of eligibility that took place during the 1980's and early 1990's.

SMITH: From across the aisle, so to speak, we were talking with Howard Cohen. He was also much interested in the governors' response to the President's initiative. They were scratching their heads and saying, "Where does this really leave us in the long run?" Earlier they were so mad they would take block granting, and so forth. Now, you weren't hearing any of that.

WEISS: Well, if you take a look at the discrete pieces added to this program over the last 15-20 years—even though Members worked on different parts at different times and it didn't always look as though individual initiatives held together as an integrated whole—I think there is a coherence. If you look for instance, at the federal nursing home rules, there are some very important protections for patients covered under Medicaid.

The federal guidelines have had a profound effect on the way in which the nursing home industry works. And if you look at children's hospitals—the fact that Congress opened up eligibility for Medicaid to children with family incomes of up to 185% of the federal poverty level, means that today, on average Children's hospitals rely on Medicaid for nearly half their annual revenue and in some cases that number is as high as 85%.

SMITH: I had no idea it was that high. Did you know that Judy?

MOORE: I knew it was high—I didn't know it was that high.

WEISS: And of course, for children with birth defects and other chronic conditions, Medicaid coverage is critical. Across many different sectors of the health care industry growth in Medicaid has become a permanent part of the landscape. So I'm proud, very proud to have been a part of that.

SMITH: Yet there was a time when people were not proud to be a part of Medicaid, except for a few of the "lifers" who were around.

WEISS: I can remember a time when we had a devil of a time getting Members, and even staff, to focus on Medicaid. I can remember, when I was first working on the Hill, that Members and staff would go through all the Medicare provisions to be included in a reconciliation bill, and we'd get to Medicaid and all the Members would leave. Legislative work on the program became a staff issue. That is no longer true.

MOORE: It was so hard. No one wanted to do it. It's still complex—hideously complex.

WEISS: But now we have some core consistency. Every child whose family income is below l33% [through age 6] or 100% of poverty [age 7 through 18] is eligible for the program, no question about it. Last year we celebrated a twenty year anniversary [it took twenty years to inch up eligibility thresholds so that now the program covers children through age 18 on a mandatory basis and states can go all the way to age 21 if they choose].

And the world didn't come to an end, the states didn't declare bankruptcy. And there are the improvements in nursing home care, and in other areas where I think federally initiated consistency across the program makes good sense.

Of course, there's always this tension between diversity and uniformity. And I certainly don't want to say that Arizona and Vermont should run their Medicaid programs in exactly the same way. But because of the work of the last two decades, we now have a basic framework that applies nationwide.

I see the importance of this program every day at the March of Dimes. We deal with some of the sickest children in the country. Children who are very medically compromised. And if it weren't for Medicaid, I don't know where the families would go to finance their care. I remember a child who was our national ambassador during the second year I was here. He was five years old at the time. This young child had had nineteen surgeries during his first year of his life. The father was a construction worker, and his mother worked when she was able to leave him with a babysitter. Without Medicaid to cover the cost of this child's care, I don't know what the family would have done. We see the importance of Medicaid every day.

MOORE: If you have just five more minutes, could we ask you about Katy Beckett and home and community based waivers?

WEISS: Sure. The Katie Beckett waiver was created after President Reagan drew attention to the excruciating dilemma facing Katie's family—institutionalize her or take her home and lose health coverage. At that time, Senator Dole chaired the Finance Committee and Sheila Burke was the committee staff member with responsibility for the health portfolio.

Negotiations over creation of the waiver were done behind closed doors. Chairman Dole and other members of the committee didn't want a broad rule, but it was obvious to everyone concerned that this family was facing a problem that had to be addressed. The question was how to help families take care of a child with major medical needs, but at the same time not

open the floodgates to a costly program expansion. And so, a narrowly defined waiver was created. Later on, once the Katie Beckett waiver had been used for a period of time and Members were more comfortable with the probable cost, Senator John Chafee proposed a more expansive home care initiative—Rhode Island was a pioneer in the closing of institutions and outplacement of children with special health care needs who required intensive services. Senator Chafee was so well regarded, so loved, his proposal was controversial, but he was able to take the Katie Beckett waiver one step further. During debate over Senator Chafee's proposal, Christie Ferguson arranged for me to visit several Rhode Island group homes. I was especially struck by the fact that the state was able to find enough health professionals to take care of these profoundly disabled individuals—eight people in one site, ten at another and two at the smallest site—the state had recruited and trained enough staff to be able to care for them, and care for them well.

I hope this has been what you were looking for.

SMITH: Well, thank you so much. It's been great fun.

WEISS: Well, thank you. It's been interesting for me. One puts history such as this out of mind and then its fun to recollect.

MOORE: That's exactly what we are looking for.

INTERVIEW WITH KARL YORDY
JUDY MOORE AND DAVID SMITH – OCTOBER 28, 2004

MOORE: —It is October 28, 2004. Judy Moore and David Smith are interviewing Karl Yordy, by telephone at his home in Tucson, Arizona. We would like to start by having Karl talk a bit about how he came to be in health policy in the first place.

YORDY: Okay. I actually have thought about that a bit in getting ready for this conversation, trying to keep a little focus because I have had an interesting career but don't want to bore you with too much of it.

Let me give you a brief sketch of where I came from because I think it's going to be relevant to my perspective on the beginnings of Medicare and early years of Medicaid. I was always interested in politics and government as a kid and went off to Princeton partially because of that, because my father's lawyer in Denver talked to me about the Woodrow Wilson School as an undergraduate major.

I was interested in foreign policy in those days, talked about the foreign service, and graduated from Princeton and went off to Washington. By that time one of my professors had done me the good service of saying that he knew I had bad allergies and that I would never pass the foreign service physical.

Therefore, I switched my sights onto the domestic scene and ended up with a job off the management intern register at NIH in the planning office, in the Office of the Director of NIH. This was 1957. The total budget of NIH the year before had been, I think, $200 million.

SMITH: Who was the planning director at that time?

YORDY: Anyway, I was down the hall from Jim Shannon, the Director of NIH, with whom I had lunch the first day and I mention this because it was essentially a fortuitous accident. I had hardly heard of NIH. But I got this job and it was as the junior professional in this planning office, which had two senior folks, two secretaries, and me.

Again I mentioned this because one of Jim Shannon's strengths—he's probably the greatest Director of NIH and a distinguished medical scientist—was to surround himself with people who were unlike him. Chuck Kidd, who

was the director of the office and a Princeton graduate (probably had something to do with me getting the job) was a protege of J. Douglas Brown.

I don't know if either of you know who J. Douglas Brown was. He was a professor of economics at Princeton and one of the intellectual fathers of the Social Security program.
Chuck Kidd, after he had gotten a master's degree at Princeton in economics, needed a job, so he came to Washington in the late 1930's and worked for the Social Security board, for Ida Merriam.

Then, during the war, he went to the staff in the White House. After the war he was a member of the staff of the first Council of Economic Advisers, 1946, and became an assistant to Steelman when Steelman was one of the key assistants to Truman. And Kidd was involved in Steelman's activities that came up with a Truman health message or health program, which expressed some of Truman's early interest in national health insurance.

I say all that because that's where Chuck Kidd was when a very farsighted Surgeon General plucked him from that environment to come head up the planning office at NIH in, I think, the early '50s. And that was the office I joined in 1957. But that was Chuck Kidd's background.

The other senior person in the planning office, Joe Murtaugh, had come an entirely different route as a statistician in a regional office of the WPA during the New Deal, had then made his way after the war into the Public Health Service and had come up through the service side of the Public Health Service: PHS hospitals and Indian Health.

He was involved with the transfer of the Indian Health Service from Interior to the Public Health Service. Jesuit training, Aristotelian thinker. But my point of mentioning these backgrounds is that was the intellectual environment I went into as a green kid.

And every day I had a graduate seminar in public policy. I was sitting in the middle office with the secretaries, between their two offices. They would come out, stand in front of my desk, and talk to each other about the policy issues of the day.

And so it was an incredible graduate school-quality experience, very broadly on public policy. Because not only did they have that broad sense from their backgrounds but they had instincts in that direction and Shannon took

advantage of their backgrounds as they carried out a sort of intelligence function for NIH.

Our office followed the broad fields of science policy, health policy, and essentially higher education policy, all three of which in one way or another were environmental concerns for NIH. And we—the NIH—continually knocked the socks off of the competitors within the Public Health Service, you know, competition for funds and that kind of stuff.
Partially because of this perspective I once said to Chuck Kidd, "Gee, I feel sort of bad that we always win."

And he said, "Well, it's up to the others to stay competitive."

But I say that because my own broad background, accidentally getting into a health agency where I was tutored by these mentors who had this broad policy sense themselves but were able to help me focus on the kinds of concerns that NIH had.

SMITH: Who was the Surgeon General at that time?

YORDY: The one who recruited Chuck Kidd I think was Leonard Scheele, who was gone by the time I was there. The Surgeon General when I came was Leroy Burney, who was not that much of a towering figure in my estimation. But then—you know, interesting.

SMITH: Well, Scheele was the first Surgeon General to come from the NIH.

YORDY: Yeah, I think so. I think you may be right. But anyway, I give that as a background because it was an incredible experience, both for me personally but obviously it shaped my way of looking at things.

SMITH: From where you sat, how significant or apparent to you was the influence of the Lasker Foundation at that point?

YORDY: Gigantic. I should say that this little office, which had these three professionals and two secretaries, by the time I left some years later had I think 45 staff. But in the process of growing and specializing we always handled issues that had legislative implications. And finally Chuck Kidd and Joe Murtaugh decided, maybe they ought to have a little stronger focus on that. So in 1960 they created an office within the office of planning that was focused on legislation and legislative analysis and so forth. And I was made the head of that.

SMITH: When you were there did you have the sense that you were perhaps creating one of the most unique and extraordinary institutions in American history?

YORDY: Well, I came to understand that. I honestly didn't know that to begin with. But I certainly came to understand it. And then there's another thing you should know—which directly speaks to that point, David. In 1961, NIH sent me away to Harvard, Littauer School. Partially because Chuck Kidd had been there, too, and he knew Don Price well.

SMITH: Uh-huh.

YORDY: And so I went with the sort of specific target originally of Don Price's science and public policy seminar, for which he had Ford Foundation money.

But, you know, I was a student. I took a lot of other stuff. And I was in it for two years. And I could pick anything I wanted to, from very theoretical, political theory kinds of things to more public administration topics.

Anyway, Art Moss was teaching a graduate seminar using that case study book in public administration. And he had heard about Jim Shannon and he came to me once and said, "You know, I have heard about Jim Shannon." Because you remember, Art Moss had written a book, Muddy Waters, on the Corps of Engineers. So he was fascinated with this business of politically powerful agencies that were not really totally subject to the discipline of the executive branch.

And that certainly fitted NIH to a T. And because I was involved with the legislative stuff, of course I saw all that intimately. And the fact that we broke the president's budget every year. And that—well, I won't get you into all that stuff.

But anyway, that was my perspective. And I met Mary Lasker many times and we—and believe it or not, one of Shannon's great strengths and one of the perspectives that my immediate bosses had was to try to balance the Lasker influence.

Because in a sense we took that as a given. We really had no choice. I mean, Mary Lasker was going to do her thing anyway, and so the NIH budget was going to lock it up...and we would pay a lot of time and attention

to things that were aimed at saying, well, given this growth, what are the implications for a bunch of things that somebody ought to be thinking about?

SMITH: Well, science versus health.

YORDY: Yeah. And so one of my first assignments when I first went to NIH was to work with Chuck Kidd on a Secretary's task force on the future of medical research that had been appointed by Marion Folsom and called the Bayne-Jones Commission after its chair.

And that group consisted of people like Jim Webb,

...I guess, pre his NASA time, and, you know, the executive vice president for planning at DuPont and the dean of Harvard Medical School, and, you know, people like that. So I'd sit around and hear these people talk about how to plan for the future.
I could go on for a long time about that kind of stuff. Let me just say that that was an extraordinary kind of background experience because it meant as a very junior person, in terms of perspective on the issues, I sort of started at the top.

I mean, I was meeting Department Secretaries and—by the way, while I'm basically a Democrat, the Secretaries I admired the most in my years in the government were all Republicans. Marion Folsom was a terrific guy. Also involved in the early days of Social Security as you probably know.

He was followed by Arthur Fleming. Arthur, yes, and then in my later phase—and I'll talk about it some more—directly related to Medicaid, there was Elliot Richardson. Oh, and by the way, a little side note on the business about balancing Mary Lasker. We had superb relationships with what in those days was the Bureau of the Budget. Which I say because in some ways that might seem surprising, given the fact that we could be viewed as a maverick agency that was breaking the President's budget every year. But the fact is that Joe Murtaugh used to sort of get rhapsodic about the discipline of the budget process.

I mean, they knew what was happening to us and we knew what their responsibilities were. And therefore, we could work well with them and focus on such broad issues as what was the impact of the rapid growth of NIH money going to be on medical schools.

SMITH: Well, and the fact that they knew you controlled some key appropriation subcommittees.

YORDY: Yes. Lister Hill and John Fogarty were in our daily orbit.

SMITH: It was fabulous.

YORDY: But anyway, that's my NIH experience. Now—

SMITH: Well, I just wanted to ask you one question before we depart from that because, my first exposure to Washington was the time when the Medicare bill was being passed along with heart-cancer-stroke...

YORDY: Yeah...to get to that. I was going to fast forward to '64. I was back at NIH by this time and the Johnson election of '64 was in process. But as you will recall on heart disease, cancer and stroke, the DeBakey Commission, Johnson had inherited that idea from the Kennedy Administration. And Mary, with her usual skill had worked on the Kennedy Administration. And by the way, when the Kennedy Administration came in that was where I first met Wilbur Cohen, who was head of the transition team for HEW.

The DeBakey Commission had been set up by Lyndon Johnson and partially, I suppose, had something to do with DeBakey getting appointed because he was in Texas. But that was a sort of thing that was bubbling along. And in—when Johnson got elected, landslide, he immediately—you know, all sorts of activity got cranked up across a broad range of things, sort of pushing every button in sight. And one of those was the DeBakey Commission which turned into regional medical programs. And I first got involved in that in my legislative capacity at NIH.

And then, as it went into the spring of '65 and it looked—because at that time we were assuming that anything Lyndon Johnson wanted he would get—that the program was going to happen. And we fought a battle to have NIH administer that program, and of course we won that in the usual way we won things.

And Shannon then bequeathed me to that program in his typical Jim Shannon style. He never asked me. He simply—I heard him—I think he was talking to Mike DeBakey—say, "Oh, by the way, this young man on my staff," you know. But of course I thought it was great. So I became—it was

known that I was going to be involved in that program while it was still in its final legislative stages.

And I was involved in all those negotiations which were tricky and tough. It got through the House committee by one vote in spite of Johnson's power because—and this now brings us to Medicaid—as you will recall something else was going through the Congress at the same time.
SMITH: Right.

YORDY: And the docs of the world who didn't like RMP, along with not liking Medicare, were busy fighting these things. Right before RMP passed in October of ’65 the leadership of the AMA—and this story I've heard from Wilbur Cohen, I was not there myself—had gone to the White House.

The meeting was probably with Joe Califano. The AMA leaders said, "Lookit, Medicare and Medicaid have just happened. We're having a hard time holding our constituency together." Because some state medical societies—Ohio, I think, and some others had already voted, you know, not to participate in Medicare and Medicaid. “And we're going to try to hold them together, but maybe we can't if you hit us with this additional blow.”

SMITH: Now that's a very interesting tale.

YORDY: “So please—please don't go along with regional medical programs.” And I am told, and this is second-hand, that Lyndon Johnson at that point walked in and Califano basically told him what had been said. And Lyndon Johnson turned to the leaders of AMA and said, "It's a shame that such a worthy profession has to be burdened with 19th century leadership," something to that effect, and walked out of the room.

Anyway, so my first sort of awareness—I mean, I read the Congressional Record on a daily basis. I was certainly aware of the origins of Medicare and Medicaid, how the two happened, and so forth. But that was not my primary focus. But it was clear that that was an extremely important part of the environment. And so then I became eventually associate director and then deputy director of RMP and lived through that whole fascinating experience, which was terrific for me. I'm not sure what it did for the country.

My experience to this point had been in Washington at NIH—but beginning in 1966, I had an intensive exposure to the rest of the country. I once figured out that in 1965 I had spoken face to face with the dean of every medical school in the United States, one on one, one time or another.

But we also had a lot of engagement with the hospital community, with the physician community, and so forth. So I was interacting with those folks at the same time that they were getting ready for the onset of Medicare and Medicaid. And—

SMITH: One question I wanted to kind of ask you.
When I was there in Washington, I was told that really in many ways heart-cancer-stroke, before it became RMP, was more abhorrent to the medical profession than Medicare and Medicaid, and not only that but in many ways was more visible as far as the medical community was concerned. Does that...

YORDY: Yeah. I mean, how it would have become that much of anathema had Medicare not been part of a broader phenomenon that included Medicare and Medicaid, I don't know because there's the anecdote I told you. But that actually feeds into a theme that I was going to get to in a moment. But as you can see, my perspective on this, my immediate perspective, was from the substantive health side, not from the income protection welfare-social insurance side.

I had the virtue of having been exposed to people like Chuck Kidd and so forth who knew that other side well. But that was clearly not the primary focus of my attention or the activities. But you're right, there was a lot of opposition especially—especially from the physician groups to Medicare. Shannon had recruited Bill Stewart to become the head of RMP.

He was the director of the heart institute at the time and of course he was a health care-nik, interestingly enough. And then in October, same time the bill passed, he was appointed Surgeon General.
So that had an immediate impact on the program. I was working with him on a daily basis. The person I thought was going to be my boss suddenly wasn't.

And then this new person was recruited in by Shannon, who he had been trying to recruit to NIH anyway, which was Bob Marston. And Bob had been the dean of the medical school and head of the medical center at the University of Mississippi.

And so he came to Washington to head up RMP and also had the title of associate director of NIH. And I was, you know, bequeathed to him by Shannon. Bob Marston didn't choose me, Shannon told Bob Marston that

that was what was going to happen. It turned out to be a fantastic experience. Bob Marston was a fantastic guy.

But the first time I ever met Bob Marston I was sent down, I think in December of '65—the law passed in October—to speak about this new program to the Texas Medical Association, in assembly gathered in Austin. And here I was, you know, everything they didn't like: a guy from Washington, not a doc, but a Washington bureaucrat coming to tell [them] about this program they didn't like, which had been started by Mike DeBakey, who lived in their backyard and they knew they didn't like. And it was not exactly a friendly environment in which to make this beginning. And evidently I handled myself well enough.

Bob Marston came to that meeting, just to sort of be there and see it. He hadn't arrived at NIH yet. He came over from Mississippi. And he came up to me afterwards and congratulated me on how well I had done. And that was—anyway, that was an interesting experience.
But I had a lot of those experiences. And learned a lot of things about medical politics, remember, because I essentially was dealing with every place in the country.

And as each of the programs came into play across the country, you know, I would deal with the forces in that particular area. So anyway, it was a fantastic experience for me. It was a quirky, crazy program.
That really got me more involved with health services issues. Which you can tell from my other background really hadn't been central for me. I mean, I had never taken an academic course that had anything to do with health. A lot of things having to do with public policy, broadly. But—and then this sort of strange business of the relationship of RMP to comprehensive health planning came up.

And I could go on for hours about that, but I won't, just to say that that relationship—and by the way, when I was writing things for RMP, justifications and so forth, I went back and wise people told me about things, and I went back and informed myself and read about the whole history of regionalization, going back to the Dawson report in England in 1920, and then that fascinating aspect of regionalization that's in the original Hill-Burton Act, mandating a type of health planning. So I sort of knew about that. And then the whole crazy business of CHP and RMP, which deserves a long account, but not now.

SMITH: Before you leave that area I wanted to ask you when you went to HSMHA?

YORDY: Right. I was going to say, what happened then—let me just continue with my personal odyssey here. There was a reorganization of the Public Health Service in 1966 done by Bill Stewart after he became Surgeon General.

What I have always referred to as the Bill Stewart reorganization. John Gardner wanted things reorganized. And part of why he wanted it reorganized was he had a sense—you know, I have never heard these words from his mouth directly but I've had a lot of indications of this, and I know this from Phil Lee, who was around by this time up in the Secretary level. Gardner had a sense that the Public Health Service was an old-line agency that wasn't responding very well to this new environment. Especially in a sense that OEO, a sort of rival, was out there doing things in many of the kinds of areas that I think John Gardner appropriately thought ought to be concerns of the Public Health Service. And he didn't see those concerns very strongly expressed by the leaders of the PHS. And so I think that's why Bill Stewart was appointed Surgeon General. Because Bill Stewart had those kinds of interests. And so he then reorganized Public Health Service to try and emphasize health care issues. Almost as soon as he did it though he made some appointments that Gardner—and this I do know directly—Gardner and Phil Lee didn't like.

Bill Stewart did the classic business of a reorganization. He then appointed to the heads of some of the units people to sort of appease the forces that didn't like the reorganization.

SMITH: Appease the Uniformed Service...

YORDY: Right. Appease the PHS Commissioned Corps.
And so they were disenchanted with Bill Stewart early on. And by, I think February of '66—and remember, by this time I was up to my ears getting RMP started. But we kept track of these things, obviously, because it affected us. Gardner made a public statement saying, well, the reorganization was okay but he thought more was in order, or something like that. And I had gotten to know Bill Kissick fairly well by that time.

SMITH: Oh, yeah, I know Bill well.

YORDY: And Bill was, you know, was Bill Stewart's planning person. And Bill told me about that. And he said that he and Stewart knew from February of '66 on that, you know, they were sort of under a bit of a cloud. You know, we're expecting you to do great reform things but we have been disappointed by what you're doing so far.

Anyway, by the spring of '68 Gardner wanted to do more and Phil Lee wanted to do more. So they did what you could call the John Gardner or Phil Lee reorganization of April 1, 1968. Actually, by the fall of '67 they were moving in that direction. And we were concerned from a narrow bureaucratic view what was going to happen to RMP in that. Because the notion was that RMP ought to get started under the wings of NIH, you know, sort of NIH arrogance, get off on the right foot.

But then even Shannon understood that at some point it ought to spin off and go into the health services part of the PHS.

So we knew and Bob Marston and I sat around and thought of different options of how to reorganize the Public Health Service and actually drew up a bunch of charts, had various options on it, with RMP always being in there in various ways, which was our particular interest. But I had to think about the rest of the things in order to do that.
We had a meeting in October of ’67 in Phil Lee's office. And we showed these charts and Phil Lee liked the charts. And afterwards he said to me, "Karl, can I keep those?"

He kept those, and sure enough one of those charts, with one exception that I hadn't anticipated because I didn't think the mental health lobby would allow it to be subsumed under something else. But it was. And so it became what I called the Health Services Administration, which had all the components in there, ended up there, had in addition the mental health pieces taken out of NIH and put into that so it became also the Mental Health Administration.

SMITH: Could I ask you a question about that? Was part of the reason that mental health people recognized the dynamism and the quality of what was coming out of NIH but were concerned about being co-opted and about mental health losing its community aspect.

YORDY: Well, you're right, but let me finish off one little piece and I'll come back to it.

Anyway, the reorganization took place in April of '68, which was strange because, as you'll recall, John Gardner had resigned by that time and Wilbur Cohen had become secretary.

But in a maybe lame duck circumstance, given the fact it was an election year, Wilbur was still anxious to do things. And having sat around all those years waiting to be Secretary he vigorously went off and did everything he could think of.

And I don't say that in a negative way, just—you know, he knew all about these things so he said, "Let me do them." So he went ahead with the reorganization which had been sort of put on the back burner in January with Gardner's resignation.

So HSMHA was created in April of 1968 and Bob Marston was appointed by Wilbur Cohen as the first administrator of HSMHA. So at that point I had a decision to make. Did I want to leave NIH, where I had been all those years, and follow Bob Marston, who offered me the job of heading up planning at HSMHA? Or did I want to stay behind at NIH. And I said, "You know, time to go do something else." So I went off to HSMHA in July. Then, Jim Shannon retired and Wilbur Cohen appointed Bob Marston the director of NIH.

So I had gone off and then I faced the thing. Well, do I want to follow him back? And though I had loved my years with Bob Marston I said, "No, no. Made this new move. I'll stay there."
So anyway, the—now I have lost the thought. You were asking...

SMITH: Oh, I was just asking about some of the reasons for tacking on mental health—

YORDY: Oh, yeah. You're absolutely right. The mental health program had had from way back an interest in mental health services that was stronger than was true of most of the other NIH institutes. To some extent the other institutes had interests in the services in their arena, but it was a weaker interest.

And then with the passage of the community mental health service program in, what, 1964?

SMITH: Uh-huh.

YORDY: The service interests of NIMH became explicit and they now had a service program.

SMITH: Right.

YORDY: I mean, which was directly and specifically and exclusively that. It wasn't really an NIH program. It wasn't even like RMP, you know, trying to create a bridge between research and service kind of thing. It was a service program.

So they felt that NIH was hostile. And given my organizational position, I would see these memos, you know,...respond to them, to that aspect of their program. Ah, you know, it wasn't really true, I think, in terms of the way they thought of it as hostile.

But they were certainly right in that it didn't get the attention and that the perspective of NIH was not very compatible with that aspect of their mission. So that really I think is why they went along, although they would have preferred to be totally independent.

But the funny thing—and then I'll end that with this comment. I was, you know, recipient of many memos through the years or read them where they were, you know, just a classic budgetary line. And the director of an institute writes to Shannon and says why he doesn't like what we're doing to their budget. They always were saying, "You don't appreciate our service programs."

SMITH: Right.

YORDY: Then when I got to HSMHA I would see those memos coming from many times the same folks saying, "You don't appreciate our research mission." Well, anyway, they were fairly consistent on that...

SMITH: As they say, money is fungible.

YORDY: But, you know, I got along fine with Bert Brown and the folks over there through that transition but—and I hired away to work for me at RMP a person who had worked in the mental health centers program, Lee Goldman, who then ended up on the Hill later.

But anyway, I made that move to HSMHA. And of course HSMHA, as you will recall, was essentially a conglomerate agency.

SMITH: Yes.

YORDY: Where really what happened was that it got everything in the Public Health Service that didn't fit in some other box in that reorganization...

So we had a wide array of health services programs, everything from direct services because PHS hospitals were still around and the Indian Health Service. But then the Public Health Service piece of the community health services—community health centers program and the family planning centers.

And then while I was at HSMHA, the four years from '68 to '72, we acquired, Title V health programs which, by the way, are a course in Title V of the Social Security Act. And we then acquired the OEO programs.

A few days before Nixon was inaugurated, Wilbur Cohen, as one of his last acts did appoint an administrator of HSMHA, Joe English, who had been the head of health programs in OEO. So Joe became my boss. And so that brings us I think then to a rising contact and concern with Medicare and Medicaid.

And I would say obviously I was coming from the health services side, as I said earlier, and this sort of accentuated that. And then I was also guided by things that Irv Lewis had taught me and that I saw first-hand in a meeting that was held right after the Nixon Administration took over.

Actually, Bill Stewart was still on because he was in that meeting, and so was Phil Lee. It was actually held up at Camp David, believe it or not. And it was a meeting that sort of—but the new troops were there. Veneman was there and—oh,... I know him well.

MOORE: Finch?

YORDY: No, Finch himself wasn't there. He sent Veneman. But, you know, Lou Butler. Lou Butler. Very, very active in this meeting. And it was sort of to say, you know, what's the future direction of health programs and so forth in this department. And the meeting began with a sort of technocratic budget presentation. And it had an effect that you would know, which was that the projected expenditure lines for Medicare and Medicaid went up and up.

And essentially, if you looked at any kind of reasonable budget scenario in the future, if you assumed there were going to be targets to try to hold down overall federal spending in the next Administration, it squeezed the hell out of everything else. So there was both that budgetary sense that Medicare and Medicaid, in 1969, were really, you know, grabbing hold. And even though we would laugh these days at what those figures were, they were significant increases and bigger increases than anybody had thought they would be.

SMITH: It's interesting that in particular Medicare and Medicaid get on the map when people start noticing this upward motion.

YORDY: That's right. And I sat there in that room and watched the faces of Jack Veneman and Lou Butler. And I think this was one of the first times they had been exposed to that in detail.

And so that was one aspect. It was clearly just they were the budgetary behemoths, you know, in the room. The second thing was the perspective that Joe English had, which was in some sense just a bureaucratic rivalry perspective. But it was really stronger than that.

He really had a strong sense that these programs were going to crank up demand and that what he called capacity was going to be inadequate. And he was not an economist but he would make a sort of quasi-economic argument, a sort of supply-demand kind of thing. You know, it was going to jack up cost.

But he was really more concerned—remember he came from OEO—that simply putting the bucks out there was not going to be sufficient to bring services to these target populations. And he felt that very strongly. And through the year and three or four months that he was around before he got fired in 1970, that was his theme.

And we would go and have meetings. This is where I first met Bob Ball. We would have meetings at Social Security, and Joe would be fairly aggressive about saying you're not paying enough attention to the service delivery side. And so I had in those years a fairly strong sense and then later got involved with the Medicaid task force in 1970. I think it was 1970, around in there.

SMITH: Are you talking about the McNerney task force?

YORDY: Yeah. We had people like Maggie Mahoney and all sorts of folks on it. But McNerney was the chair, wasn't he?

MOORE: Right. It was started in '69.

YORDY: It started in '69 and it to some extent grew out of this perspective that not only in a budgetary sense things were sort of, quote, out of control, but also a somewhat vaguer sense that the program itself needed to be reconsidered.

And again, I wasn't following the details of this, so I can't—you know it better than I do. But the whole business about what was done by some of the rich states in the early days of Medicaid to take full advantage of it and they were getting a, some people thought, disproportionate share of the funds, because of the matching nature of the program.

There was a lot of concern. But the Medicaid task force, as you will perhaps recall, had broader interests. It was looking at health services issues as well. And therefore, we were asked to assign some people to work on it.

And Bev Myers was a Public Health Service staff person who was assigned to it. And I got to know Bev in working with that task force.

And then after the task force was over—Joe English was still around here at that point—and I said, you know, we ought to recruit her into the office of the administrator. So she became my deputy and then succeeded me in that when I left to go to the IOM in '72.

And Bev taught me a lot of things because she had been involved in that part of the Public Health Service which had been given some responsibilities with regard to the implementation of Medicare.

And she had some fairly strong views about the extent to which the people launching Medicare—and she had, you know, somewhat similar views I think about some of Medicaid—were not paying enough attention to the service delivery implications of those programs.

So all of this is a way to say this all made a sort of pattern. I was viewing Medicaid and Medicare from the health services side and with a concern not only about budgetary rivalry but also that not enough attention was being focused on the question of what these programs were doing to the health care system.

SMITH: Well, I think one of the remarkable things that happened, going back to the Social Security Act, is that they were talking about services, about income support for the poor, and about public health-type services. And when you get to Medicare and Medicaid. I remember we were talking to Phil Lee and also to George Silver and they were saying, "Well, we were very concerned to get all these health services down in local communities and then get Medicaid to pay for them."

But then at some point they start drifting off separately and they become two separate programs, though at one stage we might have started planning them together but we never got to it.

YORDY: Yeah, well, but it was interesting. I'll give you a little anecdote that gives some more meat into that discussion and that is when we acquired Title V. Art Lesser, who was the head of it at the time, would call me down and would give me long lectures on Title V, assuming, correctly, that I didn't know much about it and also trying to make sure I didn't get in his way.

So he would go on and talk about how much Wilbur Mills loved Title V and so forth. But he also was very negative. I mean, this was a strong negative view. He didn't like the idea of money—of trying to figure out how to get Medicaid to pay for services in the maternal child health centers, which seems sort of counter-intuitive when you look back on it now. But his perspective was, we have these grants going out there and once we let the Medicaid money in, people will use it as an excuse to cut the grants.

MOORE: Well, and you know the truth of the matter is, you mentioned this a little while ago, the concern by some people who were probably a little more forward-thinking when they looked at those numbers in the late '60s that Medicare and Medicaid would squeeze absolutely everything else.

YORDY: Oh, yeah.

MOORE: And in fact, that's exactly what's happened.

YORDY: Sure. I remember as head of planning and evaluation I got very much involved with the budgetary process and we would start off the typical budget exercise. OMB would give us guidance for the early stages of the planning and they typically would give some kind of ceiling. And then they sort of subtracted the entitlement programs from the ceiling and then said, "Okay, here's what you've got to budget against." I mean, it was that

explicit. And so it was—it was both in that sort of general budgetary sense, but Art Lesser was making an even more specific point. He was making the point that it was going to be hard to maintain a grant program—

SMITH: Yeah.

YORDY: —if people could argue and say, "Well, we've got this Medicaid money out there. It's paying for the same, you know, services and same population. Why do we need the grant?"

MOORE: Right.

YORDY: And so that was—though he was really saying it in a somewhat different way—was equivalent to what Joe English had been saying. That, you know, there needed to be more attention about how you in fact organize services and brought services to these target populations, not just how you paid the bills after the fact.

I knew them in the beginning then and all the way after that, Bob Ball and Art Hess, and had a lot of involvement with them in my IOM days. And both of them admitted that when they started off, given their backgrounds, they were mostly interested in how to get this benefit out there.

They really did sort of go along with the notion, actually of course written into the statute, that somehow this flow of dollars was going to be neutral with regard to the nature of the health care system. So, it was an important intellectual point with a lot of practical implications. The simple point being you couldn't let loose that kind of dollar flow without having some kind of impact. And so anyway that was my perspective on those early days of Medicaid, which is a sense that it was an incomplete strategy.

And then there's another bias I should mention which was very much an NIH bias, and certainly an RMP bias. And the early days of my HSMHA experience probably also accentuated this, which was—well, you know, from a theoretical point of view I understood the federal system quite well. It was basically an anti-state bias. Because the whole NIH approach, the RMP approach, the OEO approach was to say that the states are at best a bother and at worst a barrier to what we're trying to do.

I remember my early HSMHA days when we were sitting around, making some appointments and going over names and so forth. Somebody said,

"Well, you know, we ought to get a good state health director in here." And people—and these were people who worked with them all the time.

They were actually fairly sympathetic. They would sit around and say, "Oh, gee," you know. There was a very strong bias that the talent in the states was inferior, that states for a variety of reasons were laggard, and not the least of which were the civil rights concerns. Which in '65, '66, '67 was anything but a past issue, that the states were a barrier. And of course the strange quirky thing that you have Medicare and Medicaid with Medicare coming from the social insurance federal side and Medicaid being built on the history of the federal state welfare model, that was something which I understood and knew but clearly had been conditioned to be on the federal side of that argument, that way of looking at the world. And this is also present, of course, in the RMP/CHP tension.

So that's another perspective I had which I think remains, you know, an important reality of the Medicaid program sitting here in Arizona. And in my IOM days I was asked by Keith Weikel when he was the head of Medicaid—I don't know when that was—but there was a meeting of the National Association of State Legislators, which was actually occurring in Phoenix. And he asked me to come and from my perspective talk about some aspects of the Medicaid program. In my presentation, I was talking about problems with Medicaid.

And after my presentation one of the people from the audience got up and said, "Wow." It turned out he was the head of one of the health committees here in Arizona. He said, "Well, after hearing all these problems that Mr. Yordy has described I sure am glad we don't have a Medicaid program." And so the governor's staff came up to me afterwards and said, "We need to get busy trying to, you know, redress the damage."

SMITH: Yeah, damage control.

YORDY: Anyway, that was a sort of a thumbnail—long thumbnail—of where I came from on the origins of Medicaid. And the key sort of takeaway message is a sense that the health services perspective wasn't getting enough attention.

And then, from a conceptual program point of view, as well as a bureaucratic point of view, there isn't any question—and others more knowledgeable than me can tell you this in greater detail and probably have—that there wasn't very good coordination among these programs.

One of Bev Myer's comments—and I know and admire Bob Ball as one of the great public servants at the time—was that they [Social Security] were the big gorilla and that they sort of dealt in an off-handed way with the Public Health Service.

I mean, they had nice words and signed nice cooperative agreements and so forth, but Bev's perspective always was they paid attention to Public Health Service when they felt like it. And I think that was pretty much true of Medicaid as well, although in a different way. There wasn't much coordination of the two. I mean of the three, really. And everybody was busy doing things. But there were also, I think, conceptual, attitudinal, programmatic barriers to that occurring.

And I know Phil Lee and George Silver and others, a lot of those folks, thought about that and cared about it but it was very difficult to do much about it substantively.

SMITH: Now, when and why did you go to IOM?

YORDY: Well, I—when the IOM was getting created there was a sort of predecessor organization within the NAS structure called the Board on Medicine, which was Walsh McDermott's first effort to try to get a stronger focus within NAS on health issues. And the staff person for that board, interestingly enough, was Joe Murtaugh. Who had been the assistant chief of that planning office back in 1957 at NIH. And then, so I knew about it from that perspective. But then John Hogness, who was the first president of the IOM and had been the dean of the medical school of the University of Washington for some time, a very successful dean, and then had become executive vice president of the university, had been involved in RMP and was I think on my first national advisor council. He was a good friend of Bob Marston.

He got to know me through that. And so when IOM was being created, when it went beyond the preliminary stage of the board to become a full-fledged—although disliked by the head of NAS—component of NAS, John came and recruited me.

And I became the third employee of the IOM. It was John Hogness and then Roger Bulger—who had been an associate dean at University of Washington and was the first person he recruited. Then I was the next and then Ruth Hanft was the next.

So, you know, literally we were it when the place really opened for business in the spring of '72—

MOORE: Karl, when did you retire from IOM?

YORDY: I sort of phased out by deliberate plan and intent in '93. But what happened was I sort of thought, well, one of these days I'm going to retire. And by that time I was the person who had been around longer than anybody else at the IOM. And I had always believed from watching my father and others in tapering off into retirement. You know, rather than in the end, getting the gold watch and leaving, going and playing golf. So I had the notion a year or so before I left that I really could run an IOM project from someplace else because I knew how it was done.

So I made that proposition to Sam Thier when he was the president of the IOM. Then when Ken Shint became president I broached the idea with him as well. So I came out here with the arrangement that I would direct an IOM project on primary care.

And I had gone out and gotten the money. And so I was funded by IOM via the university here. I got a university appointment. And ran that project and used that as sort of a phasing out of my IOM activities. So, you know, I left the scene of IOM in September of '93 but I stayed involved up until actually early '96 by this other arrangement and then totally left.

And I have been semi-retired ever since. I do some lecturing at the University. I serve on some pro bono boards in the health area. I get involved in consulting things every now and then in a sort of opportunistic basis, worked with Monte Duval on a project a couple of years back on issues about the uninsured in Arizona. And so forth. I grew up in the West, grew up in Denver and I had always wanted to come west again. And I had an aging mother in Denver and my wife has an aging mother in San Diego, and Tucson is in between. And that aspect has actually worked out very nicely. They are both still alive. My mother is 97, her mother is 94.

MOORE: Wow.

YORDY: And, you know, we get to see them fairly frequently. So anyway, that's the story.

SMITH: Could I ask you one question in particular about IOM? How did you come to get involved in the nursing study, the nursing home study?

YORDY: The nursing home study? Because we also did a big nursing study.

SMITH: Nursing. No, the nursing homes.

YORDY: Well, by that time I had become the head of the division that handled health services issues at IOM. That was a study that arose essentially out of the controversy over nursing homes—things like Bruce Vladeck's book. And so forth. Congress was concerned about this attempt by the Republican Administration, the Reagan Administration, to back off from regulation of nursing homes just at a time when many thought what was needed was better regulation.

And so it was a Congressionally-mandated study. Elma Holder and her group were very antsy about us doing it because they viewed us, somewhat correctly, as a medically-oriented group.

And they weren't at all sure that we would be able to do a good job on that kind of a study and also weren't sure where it would come out, as was true of IOM in general. I mean, when you launch a study at IOM you don't know where it's going to end up. And the study had a very fractious life for a variety of reasons. So I was more involved as division director than I would on some studies because some of the members of the committee were unhappy with the study director and I got drawn into that a lot. But the end result was such that at the Congressional hearing where the report was released, Elma Holder came up to me and shook my hand and said, "You know, I was wrong. You did a fine job." So anyway, it was a classic example of one way that IOM got studies, which was a big controversial issue that nobody else could quite deal with. And they sort of threw the hot potato at the IOM.

SMITH: How important or useful was Bruce's book? Because I've read it from cover to cover. I thought it was a splendid job.

YORDY: Oh, yeah. Bruce was on the committee as were some other people who had been informed analysts for reform of nursing home regulation.

But the book was very useful. Work done by others that was parallel to Bruce's book were very useful in illustrating that there was a real problem to be addressed. And that problem was different. And something that I found, because this was really my first exposure to nursing home issues, was that

the presumption over on the sort of hospital side was that basically hospitals are pretty good places. But they might need to have some regulation because there might be somebody that strays off the noble path. Whereas the mindset regarding nursing homes was the other way around. Which was that there were a lot of bad things going on in the nursing home world that you ought to be concerned about, and that there was a need for a strong attention to care for this vulnerable population. That was not as true on the hospital side.

Secondly, that this population was different and that's illustrated by a single word, which I learned in the course of that study. When you talk about hospitals you talk about patients. And when you talk about nursing homes you talk about residents—because they are. My mother is in one, so I know. And so I think the substantive contribution of these concerns is that you need regulation but that you need effective regulation and it needs to go beyond the structure of care, the fact that the states could be carrying out the regulatory responsibility with regard to nursing homes and never see or talk to a patient—I mean a resident.

The chair of the committee, Sid Katz, wasn't always a strong chair, but when controversy broke out he made wonderful substantive contributions to the study. He's the guy that invented the ADLs [activities of daily living] and was a distinguished researcher in this area.

He was very interested in how you would come up with approaches that could be, in the first place, more resident-based and, in the second place, more concerned with some kinds of outcomes. And how you could start to create the database that would do that. And that leads to another important observation—an education for me with regard to that study—which was that, for hospital patients, the assumption is that they ought to get better. And therefore, a higher mortality rate, for example, is something to be concerned about. In the nursing home population the expected outcome is decline.

So you can't say, well, people got worse because they were in this nursing home however you're going to measure it—ADLs or something else—and therefore this nursing home is doing something wrong. Well, of course, that's not true.

If they were getting absolutely optimal care they would still decline. So the need was to create a database from which you could look and say, does this nursing home vary from the expected rate of decline? Now, a data set was put in place, which is more relevant to assessing the care provided.

But that certainly was an important conceptual contribution of that study to say that it's not just that you need regulation. You can't back off of regulation but the nature of regulation needs to change. And in that sense it was—after all, it was 1986—was preceding what has been happening in medical care in more recent years with HEDIS and so forth.

So anyway, that's my view of that. But some IOM studies go off into the mists and others have considerable impact. That was one in the latter category. And the first lines of the Congressional bill that resulted was "to implement the report of the Institute of Medicine."

MOORE: Are there any other closing thoughts you might have looking back over your years at IOM about the Medicaid program and the way it evolved over the years?

YORDY: Well, let me make just a couple of observations with one important comment. Walt McNerney got me involved—not Walt, excuse me. But it was actually George Bugby. I don't know if you have ever heard of George Bugby. He was a grand old man of hospital administration in this country who ran a series of sort of continuing education programs for V.A. Hospital directors. One of the people that George had involved in these week-long sessions, held several times a year, was Sir George Godber.

I got to know Sir George through our joint involvement in those sessions. And he made a comment once that always fascinated me, which was to say that he wanted to come to the United States and poke around and see what was going on because there was such a richness of activity. A sort of chaotic diversity, without the top-down organized system such as that which he had been responsible for in England.

He said even going to Sweden was better. He learned things because Sweden at least had the different counties or Canada had some differences among the provinces. But he said one of the real barriers to taking action in the British National Health Service was that if you did it you had to do it for everybody.

Medicare is, of course, a uniform national program. However, Medicare is a funny hybrid, a national program but with decentralized administration of a lot of aspects of it. But certainly Medicaid has great variety across the states.

And again, sitting in Arizona is a good place to observe one of the good things about the decentralization inherent in the federal-state aspect of Medicaid: that you are able to see things done in different ways.

And so I think that is a potential strength of the Medicaid program. But it is probably—and I say this without knowing in detail, but it probably is an under-evaluated and rationalized aspect of the program. In other words, who was it, one of the famous Supreme Court justices talked about the states being the...

SMITH: Experimental laboratories. That was Brandeis.

YORDY: Yeah, right. And, you know, somebody that believes that fairly strongly is Monte Duval, who feels fairly strongly that what was done with AHCCCS [Arizona's Medicaid program] here in Arizona ought to be a model to be expanded, made available, to the population more generally. I am not so sure about that, though certainly, his point was more palatable back when managed care was on the upswing.

But you need to have some kind of organization to the system in order to expand access to care, and I think that Medicaid does have that potential. The trouble is, Medicaid keeps running across the budgetary constraints of state and federal funding. Also it still suffers as it always has from being a program for the poor, with all of the programmatic and budgetary implications that that has. But I still think that that's there as a potential. For example, the recent series of IOM reports, you know, on the quality dimension and especially the one on crossing the quality chasm.

One of the things—and I have said this to Berwick and others—is that to do what is stated in those reports requires more of a health care system than we have. I mean, just as they are making the point that a lot of the problems that are identified are systemic problems, the response to them needs to be systemic.

And in fact we're doing the opposite. Here in Tucson the effects of the changes in health care in the years I've been here, the 10-plus years I've been here, has been to take apart all of those things in town which had some semblance of an organized system of health care.

So the Thomas Davis Clinic, which was one of those classic multi-specialty mini-Mayo clinics and which had been here since the '20s and had been for

many years quite successful, launched branches in Phoenix, started its own HMO, but now that whole package has disappeared.

And everything else that had that kind of character, a sort of a group practice—and I'm talking fee-for-service group practice—disappeared. And so it seems to me that we have been in fact moving away from the kind of organization in the system that we need more of.

And this goes then back to the early days of things like OEO where the people that were thinking up community health centers are actually sitting there thinking, you know, how should these services be organized to meet the needs of the less fortunate in this society. And, you know, we don't do very well at that. That goes against the forces that have been wrecking medicine and health care in recent years.

SMITH: Well, Bruce Vladeck feels that perhaps more strongly than anybody I know and would certainly agree with you very much that the challenge of the future is—

YORDY: You know, the issue does get back to that sort of conceptual thing I was talking about early on. The issue really has to be more than just how do we extend coverage.

As crucial and important as that is, and indeed, you know, one can make, I think, a reasonably decent argument that says until you have done that it's difficult to do these other things. But that puts you in a terrible bind, as indeed the Clinton plan showed.

You noticed one of the Republican ads I saw for the—in criticizing Kerry's health plan they brought out that old thing from the Clinton plan?

MOORE: Oh, the big three...

YORDY: Yeah, the big chart with all the boxes and arrows and lines. It's a bureaucratic monstrosity, you know.

MOORE: Oh, my. The more things change, the more they remain the same. Well, thank you, Karl.

YORDY: Well, I have wandered around quite a bit but I hope it's been of some use.

MOORE: Very helpful. Thank you so much, Karl.

SMITH: It was a lot of fun. Thanks again.