UNFUNDED MANDATES IN MEDICAID

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

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CONTENTS

	Page
Hearing held on January 18, 1996	1
Statement of:	
Beach, William, visiting fellow, the Heritage Foundation; Philip Dearborn, director of government finance research, Advisory Commission on Intergovernmental Relations; and Judith Feder, Institute of Health Care Research, Georgetown University	144
Petraborg, John, deputy commissioner, Minnesota Department of Human Services; and David Parrella, Medicaid director, Connecticut Department of Social Services	4
Scanlon, William J., Associate Director, Health Financing Issues, General Accounting Office, accompanied by Richard Jensen, Medicaid Specialist	122
Vladeck, Bruce, administrator, Health Care Financing Administration	67
Letters, statements, etc., submitted for the record by:	
Beach, William, visiting fellow, the Heritage Foundation, prepared statement of	165
Dearborn, Philip, director of government finance research, Advisory Commission on Intergovernmental Relations, prepared statement of	148
Feder, Judith, Institute of Health Care Research, Georgetown University, prepared statement of	156
Parrella, David, Medicaid director, Connecticut Department of Social Services, prepared statement of	37
Petraborg, John, deputy commissioner, Minnesota Department of Human Services, prepared statement of	7
Scanlon, William J., Associate Director, Health Financing Issues, General Accounting Office, prepared statement of	125
Shays, Hon. Christopher, a Representative in Congress from the State of Connecticut, list of Governors eager to get into program	182
Towns, Hon. Edolphus, a Representative in Congress from the State of New York, prepared statement of	112
Vladeck, Bruce, administrator, Health Care Financing Administration:	
Information concerning mandatory services and people	92
Prepared statement of	72
Waxman, Hon. Henry A., a Representative in Congress from the State of California, prepared statement of	108

UNFUNDED MANDATES IN MEDICAID

THURSDAY, JANUARY 18, 1996

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 12 noon, in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays and Souder.

Staff present: Lawrence J. Halloran, staff director and counsel; Kate Hickey, and Robert Newman, professional staff members; Thomas M. Costa, clerk; Dave McMillen, minority professional staff; and Jean Gosa, minority staff assistant.

Mr. SHAYS. I would like to call this hearing to order and to welcome our witnesses, our guests and our C–SPAN audience as well.

This is a hearing that won't die. Despite near mortal assaults from snowstorms, scheduling conflicts and time changes, this hearing to examine the issue of unfunded mandates in Medicaid is at last convened. We deeply appreciate the patience and cooperation of all of our witnesses.

Last year, this subcommittee held four hearings on fraud and abuse in the Medicare and Medicaid programs. Two of those were on the legislative proposals to strengthen antifraud activities and to protect the integrity of health care spending. We also heard testimony from the Health and Human Services Inspector General, the Health Care Financing Administration and the Department of Justice, State officials, scholars, commentators and many others on the staggering costs of scams, abuses and mismanagement.

Some estimate that fully 15 percent of all Medicare and Medicaid spending is wasted. Many of us think it is much higher.

Today, we address another factor driving Medicaid spending to unsustainable levels: unfunded mandates.

Over the years, when Congress added to the Medicaid entitlement through expanded eligibility or additional covered services, little or no thought was given to the fiscal impact on the States or, in fact, even to the Federal Government. The Boren amendment, one effort intended to help States limit Medicaid reimbursements to reasonable costs, has been transformed into an unfunded mandate, enforceable in Federal court, to reimburse providers for the full attributable cost of every Medicaid service.

In a draft report prepared pursuant to the Unfunded Mandates Reform Act, Public Law 104–4, the Advisory Commission on Inter-

governmental Relations identified the Boren amendment as a mandate which many States feel handcuffs their ability to constrain the growth of Medicaid spending during times of fiscal crisis.

As a result, Medicaid spending, driven by rigid Federal rules, relentlessly commands a greater and greater share of State budgets. At projected growth rates, State Medicare expenditures between now and the year 2002 will grow from $69 billion to $104 billion, a 50 percent increase. Federal Medicaid spending is projected to double during the same period. No one claims spending at this uncontrollable pace can be sustained for very long without crippling fiscal and human consequences.

In an effort to regain control of Medicaid spending, both Congress and the administration have proposed to limit the growth of Federal expenditures on the program. Now let's be very clear on that point from the outset. Both parties, both political parties, have proposed to limit the growth of Federal Medicaid spending, albeit through very different mechanisms and at different rates as well.

Before anyone indulges in any politically charged and telegenic theatrics about cuts, I want to be very clear on this issue, that both sides have acknowledged the need to restrain the rate of growth in Medicaid spending. We are not talking cuts. We are talking about restraining the rate of growth.

The question then is how. Or, more specifically, how can Federal Medicaid spending be restrained without shifting unbearable costs to the States through unfunded mandates?

The Congress proposed to transform Medicaid into a block grant, providing a defined Federal grant to the States along with the responsibility and flexibility to design and purchase health care for those in need.

The administration proposed a per capita cap on Federal Medicaid spending, limiting the growth of per-beneficiary expenditures but maintaining mandated eligibility and services.

We both have different approaches. We will discuss both proposals today, asking our witnesses which approach offers States the most effective, physically sustainable opportunity to provide for the health needs of vulnerable citizens.

The States are already leading the way to Medicaid reform. Minnesota, Connecticut, Tennessee, Arizona and many other States are pursuing managed care options to control costs and meet expanding needs. But they must do so through a cumbersome waiver process. In the Federal-State Medicare partnership it seems only one partner gets to make the rules.

To anchor its domineering position, HCFA points out that Medicaid is a voluntary program. But it is a fiction to suppose that a State would withdraw from the program, just as it is fallacious to assume that States would race to the basement in structuring their own health care programs.

The Medicaid partnership, like a marriage, must be sustained by a mutual respect and trust. The mere possibility of divorce is no justification for Federal extortion in the form of unfunded mandates.

The President recently observed that the perfect should not be the enemy of the good in Medicare and Medicaid reform. I agree with the President but would go further. State flexibility should not

be the enemy of national standards for health care. Managed care should not be perceived as the enemy of quality care, and fiscal sustainability should not be seen as the enemy of compassion.

No one wants pregnant women and children to go without health care, and they won't. No Governor or legislature wants to deny nursing home care to the elderly, and they won't. Yet on our current course, if we don't reform Medicaid, those who we want to help the most will surely be hurt the most.

Unless we use every tool available to reform Medicaid, including State ingenuity and accountability, the Medicaid partnership will lock both partners in a fiscal death grip. More unfunded Medicaid mandates are not the answer. Having all but used up Federal fiscal capacity while amassing $5 trillion of accumulated deficits, we cannot demand the States pick up the tab.

I look forward to the testimony of all of our witnesses on this important topic and do want to state that we postponed this hearing for Mr. Waxman, who is truly the expert on this issue, has been involved in this for such a long time. He is, as we talk, trying to get a flight down in a foggy day.

Mindful of the fact that we have two Republicans and no Democrats, I am going to be very cautious of the fact that we don't, in that sense, have someone from the other side of the aisle; and any witness who thinks that we are not being fair on that grounds, speak up and I will take pause.

Mr. Souder, I welcome any comment you would like to make.

Mr. SOUDER. Thank you.

I don't have an opening statement. I am just one of those shy freshmen, who is here to learn. So I am looking forward to hearing the witnesses today.

Mr. SHAYS. Thank you.

We have four panels; and I would invite our first panel, the deputy commissioner of the Minnesota Department of Health Services, John Petraborg; and the director of medical administration policy, Connecticut Department of Social Services, David Parrella.

If there's any Democratic staffer here, I would more than welcome them to come up—if Henry Waxman's staff is here—and I might even invite them to ask questions. We will see how that goes.

Dave, you are from the full committee?

Mr. MCMILLEN. Yes.

Mr. SHAYS. You are more than welcome to participate in this hearing and ask questions, in fact. So you may sit up here, if you would like. You don't have to if you don't want.

Mr. MCMILLEN. Thank you.

Mr. SHAYS. John, why don't we start out with you and welcome your testimony.

Excuse me. We are going to swear our witnesses in. That is our practice with all of our witnesses, be they the Secretaries of a Department or a guest, whatever. If you would please both stand.

As is the custom, we swear in our witnesses.

[Witnesses sworn.]

Mr. SHAYS. For the record, both have responded in the affirmative.

STATMENTS OF JOHN PETRABORG, DEPUTY COMMISSIONER, MINNESOTA DEPARTMENT OF HUMAN SERVICES; AND DAVID PARRELLA, MEDICAID DIRECTOR, CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

Mr. SHAYS. John, why don't you begin your testimony?

Mr. PETRABORG. Mr. Chairman and members of the committee, thank you for this opportunity to share with you Minnesota's vision for reforming the Medicaid system.

Mr. SHAYS. You know what I am going to ask you to do—your mike is the silver one. C–SPAN is the darker one. I think they pick up fine. If you could talk into that silver mike.

Mr. PETRABORG. That better?

Mr. SHAYS. Yes. Talk nice and loud, if you will.

Mr. PETRABORG. All right. Thanks for this opportunity to discuss Minnesota's vision——

Mr. SHAYS. I don't think your mike is on. We are going to wait a second. Turn it up.

Those in the back of the room who cannot hear, we welcome you here. If you can't hear, raise your hand. I will ask our guests to speak louder.

Mr. PETRABORG. Mr. Chairman, thanks for this opportunity to share Minnesota's vision for reforming Medicaid in the context of this hearing on unfunded mandates.

As the various discussions continue, I want to assure you that Governor Arne Carlson of Minnesota and his administration are working hard to find ways to meet the needs of Minnesotans while supporting the goal of a balanced Federal budget.

In Minnesota, we already have a number of market-based reforms under way that show how innovations in health care can work. In fact, in Minnesota, contrary to what some people would have you think, we have shown that managed care is high quality care. We have shown that when people don't have to worry about their health insurance, they are more likely to get off welfare and to get jobs. And we have shown that saving money doesn't have to come at the expense of our children.

In spite of our successes, we know we have just begun; and that's why Minnesota is wholeheartedly behind efforts here in Washington to create a better publicly funded health care system. As Congress works to create that new system, we in Minnesota want to make sure that States have the right balance of flexibility and funding to achieve our ultimate goal, access to affordable, quality health care for people in need.

When we talk about this balance between adequate funding and flexibility, it is also critical that any mandates that come out of Washington receive proper funding, and I will talk a little more about that later.

First, the case for retiring Medicaid. Tinkering with the current Medicaid system will provide, we believe, neither the broad flexibility needed nor funding that can sustain our goal of meeting the needs to care for our citizens.

Medicaid has been altered in large and small ways for many years, and the result is a system that's difficult to administer. Even experts find it difficult to understand the nuances of the system.

A marvel in its day, Medicaid is now a system that is collapsing under its own weight. The rate of growth in the Medicaid program exceeds the rate of growth of personal income in our State. In Minnesota and many other parts of the country, the State's share of the current Medicaid program will soon consume a majority of the State's general fund budget.

This is a path that is simply not acceptable, and another round of incremental change is not enough to turn the situation around. If we try that course, we believe that the people we are trying to serve and protect will be hurt. There simply will not be enough money available to support Medicaid as we know it, and we will have to make cuts in the program at the expense of some of our most vulnerable citizens.

So in Minnesota, we believe, we need to start fresh; and, to do that, we need a system that allows us to be true to our values and allows us to create efficient, simple and people-centered approaches.

In Minnesota, as we have participated in the national debate, Governor Carlson's administration has gone to great lengths to try to secure public input into the nature and the direction of our publicly funded health care programs. We have traveled around the State this summer and fall and found people very open to change.

For the record, I have included a document that outlines Minnesota's plan and which grew out of this broad-based input. The plan would create a new health care system built on a number of guiding principles: first, providing access to quality—high quality care, promoting personal independence and wellness, ensuring efficiency and value, and reinforcing accountability and responsibility.

For Minnesotans who are elderly or disabled, we are trying different ways of coordinating care to stress independence and quality of life, ways that would focus our purchasing toward buying comprehensive packages of services, providing an incentive to find appropriate care in the appropriate place. The current Medicaid program has a strong residential bias, if you will. This is not only physically prudent but it is what our people want and need.

But, when we talk about flexibility, this does not mean putting consumers at risk. In fact, in Minnesota, consumer protection and education must be at the core of any redesigned program.

We believe that the new system has the potential for greater consumer protection than does the current system, which is based on complex, highly prescriptive regulations and regulatory enforcement mechanisms. Using market-based strategies to maximize the State's tremendous purchasing power, we believe we will have the option of demanding higher standards. As for marginal providers that are protected by the current system, they will either improve or we will take our business elsewhere.

We must also develop mechanisms for health care consumers to have a voice—mechanisms that focus on outcomes, not rules and regulations, and mechanisms that are available to all health care consumers, not just special procedures for public clients only.

Options include consumer satisfaction surveys, which we are already trying in our State.

We have recently completed a quite—a comprehensive survey of Minnesotans about their health care and published the results in

newspapers around the State. Minnesota's publicly funded programs scored very well in this survey. In fact, the State-subsidized program for low income working families, Minnesota Care, scored No. 1 of all public and private health care plans in the State.

Because of Minnesota's tremendous health care infrastructure we believe that within the new system we also must address the need for education and research, which are now indirectly funded through the Medicaid program.

Given the expected cuts—or changes in Medicare for medical education and the impact of an increasingly competitive market, the Governor has become concerned about the erosion of this resource in our State.

Let me address the issue of caring for the needy and the issue of an entitlement briefly. There has been a lot of talk concerning this issue.

The absence of Medicaid does not have to mean the end of our commitment to providing a safety net for certain populations. We believe a safety net must be maintained but that it should and can exist in the context of a new system. We do not need to preserve Medicaid to guarantee access to health care for our citizens.

Finally, let me say that we, in Minnesota, set out a very ambitious agenda, one that we are eagerly taking on in Minnesota; and we believe we can be successful if we have the kind of flexibility that has been discussed here in Washington and adequate funding to do that.

This will also take time. It has taken nearly 30 years to build the existing Medicaid program, and we need to have sufficient transition time to implement this new system and minimize disruption to the people who need services.

Finally, I think there are several areas where there is a lot of agreement in spite of the discussion here. Most of us believe that eligibility should be simpler, that our focus should be on people, not on programs, and that market forces should be used to the fullest extent possible and that people shouldn't have to quit their jobs to get health care for the children. So if we step back from the debate and focus on some of the things that we agree on, I think that we have the basis for further work.

Thank you very much.

Mr. SHAYS. Thank you.

[The prepared statement of Mr. Petraborg follows:]

Minnesota's response:

Designing a better health care system

Deputy Commissioner John Petraborg ■ Testimony

Committee on Government Reform and Oversight,
Subcommittee on Human Resources and Intergovernmental Relations

Minnesota Department of Human Services ■ January 1996

Introduction

Mr. Chairman and members of the committee, thank you for the opportunity to share Minnesota's vision for reforming Medicaid.

As negotiations continue, I want to assure you that Governor Arne Carlson and his administration are working hard to find ways to meet the needs of Minnesotans while supporting a balanced federal budget.

Minnesota already has a number of market-based reforms under way that show how innovations in health care can work.

- Contrary to what some people would have you think, we have shown that managed care is high quality care.

- We have shown that when people don't have to worry about health insurance, they're more likely to get off welfare and get jobs.

- And we have shown that saving money doesn't have to come at the expense of our children.

In spite of our successes, we know we have just begun. That is why Minnesota is wholeheartedly behind efforts here in Washington to create a better health care system.

As you work to create that new system, we in Minnesota want to make sure states have the right balance of flexibility and funding to achieve our ultimate goal–access to affordable, quality health care for people in need.

When we talk about adequate funding and flexibility, it is also critical that any mandates coming out of Washington receive proper funding. I'll talk more about that issue in a few minutes.

The case for retiring Medicaid

Tinkering with the current Medicaid system will provide neither the flexibility nor the funding that Minnesota needs to care for our citizens. Medicaid has been altered in large and small ways for many years.

- The result is a system that is cumbersome to administer and difficult for even the experts to understand.

- A marvel in its day, Medicaid is now a system that is collapsing under its own weight.

The rate of growth in Medicaid exceeds the rate of growth of personal income. In Minnesota and in many other parts of the country, the state share of the current Medicaid program will soon consume most of the state's budget.

That is unacceptable. 3

Another round of incremental change is not enough to turn this situation around. If we try that course, the people we are trying to protect will be hurt.

- There is simply not enough money available to support Medicaid as we know it.

- We would have to slash the program at the expense of some of our most vulnerable citizens.

We need to start fresh.

Minnesota and many other states prefer the creation of a new structure, such as Title 21. We need a system that allows us to be true to our values–one that allows us to create efficient, simple, people-centered approaches.

Minnesota's approach

Since it became clear there would be significant reforms at the federal level, Governor Carlson's administration has gone to great lengths to gather the ideas of stakeholders and the public at large. We traveled the state throughout the summer and fall, and people are open to change.

- For the record, I have included a document that outlines Minnesota's plan, which grew out of this broad-based input.

Our plan to create a new health care system is built on a number of guiding principles. We intend to design a system that:

- provides access to high quality care,
- promotes personal independence and wellness,
- ensures efficiency and value, and
- reinforces accountability and responsibility.

For those Minnesotans who are elderly or disabled, we are trying different ways of coordinating care to stress independence and quality of life.

- Under the current system, the incentive is to place people in nursing homes because that is where the funding stream is.

- But if we are given the flexibility to contract for a comprehensive package of services, the incentive will be to find appropriate care at the appropriate place.

- That's not only fiscally prudent, it is what our people want and need.

When I talk about giving states flexibility, that doesn't mean consumers should be at risk. Consumer protection and education must be at the core of any redesigned program.

In Minnesota, we believe a new system has the potential for greater consumer protection than does the current system, which establishes a basic threshold, but no more.

- With market-based strategies that maximize the state's tremendous purchasing power, we will have the option of demanding higher standards.

- As for marginal providers that are protected by the current system? They will improve, or we will take our business elsewhere.

We must also develop mechanisms for all health care consumers to have a voice–mechanisms that focus on outcomes, not rules and regulations. This is essential.

Options for consumer input include consumer satisfaction surveys, which we're already trying in my state.

Recently we surveyed Minnesotans to find out how they feel about their health care and published the results in newspapers around the state.

- To my knowledge, this marks one of the first times any state has taken the collective pulse of consumer satisfaction for public and private health care consumers.

- By the way, Minnesota's publicly-funded programs, especially a state-subsidized program for low-income working people, fared very well.

Because of Minnesota's tremendous health care infrastructure, we believe that within the new system, we need to address education and research, which are now indirectly funded through Medicare and Medicaid.

Given the expected cuts in Medicare for medical education and the impact of an increasingly competitive market, we have been concerned about the erosion of this important economic infrastructure for our state.

Without adequate financial support for medical education, we as a nation will witness a systematic dismantling of the high quality medical care to which we have all become accustomed.

- That's why Governor Carlson is proposing the creation of a Medical Education and Trust Fund at the state level that will be financed broadly across all payers and distributed to teaching programs.

The support cannot end here. You at the federal level must continue a similar financial commitment to ongoing medical education. High quality medical care and education must remain a priority.

Caring for the most needy

There's been a lot of talk recently concerning the "entitlement" aspects of Medicaid. There has been understandable concern that without Medicaid, there would no longer be a safety net.

But the absence of Medicaid does not have to mean the end of our commitment to providing a safety net for certain populations.

- We believe a safety net must be maintained, but that it should and can exist within the context of the new system.

- We do not–let me repeat, we do not–need to preserve Medicaid to guarantee access to health care for our vulnerable citizens.

If given the flexibility, we can design a system that provides a safety net ***and*** reflects our principles of independence, efficiency and responsibility. **10**

Unfunded mandates: An underlying concern

One issue that is related to both funding and flexibility is the issue of unfunded mandates.

- With shrinking state dollars and a growing need for services, it is becoming more important that rules, regulations, and programs imposed by the federal government come with the funding to pay state costs.

You've heard states talk about our concern over unfunded mandates for many years. But the time has come when we can no longer absorb these costs. If reform efforts at the state level are to succeed, we must have assurance that the federal government will back up their ideas with a financial commitment.

- Likewise, it is important that if new responsibilities are placed on states, adequate funding be provided to permit us succeed.

Keys: Flexibility, funding, transition time

I've just described an ambitious agenda. It is one we are eagerly taking on in Minnesota. We believe we can be successful if we have:

- flexibility and
- adequate funding.

Even so, we must be realistic. The Medicaid program we have today was thirty years in the making. We must have sufficient transition time to design and implement a new system and to minimize disruption to people who need services.

- The longer the debate in Washington takes, it becomes more and more critical that you adjust the effective date accordingly.

Conclusion

In conclusion, a few brief thoughts. Much has been made in the news reports out of Washington about the lack of final agreement on a budget–particularly Medicaid. From where I sit, there appears to be a great deal of agreement. Most of us believe:

- that eligibility should be simpler,
- that our focus should be on people, not programs,
- that market forces should be used to the fullest extent possible, and
- that people shouldn't have to quit their jobs to get health care for their children.

I urge you to step back, reexamine these common principles, and build on them together. Thank you.

Crafting Minnesota's Response:

Federal Reform Briefing Medicaid

Fifth Edition
January 1996

PREFACE

Congress has been working for several months to balance the federal budget, reshape federal programs and send those programs to the states in the form of block grants or capped state entitlements. The Department of Human Services has monitored federal actions and is developing policy approaches to address these potentially massive changes. This document outlines proposals that respond to federal changes that could be anticipated in the area of Medicaid, as well as publicly funded health care policy changes that should be done to improve the program regardless of federal Medicaid reform.

This is the fifth in a series of documents that the Department has used to inform the public and gather comment on how publicly funded health care should be subsidized, purchased, and delivered and how the Department should respond to proposed federal changes. Earlier editions outlined the potential federal changes and presented policy frameworks that we would use in developing our proposals. This document goes a few steps further. It describes the major components of a proposed publicly funded health care system for Minnesota that could be implemented in response to anticipated federal reforms or potentially in the context of a federal waiver under existing federal Medicaid law. This proposal is based on our analysis of congressional legislative proposals and the public input we have received to date. The proposed response describes an approach that is conducive to changes in available funding. While our approach is not etched in stone, responding to the new federal fiscal realities is central to any proposed strategy for publicly funded health care. Fiscal reality does limit our choices.

It is our hope that discussion of this document will be useful to policy makers in shaping Minnesota's response to changes in the funding and delivery of health care in a way that improves access to quality health care for all Minnesotans.

SYNOPSIS OF PROPOSAL

Minnesota's publicly funded health care programs are growing at a rate that clearly exceeds the available state funding. This growth, coupled with the potential reduction in future federal Medicaid funding, makes it imperative that these programs be redesigned to meet the needs of Minnesota's most vulnerable citizens within a limited appropriation. The Department of Human Services' role in providing health care coverage to low-income, uninsured, and special needs populations must change to address this new paradigm. Our focus must be on three essential functions:

- Subsidizing health care;
- Purchasing health care; and
- Consumer protection.

Minnesota Department of Human Services
January 1996

To meet these challenges with the potential for reduced funding, fundamental policy changes will be required. The current Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare programs must be integrated to better serve enrollees, to reduce administrative expenditures, and to facilitate streamlined purchasing of health care services. Eligibility for the programs must be simplified by use of gross income tests, streamlined eligibility categories, and by offering multiple eligibility access sites. Coverage must be designed to target the needs of the population, calling for a benefit set for most enrollees that would be similar to a typical employer benefit set and supplemental, long-term or continuing care coverage to wrap around Medicare for most elderly and disabled enrollees.

To achieve efficiencies in purchasing health care, coverage would be purchased through health care service networks on a risk basis. For elderly and disabled enrollees, Medicare coverage must be purchased or coordinated with long-term care or continuing care coverage if cost-shifting between acute and long-term care providers is to be diminished and continuity of care for the individual is to be assured. Certain social services that have been funded with Medicaid may need to be purchased separately from the more traditional health care services, but those that support or are alternatives to more costly health care must be somehow tied to the delivery of health care to reduce the gaps in the system and avoid cost shifting.

As we look at methods to allow enrollees and providers more flexibility in determining the most appropriate services, it is important to maintain assurances of value and quality for the funding expended. Additional performance measurements must be developed that build upon the measures already in place to assure value, quality, and accountability.

Efficiencies in administration must be achieved to assure that funding that could be used for the delivery of services is not used for administration as available dollars become more scarce. To achieve the transition from the current programs to a mature, integrated strategy for subsidizing, purchasing, and measuring the quality of health care services for low-income, uninsured, and special needs individuals, the maintenance of substantial administrative resources may be necessary for an allotted period of time.

There are still significant components of this general strategy that must be more clearly defined in the coming months. Your input in the development of these strategies is welcomed by the Department. As additional detail and fine-tuning is achieved, information will be provided so that enrollee, community, advocate, and provider input can be obtained.

BACKGROUND

Profile of Current Programs

Minnesota, through the Medical Assistance (MA), General Assistance Medical Care (GAMC) and MinnesotaCare programs, currently provides health care coverage for more than half a million low-income, uninsured or special needs individuals. Expenditures for 1995 are projected to have exceeded $3 billion. This spending equates to approximately 20 percent of the State's annual budget.

Program	Estimated Average Monthly Number of Enrollees for 1995	Estimated Expenditures for 1995
MA	430,000	$2.752 Billion
GAMC	53,000	$196 Million
MinnesotaCare	79,000	$64 Million
Total	**562,000**	**$ 3.01 Billion**

The MA Program is administered under Title XIX of the Social Security Act. The federal government funds the program at a rate of more than 50 percent. The program covers health care services that address preventive, acute, long-term care, and continuing care needs for approximately 430,000 Minnesotans. Eligibility is limited to individuals who fall within one of the following categories, and who meet the income and asset requirements established by the Minnesota Legislature within the parameters of Title XIX:

- Children
- Pregnant women
- Parents in families that have an absent parent, an incapacitated parent, or an unemployed parent
- Elderly, age 65 or older
- Disabled according to SSI (federal Supplemental Security Income Program) standards

GAMC is a state-funded program that covers acute and non-long-term care for approximately 53,000 Minnesota residents who are not categorically eligible for MA, but who meet income and asset requirements comparable to the medically needy standards and methodologies of the MA Program. GAMC administration is both state and county funded.

MinnesotaCare is a program funded with enrollee premiums, provider taxes, and federal Medicaid funds. The program covers acute care services for adults and the full MA benefit set for pregnant women and children who are uninsured.

Federal Funding Changes

As part of an effort to balance the federal budget over the next seven years, Congress enacted a budget resolution requiring that growth in federal Medicaid spending be limited beginning in federal fiscal year (FFY) 1996. The Congress passed, and President Clinton vetoed, the Balanced Budget Act of 1995. The bill would have reduced the growth in Minnesota's forecasted Medicaid expenditures by approximately $1.9 billion over seven years. The following table compares the national limits of the budget resolution to the state-specific limits that would have been applied to Minnesota under the Balanced Budget Act of 1995. In considering the impact of these limits, it is important to note that Minnesota's Medicaid Program expenditures have grown ten percent or more over the years, and while current favorable economic conditions result in the forecasting of a growth of less than ten percent for the very short-term, it is anticipated that program growth would return to an average of 10 percent in the long term in the absence of significant change.

Federal Medicaid Growth Limits:

FFY	BUDGET RESOLUTION	BALANCED BUDGET ACT
1996	7.2%	13.76%
1997	6.8%	3.5%
1998	4.0%	3.0%
1999	4.0%	2.0%
2000	4.0%	2.0%
2001	4.0%	2.0%
2002	4.0%	2.0%

Recognizing that balancing the federal budget is a laudable goal, many state governors, including Governor Carlson, have supported these Congressional efforts on the condition that states be given sufficient growth in funding and complete flexibility in designing and administering the Medicaid Program. Based on the impact this congressional action could have on Minnesota, the need to address publicly funded health care's growing share of the State's budget, and the importance of subsidizing health care for low-income, uninsured, and special needs Minnesotans in a way that makes good sense, the Department is developing a proposal that has the capability to address capped Medicaid funding and still provide affordable access to quality health care.

BUILDING BLOCKS

Guiding Principles

- **Appropriate access to quality care.** Within taxpayer affordability, the largest number of uninsured, low income Minnesotans possible should have access to publicly funded care. If priorities must be set, then the people most vulnerable and least able to provide for themselves must be served first.

- **Personal independence and wellness.** To the greatest extent possible, health care benefits should promote personal independence and wellness. Prevention should be a focus in the area of acute or episodic care, and independent living, to the extent possible and practical, should be the focus in the area of long-term or continuing care.

- **Efficiency and value.** With limited resources, the State, as a health care purchaser on behalf of its enrollees, must promote efficiency within its own processes and require efficiency from those it contracts with for services. Getting value for the money spent and the most service for the best price must be a priority. Marketplace forces will play a key role in efficient service delivery and value.

- **Accountability and responsibility.** A system with no accountability or responsibility serves no one. The State and those from whom it purchases health care must be accountable to enrollees and taxpayers. Responsibility must underscore any system. The State has a responsibility to provide access to health care while balancing ability to pay. Service providers have responsibility for appropriate, quality care that is delivered as affordably as possible. Individuals must be responsible for full participation in their own health both through healthy lifestyle habits and by bearing some financial responsibility for care when possible.

Key Assumptions

This proposal is based on the following key assumptions:

- Minnesota will be granted sufficient flexibility in the design and administration of its Medicaid Program, either through Congressional action or to some extent through the granting of Phase 2 of the MinnesotaCare Health Care Reform Waiver under §1115(a) of the Social Security Act.

- Federal Medicaid funding will be sufficient to allow Minnesota to transition to this new approach.

- Sufficient time will be granted to design and implement a new system and to minimize disruption to people who need services.

These key assumptions are subject to change as various federal Medicaid funding formulas, eligibility and coverage requirements (in addition to Medicare, welfare and SSI program changes) are addressed by Congress. As a result, the following framework and key components are also subject to change.

FRAMEWORK AND KEY COMPONENTS OF THE DHS PROPOSAL

The guiding principles and assumptions identified in the preceding section are used as the basis for the framework of the proposal. There are still many outstanding issues and undefined aspects of the proposal that will be addressed in the coming months with legislators, consumers, tribes, counties, providers, and other stakeholders. Key components of the proposal include:

- **Integration.** Minnesota's three publicly funded health care programs, Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare should be integrated into one simplified health plan that provides access to quality, affordable health care.

- **Direct resources to most needy populations.** Within available resources, pregnant women, children, low-income elderly, persons with disabilities, and families should continue to be given priorities.

- **Premiums.** A more premium-based system should be established.

- **Access sites.** Multiple sites and access points should be available for people seeking enrollment in the health care plan.

- **Contracts.** Services should be purchased in the marketplace from a variety of sources, not necessarily solely from health maintenance organizations. A prime goal is to get out of purchasing health care services one at a time and instead to purchase services more comprehensively through contract arrangements.

- **Performance measurements.** Necessary to assure value, quality, and accountability for expenditures is the modification and expansion of performance measures, allowing us to move away from a prescriptive, process-oriented regulatory approach.

- **Public health infrastructure.** Minnesota's three publicly funded health care programs help to support an infrastructure of public health, medical education, American Indian reservation health care services, and providers who serve a disproportionate share of low income, uninsured people. With the movement toward comprehensive purchasing of managed coverage, the possibility of funding certain aspects of the health care infrastructure through some other payment methodology should be explored.

Elderly & Disabled

The approach for subsidizing the purchase of health care for persons age 65 and older and for persons with disabilities, *requires continued discussion and policy exploration* to address many outstanding issues and undefined aspects of the proposal. However, a basic framework needs to be established to pave the way for this discussion and exploration.

Eligibility.

- **Simplified eligibility.** Eligibility categories would be streamlined to eliminate artificial barriers and reduce administrative costs. Income and asset tests would be simplified. It is also likely that the information verification process at the time of application would be simplified by using post-eligibility computerized income verification matches and random sample case reviews.

- **Premiums.** Rather than requiring a person to incur medical expenses to spend down their income to get coverage, a more premium-based system would be established. Unlike spenddowns, premiums put money in the health care system in advance and encourage responsible, advanced purchase of health care coverage and use of preventive care.

- **Disability definition.** To achieve administrative efficiencies and to encourage individuals to apply for the federally funded Supplemental Security Income (SSI) Program and Social Security Disability Insurance (SSDI), the definition of disability would be tied to SSI/SSDI. Revisions to this definition are currently under discussion in Congress and may impact this component.

- **Eligibility access points.** There would be locations or entities, in addition to the local county social services agency, through which an individual could enroll for health care coverage. Application sites could include local senior citizen centers or clinics. It would also be possible to seek application assistance through a toll free telephone line. This component is intended to improve the range of options for an individual seeking assistance with the purchase of health care coverage, while at the same time recognizing that the county agency may be the best place for many individuals to seek assistance with the application and enrollment process.

- **Family responsibility.** It may be necessary to reevaluate the extent to which spouses and parents should be financially responsible for the purchase of each other's health care, keeping in mind that there is much informal care giving and some purchasing of health care services and coverage that occurs outside of the Medicaid Program.

Coverage.

With the guiding principles establishing independent living as a focus for long-term or continuing care, we are challenged to meet both the health and continuing care needs of these populations in the most cost-effective manner while providing access to appropriate, quality services.

- **Medicare or Medicare look-alike coverage.** Medicare is the primary payor of acute care services for the vast majority of the elderly and disabled population served by Medicaid. For those elderly and disabled who are not enrolled in Medicare, coverage identical to Medicare would be purchased. Additional coverage for such things as prescription drugs or certain dental services would likely be included here or with the continuing care coverage, below.

- **Continuing care coverage.** Supplemental coverage would be designed to wrap around the Medicare or Medicare look-alike coverage for the elderly and disabled. This coverage would address the long-term or continuing care needs of this population and its design is critical.

  A primary challenge in designing continuing care coverage is to grant consumers and providers the flexibility to determine what services best meet the needs of an individual without creating a wholesale entitlement for all enrollees. This would be necessary to assure that costs can be managed and that value for the expenditure can be assured.

  It would also be important to provide incentives or design components to reduce the utilization of institutional services. An additional issue requires that the artificial barriers to utilization that currently exist in the system, such as the limited number of home-and community- based services waiver allotments, be addressed in a way that would allow for access to appropriate services without significantly increasing costs. It is important to note that local county agencies provide services that are currently covered by Medicaid or that support services covered by Medicaid. Decisions will need to be made about which services would continue to be part of the continuing care package and which services would no longer be purchased or would be purchased using some mechanism other than Medicaid. These issues need to be addressed in the coming months.

- **Housing or living expenses.** There are many issues in designing continuing care coverage, but another key issue is its interaction with payment for housing. Housing is not a health care service, yet Medicaid currently funds housing when purchasing nursing facility or ICF/MR services (intermediate care facility services for people with developmental disabilities). Often these services are sought by enrollees primarily because housing is provided. It is not yet clear how the purchase of housing will be designed to fit into the integrated health care strategy.

Purchasing.

Services would not be purchased one at a time on a fee-for-service basis. Rather, both Medicaid and Medicare would together purchase comprehensive managed coverage from care delivery networks on a risk-bearing basis. Coverage would be purchased in the market place from a variety of sources, not necessarily solely from health maintenance organizations (HMOs). Until design and implementation of a mature strategy is completed, purchasing for this population would be administered in three manners:

- **PMAP.** Medicaid coverage of non-institutional services (excluding home- and community-based services) is currently purchased on a prepaid, capitated basis through the Prepaid Medical Assistance Program (PMAP) for most Medicaid populations, including the elderly, within designated geographic regions. This program will continue to expand geographically to include all elderly Medicaid recipients within the state, except for those participating in LTCOP.

- **LTCOP.** The Long-Term Care Options Project (LTCOP) combines Medicare and Medicaid purchasing of acute and long-term care[1] services on a capitated basis for Medicaid enrollees who are dually eligible for Medicare. Beginning in July 1996, up to 4,000 elderly dual eligibles, residing in designated geographic regions, may enroll to receive their combined Medicare-Medicaid coverage in this manner. This project was federally approved under §1115(a) of the Social Security Act.

- **Projects for purchasing managed coverage for persons with disabilities.** Pilot projects intended to demonstrate the effectiveness of purchasing coverage for persons with disabilities on a comprehensive, managed basis would be implemented in designated geographic regions beginning in January 1997.

These purchasing approaches would pave the way to begin implementation of a more mature purchasing strategy in 1998 and 1999. This strategy is still in the early design stages and would likely have different aspects between the two larger populations, elderly and disabled, and among the various geographic regions of the state.

Consumer Protections & Performance Measurements.

Experience has shown us that a prescriptive, process-oriented regulatory approach to protecting consumers from poor performing providers does not guarantee that consumers are protected or that services of good quality are provided. Experience has also shown us that the current regulatory approach has a high cost associated with it. We have been hearing from both providers and consumers alike that more flexibility in this area may reduce costs and even *improve* the quality of services. A combination of purchasing on a comprehensive, managed

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[1]Including up to 6 months of nursing facility services.

basis through a contract with a series of performance measurements tied to payment and some less prescriptive regulatory provisions could improve our ability to assure consumers are protected and services are of good quality.

Although significant advances have been made in recent years, the field of performance measurement and outcome assessment is in its infancy. General areas for measurement could include provider, contractor, or network performance; program performance; population level performance; and statewide health care economy performance. A number of tools are available, including encounter level claims; HEDIS and other measures of aggregate plan performance; consumer satisfaction surveys; internal quality assurance processes; Department of Health regulatory oversight; medical chart audits; complaint and grievance processes; registries for births, deaths, immunizations, cancer, etc.; and contract enforcement. It will be necessary to define what should be measured and at what level, to meet our expectations for protecting consumers and assuring access to good quality care, recognizing that this is a vulnerable population with diverse health care needs.

Families with Children & Adults without Children

The approach to better addressing the needs of families with children and adults without children focuses on program integration, simplification, premiums, and purchasing of comprehensive, managed and portable coverage.

Eligibility.

- **Program integration**. The intent is to streamline the eligibility categories that currently exist among the three programs to reduce the administration necessary for completing the eligibility process and to treat families as units, all to facilitate a more efficient purchasing strategy for both enrollees and administrators. However, some variation of income and asset standards and eligibility methodologies may still exist amongst major groups of eligibles.

- **Premiums.** Rather than requiring a person to incur medical expenses to spend down their income to get coverage, a more premium-based system would be established. Unlike spenddowns, premiums put money in the health care system in advance and encourage the responsible, advanced purchase of health care coverage and use of preventive care. People with income under certain levels would be exempt from the premium requirement.

- **Eligibility access points.** As described in the provisions applicable to the elderly and disabled, there would be locations or entities, in addition to the local county social services agency, through which an individual could enroll for health care coverage. Application sites could possibly include a local WIC clinic or hospital. It would also be possible to seek eligibility through a toll free telephone line. This component is intended to improve the range of options for an individual seeking assistance with the purchase of health care coverage, while at the same time recognizing that the county agency may be the best place for many individuals to seek assistance with the application and enrollment process.

- **Insurance barriers.** Provisions would be made to prevent employers and individuals from dropping current insurance coverage to access publicly subsidized coverage. People with private individual coverage or with access to employer-subsidized insurance (where an employer pays more than 50% of the premium) would not be eligible for publicly subsidized coverage. People who had and lost employer-subsidized coverage would have to wait 12 months to be eligible (with some exceptions). People who dropped individual coverage would not be eligible for four months.

- **Flexibility to respond.** Provisions would be made for the ability to limit enrollment, if necessary, or to adjust eligibility criteria such as the income limit or the premium schedule, to ensure that spending would not exceed available funding.

Coverage.

It is not necessary to purchase the comprehensive benefit set of the current Medicaid Program to meet the health care needs of the vast majority of program recipients. Most people who are not elderly or disabled require coverage that addresses basic health care needs. In addition, it makes sense to purchase coverage that is portable, that could follow an individual from poverty to work. Therefore, coverage would be purchased that is similar to health coverage offered to state employees. The package would include the following services: physician services, including preventive services; inpatient services; outpatient hospital and surgical center; emergency room; pharmacy; lab and diagnostics; therapies, including physical therapy, occupational therapy, speech and respiratory therapy; home health care; emergency transportation; chiropractic care; mental health; chemical dependency; durable medical equipment; vision care; hearing aids and batteries; preventive dental services for adults limited to oral exams, cleaning, fluoride and x-rays; and comprehensive dental services for children, except that orthodontia is not covered.

Purchasing.

Managed coverage would be purchased from entities that agree to provide it on a capitation basis. Purchasing would be done on a competitive basis and with the ability to create incentives to enhance competition.

DEVELOPMENT AND IMPLEMENTATION TIME LINES

Because legislation has not been enacted that will transform the Medicaid Program at the federal level, the proposals in this document will be discussed with the 1996 Minnesota Legislature with the assumption that flexibility in administering Medicaid will be granted by Congress or that federal approval of a §1115(a) waiver will permit implementation of certain aspects. The overall time line for implementing the changes for families with children and adults without children is January 1998. Most aspects of the proposal for the elderly and disabled call for the Department to prepare a legislative proposal for the 1997 Minnesota Legislature after obtaining substantive input from consumers, advocates, counties, tribes, providers, and legislators.

Mr. SHAYS. David Parrella.

Mr. PARRELLA. Thank you.

Mr. Chairman, members of the subcommittee, my name is David Parrella. I am the director for medical policy for the Connecticut Department of Social Services. I would like to thank you for the opportunity to appear before you today to speak about the regulatory issues we have struggled with in Connecticut as we attempt to reform our Medicaid program. They are not unique to Connecticut, but they are illustrative of the issues the States are facing as we attempt to achieve the goals of improved access and long-term cost containment within the current Medicaid regulatory environment.

I would like to focus today on managed care and provider reimbursement. In the interest of time, I would refer you to my written testimony for a discussion of our ongoing problems with recipient cost sharing and the financing of health care for the uninsured.

Suffice it to say that my description of our travails with regulations and mandates are part of a plea for greater flexibility for the States to address issues related to the financing of health care for the poor. Simply stated, if you are to restrain the rate of growth and Federal spending on the program, you must give us the flexibility to operate programs that incorporate the innovations which are commonplace in the private sector.

In Connecticut, we currently serve over 300,000 recipients, 1 out of every 10 citizens in the State. Our benefit package is a generous one, including 27 of the 33 operational services in our State plan. The rates we pay for services are among the highest in the country.

The pressure to maintain these rates of payment is certainly related to the high cost of goods and services in the Northeast. But even greater pressure is applied by the force of Federal regulations.

The Boren amendment and other requirements in the Social Security Act, which mandate cost-based reimbursement, have contributed to higher costs for a small percentage of our total recipient population. As we have continued to expand coverage for poor families, these same families are left with a smaller pool of total Medicaid spending. In contrast, in fiscal year—Federal fiscal year 1994, the elderly and the disabled, the main consumers of institutional services, accounted for 82 percent of spending in the Connecticut Medicaid program, while representing only 27 percent of the total eligible population.

This burden represents a serious impediment to further reforms in the Medicaid program where the State share of expenditures will account for 15 percent of the State general fund in the 1996 State fiscal year.

Into this context came a Boren amendment lawsuit filed by the Connecticut Hospital Association. The suit challenged the State's application of the methodology set forth in the Tax Equity and Fiscal Responsibility Act of 1982, known as TEFRA, for the calculation of inpatient rates. After months of negotiations involving the State, the hospitals and the Federal Government over claims for an additional $350 million, an agreement was reached to settle the case at a cost of $34.6 million, subject to ratification by the State legislature. It is the taxpayer who will pay the programmatic and administrative costs to settle this dispute.

The resolution of our Boren experience was related indirectly to my second subject, the implementation of managed care for our AFDC population. By 1993, Connecticut had recognized that the cost of providing services was slowly eroding our ability to maintain our benefit structure for a population of children and families that had grown rapidly with the impact of the recession and legislative initiatives to expand coverage. We were one of the last of the high-cost, high-benefit States to move aggressively to managed care.

We submitted our waiver application in January 1995. We were ably assisted by our HCFA regional office staff during the 3 months that went by before we received our first official response, 12 pages of detailed questions.

When first elected, President Clinton had committed HCFA to a single round of questions as part of the waiver review process. However, having responded to our regional office in May, we received another set of requests for clarification from the central office the following month.

Having finally convinced the central office of the merits of the plan, we still had to negotiate with the Office of Management and Budget, despite the fact that similar 1915(b) freedom of choice waivers had previously been approved in over 40 States. All these questions and negotiations diverted energy from the real-world considerations of delivering health care. The process has been a bonanza for consultants but with little tangible benefit for the recipients whose entitlement the laws are designed to protect.

I mentioned at the outset that our managed care initiative was related indirectly to the resolution of Boren. Over the past 5 years, enrollment in HMOs in Connecticut has grown rapidly. Hospitals with excess capacity find themselves in an increasingly competitive environment, forced to grant discounts which are nearly as deep as the Medicaid rates which were in dispute. With the national debate turning to consideration of block grants to replace Medicaid, providers began to feel a certain nostalgia for the good old days of cost-based Medicaid reimbursement.

As we concluded negotiations on the Boren settlement, a key provision was that the State would promise to retain, not repeal, the current rate methodology for a minimum of 18 months until such time as a major restructuring of Federal aid would require the State to revise it.

The irony of the outcome should be lost on no one. From the snowbound vantage point of a small New England State, it appears that the chief stumbling block to concluding an agreement that would redefine Medicaid is the concept of entitlement.

I believe it's not the guarantee of coverage that frightens the States. Rather, it is the mandated benefits for recipients and providers alike, the limit on State discretion to manage those benefits and the Federal cause of action that stand in the way of an agreement. If the States and the Federal Government are to move to become prudent purchasers of health care, they must stop tying each other's hands in mandating the structure of the system to provide that care. Flexibility on amount, scope, duration and comparability of benefits will go a long way toward relieving State concerns about covered populations.

Despite our initial concerns about the funding formula, we now believe that there was enough money in the Balanced Budget Act of 1995, passed by Congress and vetoed by the President, to do the job, given added flexibility. In contrast, the President's own proposal would have cost our State $450 million over the 7-year period from 1996 to 2002 with little or none of the flexibility we need to manage more efficiently. It is clearly an unfunded mandate for the States.

I wish the budget negotiators here in Washington success in their efforts. Our State and the future of the Medicaid program can ill afford either the continuation of the current impasse or the status quo.

Thank you.

[The prepared statement of Mr. Parrella follows:]

Testimony Presented to the House Subcommittee
on Human Resources and Intergovernmental Relations

David Parrella, Director of Medical Policy
Connecticut Department of Social Services
January 18, 1996

Mr. Chairman and members of the Subcommittee, my name is David Parrella. I am the Director of Medical Policy for the Connecticut Department of Social Services. I would like to thank you for the opportunity to appear before you today to speak about the regulatory issues we have struggled with in Connecticut as we attempt to reform our Medicaid program. They are not unique to Connecticut, but they are illustrative of the issues the states are facing as we attempt to achieve the goals of improved access and long term cost containment within the current Medicaid regulatory environment.

I would like to focus on four main areas: managed care, recipient cost-sharing, provider reimbursement, and the financing of uncompensated care for the uninsured. Suffice it to say that my description of our travails with regulations and mandates on

provider reimbursement, managed care, recipient cost sharing, and provider taxes are part of a plea for greater flexibility for the states to address issues related to the financing of health care for the poor. Simply stated, if you are to give us less money, you must give us the flexibility to operate programs that incorporate the same features and innovations as the private sector. And if we do receive less money, we must be able to replace a net loss in federal support from whatever resources we can legitimately tap at the state level.

At the end of my remarks I would like to suggest several key elements of legislative reform which I feel are central to the national debate on the future of the program.

But first, a little background on the Connecticut Medicaid program. We currently serve over 300,000 recipients, one out of every ten citizens in our state. Connecticut goes well beyond the mandatory coverage of the AFDC and SSI populations. We also offer coverage to the medically needy, those individuals who have incomes or assets above the threshold for cash assistance but do not have resources to meet the cost of care. We also cover all children born after October 1, 1983 up to 185% of the federal poverty limit.

Our benefit package is a generous one. In addition to the mandatory covered services such as physician, hospital and nursing facility services, we also cover 27 of the 33 optional services in our State Plan. In addition, we operate three home and community based waiver programs for the frail elderly, persons with developmental disabilities and children with special health care needs. The rates that we pay for services are among the highest in the country.

The pressure to continue to pay these rates is certainly related to the high cost of goods and services in the northeast. But even greater pressure is applied by the force of federal regulations. The Boren Amendment and other requirements in the Social Security Act which mandate cost based reimbursement for institutional providers have contributed to higher and higher costs for an increasingly smaller percentage of our total recipient population. As we have continued to attempt to expand coverage for poor families, these same families are left with a smaller pool of total Medicaid spending. In FY 1994, the elderly and the disabled - the main consumers of institutional services - accounted for 82% of total spending in the Connecticut Medicaid program while representing only 27% of the total eligible

population. Spending on nursing facilities, acute care hospitals, ICF/MR's and psychiatric facilities accounted for over 62% of total Medicaid spending during the same period. I have provided exhibits with a breakdown of spending by service and eligibility category for your review.

This burden represents a major impediment to further reforms in a Medicaid program where the state share of expenditures, including disproportionate share payments to hospitals (DSH) will account for 15% of total spending in the state general fund in SFY 1996. This percentage is expected to rise to over 17% by SFY 2002. It will be impossible for the state to continue the momentum to bring cost effective care to our low income population and meet its other obligations unless these trends are reversed.

Into this context came a Boren Amendment lawsuit filed by the Connecticut Hospital Association. The suit challenged the state's application of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) methodology in the calculation of inpatient rates. As you know, TEFRA allows a national increment in the adjustment of cost based inpatient rates beginning with our 1982 base year. The suit sought the inclusion of over $350 million in

costs in excess of the TEFRA increment over a seven year period.

In defending the TEFRA methodology established in federal law, the state incurred costs for legal and consulting fees and many hours of staff time while we were actively engaged in downsizing our administration. There were injunctions granted and then lifted to order the state to pay 100% of Medicare allowable costs. In the end, after months of negotiations involving the state, the hospitals, and the federal government, an agreement was reached to settle the case at a cost of $34.6 million, subject to ratification by the state legislature. It is a scenario which is playing itself out in many states around the country involving both inpatient and nursing facility rates. It is the taxpayer who will pay the programmatic and administrative costs to settle these disputes.

The resolution of our Boren experience was related indirectly to my second topic: managed care. Like many states, by 1993 Connecticut recognized that the rate of growth in the cost of providing services was slowly consuming any chance of maintaining our current benefit structure for a population of children and families on assistance that had grown rapidly with the impact of the recession and legislative initiatives to expand coverage. We

were one of the last of the high cost, high benefit states to move aggressively to managed care. Managed care also offered the promise of positioning the state for wider reform of the delivery system.

As we began our planning for the initiative, we had to make strategic decisions. Although the disabled and the so-called dual eligible population that receives benefits from both Medicaid and Medicare consume a majority of our costs, we recognized that there were few models for the successful delivery of managed care to populations with special needs. There is no current waiver mechanism that can restrict freedom of choice for dual eligibles and require that they receive care from Managed Care Organizations, even though many of their most expensive benefits like nursing facility care and pharmacy are paid for virtually 100% by the Medicaid program. For this reason, we elected to begin our managed care effort with the AFDC population which represents close to a quarter of a million recipients. Connecticut strongly supports the Dual Eligible Medigrant Demonstration Project which was included in the Balanced Budget Act of 1995 (BBA) passed by the Congress and vetoed by the President which would have allowed the states to manage an integrated Medicaid/Medicare benefit.

Having identified our target population, the next step was to select a vehicle. As you know, there are two waiver options for states interested in requiring that all or a portion of their Medicaid populations enter managed care - a section 1915(b) "freedom of choice" waiver and a section 1115 research and demonstration waiver. Initially, we were attracted by the 1115 option because of the potential it held for greater flexibility on recipient eligibility, enrollment lock-in, enrollment composition and upper payment limits. However, we were wary of the lead time and effort necessary to obtain federal approval of such waivers. Because our state fiscal projections called for enrollment to begin in 1995, we elected the 1915(b) option and reserved the 1115 application for a future date.

We assumed a relatively quick turnaround on our waiver application with one minimal question and answer period from the Health Care Financing Administration. After all, these same waivers had been approved in over 40 states. We had worked closely with regional office staff throughout a lengthy development period with our state legislature.

We submitted our waiver application in January 1995. We were again assisted by our HCFA regional office during the three months that went by before we received an official response.

Despite earlier assurances that HCFA's review clock would not be stopped during our response to questions, it was officially halted once we received our twelve (12) pages of detailed questions in April.

When first elected, President Clinton made a commitment that his Administration would limit waiver reviews to a single round of questions. However, after we responded to our regional office at the end of May, we received another set of "requests for clarification" from the HCFA central office the following month.

We responded as quickly as possible to this round but our target implementation date of July 1, 1995 was already compromised. Recipient notices could not be issued in an atmosphere of uncertainty. We decided to implement managed care on a voluntary basis in two counties in August and withhold mandatory enrollment until October 1. This decision had a negative impact on the state budget and caused great uncertainty among recipients and providers, alike.

Having finally convinced the HCFA central office of the merits of our plan, we still had to negotiate with the Office of Management and Budget. The involvement of OMB was unprecedented in the review of the fiscal projections for a 1915(b) as opposed to an 1115 waiver application and continued right up to the eleventh hour for the August 1 implementation date.

All these questions and negotiations diverted energies from the real world considerations of delivering health care and contributed to the problems we experienced during implementation. The process has created a thriving industry for consultants with little tangible benefit for the recipients whose entitlement the laws are designed to protect.

I mentioned at the outset that our managed care initiative was related indirectly to the resolution of the Boren Amendment case. Over the past five years enrollment in HMOs in Connecticut has grown rapidly. Hospitals find themselves in an increasingly competitive environment, forced to grant discounts to managed care organizations which are nearly as deep as the Medicaid rates which were in dispute. With the national debate turning to consideration of block grants to replace the current Medicaid

system, hospitals and other providers have begun to feel a certain nostalgia for the "good old days" of fee for service, cost based Medicaid reimbursement. As we concluded negotiations on our Boren settlement, a key provision was that the state would promise to retain, not repeal, the current rate methodology for a minimum period of eighteen months or until such time as a major restructuring of federal aid would require the state revise it. Even if that occurs, it will take a two thirds majority vote in both houses of the state legislature to abrogate our promise to retain TEFRA.

The irony of this resolution should be lost on no one. The same parties that sought to overturn our reimbursement methodology are now seeking to keep it in place. They even sought to retain our capitation rate setting methodology for managed care lest the state should become more aggressive in the aftermath of Medigrant.

Recently our program received a great deal of publicity over another cost containment initiative, pharmacy co-payments. The outcry in the state over the collection of a $2.00 per prescription co-payment on pharmacy services is largely the

outcome of the federal rules which make recipient cost sharing so difficult to implement.

Our co-payment plan was shaped in tandem with the welfare reform and managed care initiatives to bring some recognition to our recipient population of the costs and consequences of decisions they make about health care. Annual savings from the application of co-payments to all non-exempt services were estimated at approximately $14 million with $1.8 million in savings resulting from the co-payment on pharmacy services alone.

In 1995 the state legislature passed a Public Act requiring the Department to implement co-payments. However, under federal rules all recipients in hospitals or nursing facilities are exempt. Pregnant women and children are exempt. All emergency and family planning services are exempt. And finally, all recipients enrolled in a Managed Care Organization are exempt from any co-payment requirements. At the same time that we were transitioning our AFDC population into managed care, we also found ourselves unable to apply any cost sharing to two thirds of our recipient population. A nominal charge which would be commonplace in the private sector, such as a charge for

inappropriate use of emergency room services, is strictly forbidden for all of our recipients.

What we were left with was the application of co-payments to non-emergency services for our most vulnerable non-institutional populations, the disabled and the elderly who live in the community. Many of these individuals have developmental disabilities, chronic mental illness, or other long term ailments that make them high volume consumers of Medicaid services, pharmacy in particular. Caught between a state mandate to act and federal regulations that caused us to exempt the majority of our recipients, we made plans to implement co-payments on populations whose special needs would yield the maximum political fallout.

But it gets worse. Not only were we limited in how we could implement co-payments, federal law renders them virtually meaningless. The Social Security Act specifically states that no recipient can be denied a service because of their inability to pay a co-payment. A provider who elects to provide the service must do so while acknowledging that they may never recover from the recipient.

It did not take long for the Connecticut Pharmaceutical Association to bring this contradiction to the attention of the press and the legislature. Pending further review, the Governor has suspended indefinitely the collection of co-payments for Medicaid services.

Finally, I would like to comment on our difficulties in sustaining an uncompensated care pool for the uninsured. I know that state disproportionate share payment adjustments to hospitals are not popular in Washington these days. But I will tell you that DSH payments to acute care hospitals have provided over $600 million to cover the costs of uncompensated care since 1991 while the percentage of the population in our state who have no health insurance has doubled over the same period.

Initially, the Uncompensated Care Pool was funded by a direct assessment on hospital revenues that came in to the state and went right back out to the providers as DSH payments based on the volume of uncompensated care at their facilities. This relatively simple system was truly redistributive and broad based with the exception of psychiatric hospitals who neither paid the assessment nor experienced the same volume of uncompensated care as acute care hospitals.

Two issues intervened to change the original design. The first was an ERISA challenge which sought to overturn the authority of the state to collect an assessment against revenues derived from ERISA plans. We ultimately were granted judicial relief on this issue following the Supreme Court's decision in Travellers vs. Cuomo. However, in response to this challenge the assessment was changed to a 6% sales tax and an 11% gross receipts tax, deposited in the general fund, with an annual appropriation to the Department to make DSH payments back to the hospitals.

The second challenge arose from HCFA's interpretation of the 1992 federal legislation which limited the amount of taxes that states could collect from providers and established the criteria for taxes that could be considered truly redistributive and broad-based. Per legislation, states may only collect taxes from providers which do not exceed 25% of the state share of Medicaid without incurring financial penalties. HCFA has interpreted state tax collections to include licensing fees for physicians, dentists, and other providers who do not participate in the DSH program, as well as assessments that fund state regulatory agencies.

The situation becomes far more complex in attempting to meet the criteria for redistribution, broad-basedness, and uniformity. Under federal regulations, a provider tax can only be determined to be redistributive if 75% of the participating hospitals receive less than 75% of their tax payments back in DSH or other state payments. This so-called rule of the 75's has severe consequences. Failure to meet it could result in the loss of all federal financial participation (FFP) in the Uncompensated Care Pool. In Connecticut, this could cost the state over $120 million a year. The test is complicated by the inclusion of other state payments to hospitals in the calculation, such as special grants and appropriations to assist economically distressed hospitals including grants made by other state agencies.

We have never been asked to provide the data for the test of 75's and it is unclear for what period we might be asked to do so. But clearly we fear it. In the operation of a program which has been subject to so many changes, such as the hospital specific limits on DSH imposed by OBRA 93, it is difficult to anticipate the consequences of a change in the distribution of funds from the pool that could be disastrous for the state.

The tests applied for broad-basedness and uniformity are too complex to describe here. We have submitted two applications of the P1/P2 test of broad-basedness over the past two years without a response. The B1/B2 test of uniformity is better left to the imagination.

I believe that it is possible to contain the cost of Medicaid by reducing the regulatory burden while maintaining or even expanding the ability of the program or its successor to provide health care to the poor.

From the snowbound vantage point of a small New England state, it appears that the chief stumbling block to concluding an agreement that would redefine the Medicaid program is the concept of entitlement. Based on their long experience with unfunded service mandates such as the EPSDT provisions in OBRA 89 or eligibility guidelines that have created a maze of coverage groups and an administrative nightmare, states are loathe to consider any proposal that mandates coverage for anyone beyond the minimum guarantees for the disabled, the elderly and pregnant women and children as described in the Medigrant legislation. At the same time it is reported that the Administration will not

sign a bill that does not contain explicit guarantees of coverage for broad segments of the poor.

I believe it is not the guarantee of coverage that frightens the states. Rather it is the mandated benefits that go with coverage, the limits on state discretion to manage those benefits, and the federal cause of action.

If the states and the federal government are to become prudent purchasers of health care services, they must stop tying each other's hands in mandating the delivery system for that care.

Flexibility on amount, scope, duration and comparability of benefits will go a long way towards relieving state concerns about covered populations. Despite our concerns about the original formula, we now believe that there is enough money for Connecticut in the BBA to do the job given the added flexibility. In contrast, the President's proposal would cost our state $450 million over the seven year period from 1996-2002 with little or none of the flexibility we need to manage more efficiently. Even though the President's plan would relieve the states of the managed care waiver burdens and repeal the Boren Amendment, it leaves in place other requirements for provider reimbursement

such as the criteria for adequate rates at Section 1902(a)(30) of the Social Security Act. It maintains the federal cause of action for entitlements and all the current restrictions on co-payments and provider taxes. With the attendant reductions in the federal share, it is clearly an unfunded mandate to the states.

I wish the budget negotiators success in their efforts. Our state and the future of the Medicaid program can ill afford either the continuation of the current impasse or the status quo.

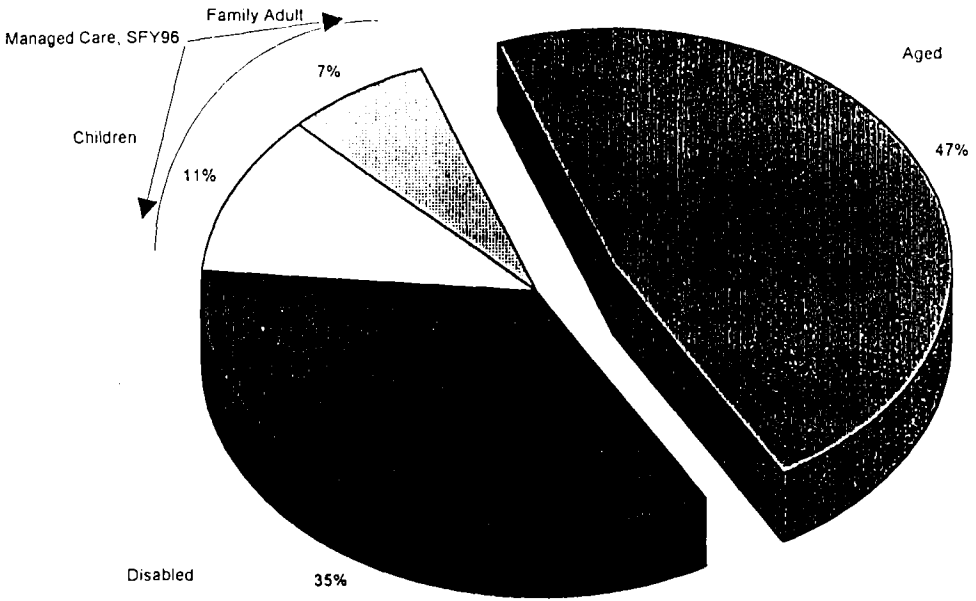
Medicaid Services Covered in Connecticut

Service	Mandatory?	Covered In CT?	% of $ for Serv.
Nursing Facilities > age 64	YES	YES	39.03%
Hospital Inpatient	YES	YES	13.34%
Hospital Outpatient	YES	YES	6.06%
Physicians	YES	YES	4.19%
Home Health	YES	YES	3.94%
Laboratory & X-Ray	YES	YES	0.33%
HealthTrack#/EPSDT-1	YES	YES	0.31%
Family Planning	YES	YES	0.10%
Rural Health Clinic	YES	YES	0.00%
Nurse-Midwives	YES	YES	0.00%
Nurse Practitioners	YES	YES	0.00%
Intermediate Care Facility/Mentally Retarded	NO	YES	9.11%
Targeted Case Management	NO	YES	8.08%
Prescription Drugs	NO	YES	7.04%
Clinics	NO	YES	2.06%
Transportation	NO	YES	1.56%
Rehabilitative Services	NO	YES	1.33%
Dental Services	NO	YES	1.35%
Institution for Mental Disease , < age 21	NO	YES	0.83%
Institution for Mental Disease > age 64	NO	YES	0.44%
Optometrists	NO	YES	0.24%
Psychologists	NO	YES	0.12%
Podiatrists	NO	YES	0.09%
Dentures	NO	YES	0.08%
Prosthetic Devices	NO	YES	0.05%
Eyeglasses	NO	YES	0.15%
Speech, Hearing & Language	NO	YES	0.03%
Chiropractors	NO	YES	0.03%
Physical Therapists	NO	YES	0.03%
Nursing Facilities, under age 21	NO	YES	0.01%
Christian Science Sanitoria	NO	YES	0.00%
Diagnostic Services	NO	Incl. in Other Cat.	0.00%
Screening Services	NO	Incl. in Other Cat.	0.00%
Preventive Services	NO	Incl. in Other Cat.	0.00%
Hospices	NO	Indirectly	0.06%
Emergency Hospital Services	NO	Indirectly	0.00%
Occupational Therapy	NO	Indirectly	0.00%
Christian Science Nurses	NO	NO	0.00%
Private Duty Nursing	NO	NO	0.00%
Medical Social Workers	NO	NO	0.00%
Nurse Anesthesthetists	NO	NO	0.00%
Respiratory Care	NO	NO	0.00%
Personal Care Services	NO	NO	0.00%

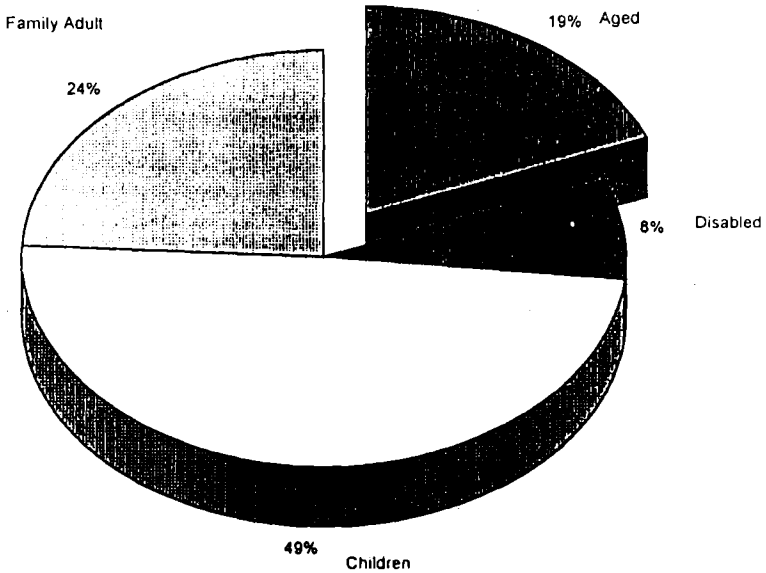
1 - Includes payment for comprehensive screens and immunizations for patients under age 21.

- HealthTrack which is the name in Connecticut for Early Periodic, Screening, Diagnosis and Treatment (EPSDT) requires coverage of all services for treatment of a condition diagnosed as the result of a screen, for recipients under age 21.

Shares of Medicaid Expenditures, FFY 1994



Shares of Medicaid Recipients, FFY 1994



Mr. SHAYS. I thank both gentlemen. I would like to ask a few questions and then Mr. Souder and would welcome counsel as well to ask a few questions.

I need to have a sense, to start with, about what the Federal Government does specifically, and maybe specifically HCFA, that causes you the most difficulty? And I would take either of you to answer it.

Let me preface my statement by saying that this is the Medicaid source book that describes what States have to do. It obviously contains data as well. The print is small. But this is kind of your Bible. You have got to follow it. And we want to candidly kind of throw this in the trash can and have a document that would be much smaller that would give you the flexibility.

Now, the danger, when you do that, is you may do some things we don't like. And so what the Federal Government is having to deal with is what is that—can there be a balance? How shall we move? Our interests, as the majority, is to get rid of this book.

Now, what would be helpful is for you to describe, if you can, some ways that you find it difficult to comply that needlessly ratchet up costs.

Mr. PETRABORG. Mr. Chairman, I believe that really one has to look at the whole. The whole is 30 years of additions to a basic concept that has become more and more prescriptive and regulated. There is a mandated eligibility coverage and multiple groups of coverage, is a serious problem.

Mr. SHAYS. When you say that, I want you to speak a little more specifically. You mean——

Mr. PETRABORG. We estimate in Minnesota—actually, our Medicaid program in Minnesota has 60 different doorways.

Mr. SHAYS. Sixty different what?

Mr. PETRABORG. Sixty different doorways, we say. Sixty different ways you can qualify or must qualify in order to become eligible for the Medicaid program. We would like to look at income as the principal determinant of whether or not someone should be eligible, rather than whether or not there is this combination of family members with these circumstances. That's a very direct example of the kind of complexity.

Mr. SHAYS. I mean, one obvious doorway is, if you are poor and have a child and you are on AFDC, you get health care costs.

Mr. PETRABORG. Right.

Mr. SHAYS. Now, that's nothing you would dispute.

Mr. PETRABORG. That's correct.

Mr. SHAYS. OK. If you are 65 and older and your income is basically nonexistent, you get nursing care. Now, that's said in more general terms. Does the Federal Government begin to outline what kind of nursing care or is that mostly State regulation?

Mr. PETRABORG. Mr. Chairman, then we get into the area of actually the kind of services that are required.

Mr. SHAYS. Yes. So the first issue is who qualifies.

Mr. PETRABORG. Who qualifies.

Mr. SHAYS. Now, would Connecticut, Mr. Parrella, see this same doorway of 60 doors or is it more or less?

Mr. PARRELLA. Well, in Connecticut we don't have 60 doors. We have 41 doors. But it is still a lot of different—a lot of different

ways to slice what is basically the same population of people that are low income.

And having the groups added on with very incremental differences, in terms of how income or assets are treated or composition of the household, number of children, all of those things can cause you to move into another coverage group, which requires the State to report separately on that group on its expenditures.

It's a tremendously complex—I would say overly complex—way of administering the program and certainly adds to the administrative costs of maintaining coverage.

I would second everything that John had said—that in Connecticut we as well are looking toward moving toward a more means-tested, straight-income-tested type of model for assistance, where we could cast the net over largely the same population without slicing it up so finely that we have to move between so many coverage groups in order to maintain the entitlement. I think that certainly is part of it.

The other side to it, as I alluded to in my remarks, is on the mandates. As far as coverage and service delivery of benefits, it's very difficult, in the current Medicaid program, moving to managed care or even within managed care, if you want to move to a system where you design benefit packages specifically for certain populations. We have done it. Minnesota has done it.

Mr. SHAYS. Well, Connecticut has just started, correct?

Mr. PARRELLA. That's correct, but we have moved away from comparability of services under our home and community-services based waivers for many years now.

Going back to 1987, we have expanded home and community-based service programs for the elderly, largely intended to keep those people from having to make a choice of going into a nursing home. But the current process does require somewhat burdensome waiver application and submission in order to structure your benefit package specifically to meet the needs of that—1 of those 41 coverage groups.

Mr. SHAYS. Medicaid basically is health care for the poor and nursing care for the elderly. I mean, I view it that way. Is that an improper way to view it?

Mr. PARRELLA. I think of it pretty much on those terms. There are three main groups. There are families that are covered, poor families, the disabled and the elderly.

Mr. PETRABORG. Right.

Mr. SHAYS. Now with the disability group that I should also add, the charge is that basically block granting to the States means that potentially we are pitting the old against the young, the healthy maybe against the unhealthy and so on. Which is an interesting concept because bottom line is, as a Member of Congress, I have to make those decisions every day. I have to decide whether more resources go to the elderly or more go to the younger incomes.

I have come to a basic conclusion that when I look at Medicaid, as an average, 70 percent of the resources go to 30 percent of the individuals, the elderly, and 30 percent of the resources go to 70 percent, which are the—which are the poor, basically, and the disabled.

Now, the question mark—and it may be—but, bottom line, on the poor versus the elderly, we have to make choices, and you all have to make choices. The big concern that some have, like in the State of Connecticut, is that the lobby group for the elderly in nursing homes will gobble up the resources that are going for the poor. Bottom line, how would a State deal with that issue?

Mr. PARRELLA. Well, I think there's a couple of answers to that. I think that's exactly a main concern. That exists in Connecticut today, even with the current Medicaid structure, there's still competition for dollars in terms of where the State is looking for expansions.

I think that the Medigrant legislation that was passed did contain provisions for set-asides, mandated set-asides. A certain percentage of the money, based on prior history, would have to continue to be spent on families, on disabled, on the elderly, which would provide some insulation for, I think, the situation that you are alluding to where suddenly there would be a tremendous lobbying pressure to move large chunks of those resources away from one of the other population groups and into the other two.

Mr. SHAYS. Since there are only two witnesses, Mr. Souder, I am going to take a little bit more time, and then we will get to you.

Ultimately, the objective is to enable you to save money. Now, in my mind, saving money doesn't mean denying services. It means, in my mind, providing better service. And, in my mind, we are not able to provide quality service because we have what I think is an archaic system that doesn't provide flexibility. Could either of you illustrate how you can provide better service at less cost?

Mr. PETRABORG. Mr. Chairman, in fact, I think one of the dangers of incremental change in this area, is that—the ability to craft innovative new solutions to make those dollars go further would be hampered.

Minnesota's goal really is one of trying to protect access in terms of the number of people covered but to do that in two ways: one, in the sense of designing benefit packages that are more like employee-based benefit packages that are now available to State of Minnesota employees or 3M employees in the State. The other is to look for more efficient ways to purchase services for the elderly and disabled, to purchase those services in comprehensive packages of service rather than in discrete little pieces.

For example, in Minnesota, nursing home care is funded directly by the State. Hospital services for that population are funded through the Medicare program and in-home services or at-home services are essentially a State-funded service, although we have some waivered services there as well.

We would like to look at purchasing health care services for that population, all of those services, in a single package with a single price, so that the incentive is to find the most appropriate level of care for that person, not encourage that person to go into the Medicare—Medicaid system in order to get covered services at the nursing home.

Mr. PARRELLA. I would second that.

I think one of the things that John was alluding to is—one of the things that contributes to higher costs, both for the States and for the Federal Government, is this kind of Alphonse and Gaston act

between Medicaid and Medicare, where Medicare has limited exposure on the nursing home side but Medicaid picks up the full brunt; Medicaid has limited exposure on the hospital side but Medicare picks up the brunt. So the two programs are sort of involved in this dance where patients are sort of discharged from one level of care to another. It doesn't necessarily serve the interests of the patient in any particular way, nor does it lead to terrific coordination of the benefits really.

Mr. PETRABORG. Right.

Mr. PARRELLA. Because both programs have somewhat different incentives right now financially.

Mr. PETRABORG. The same is true between those residentially based programs, nursing home and hospitals, and in-home services and, again, the dance between those two programs. So if we can purchase a service that is defined around a health care outcome that includes that whole range of services——

Mr. PARRELLA. That's right.

Mr. PETRABORG [continuing]. We believe that the system will move toward finding the most appropriate care for the person at the best price.

Mr. SHAYS. OK. Mr. Souder, I welcome your questions.

I am going to come back and ask you some more.

And, Mr. Vladeck, we are going to have you on exactly at 1 p.m. I appreciate you being here.

Mr. SOUDER. First, for both of you: Is the growth rate—you have kind of alluded to this, but is the inflation rate in Medicare—not the number of people going into the system but the inflation per recipient or cost per recipient—going up at a faster rate than it is at the private sector? I presume that's what you are saying. Approximately, do you know what that rate is in Medicare? We have heard 10 versus 2.

Mr. PARRELLA. Well, in Connecticut, if you average our rate of increase overall in the program for the years 1991 to 1996, we averaged in excess of 10 percent. Over the last couple of years, as the managed care has started to come in and some of the other cost containment measures, that rate is dropping, dropping rapidly. We have pretty much cut that in half, but it's still probably running between 5 and 6 percent per year.

Mr. SOUDER. That's not counting the growth in the population?

Mr. PARRELLA. No. That's just the cost per case. There were some years where we were topping out over 15 percent per year. It is—depending on the impact of legislation that would be coming down, you would see a short-term increase.

Mr. PETRABORG. In Minnesota, we would have seen a similar experience. Our growth rate for acute care, for families and children, has been pretty moderate, as have health care costs in general in Minnesota for that population. Where the growth has occurred in services for the disabled and for the elderly are where the provisions of the Boren amendment have restricted our ability to control that cost growth.

Mr. SOUDER. As we have battled through some of the arguments here, we have had some internal tension between the more rural States and some of the urban States. And as you look at these alternative managed care and HMO type systems and so on, it's one

thing in southern Minnesota where you have Mayo Clinic and other fairly widespread systems. What is it like in the northern parts of the State where it's much more spread out and the population is more spread out? Are there alternatives there that would exist?

Mr. PETRABORG. There are, and there will need to be developed more. As we move to expand our managed care strategy across the whole State, we are having to find different strategies. I mean, this is—why we need some transition time here to work out those kinds of concerns in the various parts of the State.

But even in Northwestern Minnesota, for example, managed care is impacting that marketplace, with services out of some of the population centers that are nearby, Fargo and Grand Forks, for example.

So it is an approach, we believe, that can work but has to take account of the infrastructure in those various parts of the State.

Mr. SOUDER. Are the—part of our concern was—is that the threshold of reimbursement—because when you look at the costs for nonseniors and nonacute care, it is substantially different than it is for others, because there may not be enough of them to get to a threshold, and if our reimbursement rate isn't high enough you may not have enough people with which to get the facilities that you need. Have you seen that and do you have different types of reimbursement rate problems in those areas?

Mr. PETRABORG. That is an issue that, again, I think is part of the transition process. We are struggling with that particularly around dental services in the rural parts of our State. So I certainly recognize that this a legitimate issue.

Mr. SOUDER. We heard a couple of different numbers; but, Mr. Parrella, I think you said 82 percent were elderly and disabled. Does that mean only 18 percent is going to the——

Mr. PARRELLA. That's correct.

Mr. SOUDER [continuing]. Lower income families? Is that similar to Minnesota or how is that?

Mr. PETRABORG. In terms of the expenditures or the caseload?

Mr. SOUDER. Yes. I understood that was expenditures.

Mr. PARRELLA. That is expenditures.

Mr. PETRABORG. Yes.

Mr. SOUDER. So it is up to near—over 80 percent now for the elderly and disabled?

Mr. PETRABORG. I think it is more like 75—75/25.

Mr. SOUDER. If it is 75/25, one of the comments—I am interested in this. I assume then you are just relating to the 25 where you say that the ability to get health care helps people's willingness to move into the job sector, but most of the money is not going to that area at this point.

Mr. PETRABORG. Minnesota does operate a State-subsidized health care insurance program for those people just above the Medicaid program; and we have, since that program began a year and a half—2½ years ago, been able to document a direct connection between our AFDC caseload and the use of the Minnesota care program. And, in fact, we have seen that we have around 4,000 fewer families a month using AFDC in Minnesota, at a savings to the

State and Federal Government of $2 million a month, from this—the availability of this subsidized health insurance program.

Mr. SOUDER. Another question that was raised by your testimony—is it Petra or Petra?

Mr. PETRABORG. Petraborg.

Mr. SOUDER. I am sorry. That you said that if you didn't like some of what the organizations were providing you would like the flexibility to go to alternatives. And one of the problems that we see, particularly in seniors in Medicaid—and some of this is from personal example.

Growing up, our church used to visit some nursing homes, and you could see where often the Medicaid or the poorest people were—and often they were getting cited. They had—they had not very good conditions for many people there.

We also—I just went through this with my late father-in-law when we were looking at different nursing homes and considering alternatives. You could see very clearly where there was a lot of Medicaid and where there wasn't.

We had a problem in a Fort Wayne health center that the government would like to close down, but they don't know what to do with the people if they close them down. We heard in the Medicaid-Medicare fraud hearings about, for example, one company that was providing services that was disciplined by the government. They really couldn't cut them off because they didn't know what to do with the people.

Are there really alternatives? If you had some people who you—some major providers to the frail elderly and low income elderly, where would you go for alternatives? Do they really, in fact, exist?

Mr. PETRABORG. First of all, in Minnesota, we have—we do not have a separate standard for Medicaid recipients as for private pay recipients of nursing homes. So our first defense, line of defense——

Mr. SOUDER. May I ask a question about that? I don't think it's so much that there's a different set of standards but that when you have higher paying people——

Mr. PETRABORG. We have a——

Mr. SOUDER [continuing]. You tend to subsidize the others.

Mr. PETRABORG. We have the same payment rate for both, so private pay and Medicaid pay the same amount in Minnesota. So there's no difference in payment. And I think that that goes a long way to assuring no difference in care.

Mr. SOUDER. Can I ask you one other question about that? Does that mean if somebody wanted a better place, they can't pay more? Because we have started to see nursing homes that offer a lot more facilities. So are you saying that it's capped and an individual can't pay more?

Mr. PETRABORG. They can find a different nursing home that offers more services. In that nursing home, however, the Medicaid patients and the private pay patients——

Mr. SOUDER. I was not saying it was different within the nursing home. What I was saying was there was a tiering of nursing homes that the lowest income were having a different quality, and I'm not complaining about that. But then what happened is that you get a group of nursing homes who are used to providing to that group

predominantly and is there enough money in that that there are really alternatives?

Mr. PETRABORG. I guess the ultimate answer to that is that the current system is not preventing that. OK? So let's start with that assumption.

Mr. SOUDER. Right.

Mr. PETRABORG. And then let's look at whether or not some use of the purchasing power of the State can be useful in defining a higher quality or a higher standard in terms of what kind of care we want to purchase for those individuals.

In Minnesota, we have more nursing homes than we need, and we would be able to start shaping, or pointing, our purchasing then toward those nursing homes that met our standards. I think that that would be basically our strategy.

Mr. SOUDER. I know it's a difficult question. The reason I'm asking it is because on both sides of the aisle we are—you know, those are difficult questions.

Mr. PETRABORG. Right.

Mr. SOUDER. Mr. Parrella, how—in the home health care area, as we looked at some of Medicare, one of the problems is that it's easier to audit when people are together and that while all of us see the advantages of home-based delivery systems and the saving to the system, does it not in fact engender more fraud and and/or auditing costs in that and how are you dealing with that? Have you seen any of that?

Mr. PARRELLA. I guess by your question what you are saying is that it is easier to audit a large residential facility where you have people concentrated as opposed to a more disbursed delivery model where people are in the home. I think that's sort of the sense of what you are getting at.

Mr. SOUDER. Right.

Mr. PARRELLA. Our audit efforts, as far as both home health and nursing homes, are pretty aggressive. We have conducted some significant audits of home health delivery systems within the State.

It is true that onsite audit of the delivery of services is more complicated when you are dealing with a disbursed delivery model. But there certainly are central repositories of records where you can go to for verification of service delivery. I wouldn't say that it's less—it is probably more challenging, but it can be done.

Mr. SOUDER. I would like to ask one other question yet, if I may?

Mr. SHAYS. Sure.

Mr. SOUDER. This is a hard question that nobody really likes to ask, and by asking this I don't mean that I don't prefer home-based delivery systems.

In looking at children's programs, for example, in the programs that try to—the family preservation programs, if somebody is about to be assigned to foster care and the State goes and says, let's try to work with that family and try to avoid it, it can save the State tons of money by avoiding the foster care placement. But if you don't have that criteria that they were definitely going into foster care, you wind up helping a lot of families who otherwise wouldn't have gone into foster care and, in fact, you don't save that amount of money.

Would not some of this problem also be true of health—home health care that many—do they have to have already said they are going to a nursing home or would not, in fact, many people who would—for example, in our case, with my mom and my mother-in-law, they have some resources. They desire to stay in their homes; and as long as we don't have options, we will work to keep them in their homes. But you give us a home health care option, we may tap into government programs that we wouldn't have otherwise tapped into. How do you do that type of balance?

Mr. PARRELLA. Well, in our home health—our waiver programs, the individual has to meet the medical level of care determination to be placed in a nursing facility.

In addition, we do require them to actually file an application for admission to a nursing facility in order to be admitted to the home care waiver program.

I think maybe where your question is going is would that provide incentive to individuals who might otherwise elect to continue to care for their family member and never would have explored the option of going to a nursing facility to, indeed, file that application because it would entitle them to the waiver services.

I think, under the current system, that's an open question. I think that as you move toward more of an integrated delivery model, where you are looking at a system that doesn't give the incentive one way or another financially, whether the person is at home or in a nursing facility, some of that problem is alleviated.

I don't know, John, whether you would agree with that.

Mr. PETRABORG. I think that that is the method that we would use, and we need to do it in a way that takes advantage of and doesn't discourage that kind of personal and family responsibility.

Mr. SOUDER. If I can take one more?

Mr. SHAYS. Go ahead.

Mr. SOUDER. In my generation, one of the biggest things—and this is another politically explosive question—and that's the drain down of resources. It's very tempting—as your parents have saved whatever they can, they want to pass it to their children, to empty out and say, OK, State take over. Do you see much of that in the Medicaid area along the margins? Is that going to be a growing problem?

Mr. PETRABORG. It's a very hot political issue in Minnesota and something, I think, that is of grave concern. The Minnesota Medicaid program has become the long-term care insurance program for the vast majority of our State, and so there are serious discussions in our legislature about different ways of either limiting asset transfers in different ways or finding ways to make asset transfer not necessary in terms of encouraging long-term care insurance models that can be purchased earlier. But, again, these are things that take time and almost a generational shift in attitudes, but we need to start.

Mr. PARRELLA. I think that it's really difficult to quantify the extent to which the asset transfer issue is contributing cost to your State, because you only know the ones that you find out about as you are doing your investigations during the penalty period, and there certainly are other asset transfers that occur that the State is unable to detect.

One of the strategies that we have pursued in Connecticut, and John had mentioned it, is the long-term care insurance model where we will grant asset protection when a person applies for Medicaid equal to the dollar value of benefits that they received from a privately purchased long-term care insurance policy, the idea there being that people would have an incentive to invest themselves to acquire protection against catastrophic costs in a nursing facility without necessarily just going to the option of saying, well, the State will pick it up. I think that there are innovations like that that can be looked at in ways that would encourage other sectors, including the private sector, to play more of a role as a payer in nursing facility care.

If I may, one of the things that's peculiar about Medicaid's role with nursing facility care is that it's probably the only place, at least in our State, where we are the majority payer. We are paying maybe 10 to 15 percent of the inpatient hospital cost, probably a smaller fraction of physician bills paid in the State, but on the nursing facility State we are probably 62, 65 percent of the market. I mean, we are the big deal as far as the nursing facility is concerned.

So it is certainly in our interest, through other mechanisms that we can create, if we can have other incentives for other payers to become involved in that market.

Mr. SHAYS. We just have a few minutes left. Counsel knows that he can ask questions and chooses not to at this round here. But let me be more precise, given the shaking of the head in the back.

In terms of my one-third/two-third analysis, according to the Kaiser Commission on the future of Medicaid, of the total beneficiaries, 50 percent are children, and they consume 15 percent of the expenditure. And adults mostly associated with AFDC and pregnancy and so on are 23 percent of the beneficiaries. They consume 12 percent. If I take the children and the adults, I am at 73 percent consuming about 27 percent. The blind and disabled—and this is where I was off—are 15 percent of the population consuming 31 percent of the expenditure, and the elderly are 12 percent consuming 28 percent. So it would be—then for those who are adding the percentages, the DSH, or disproportional share, is the 14 percent not associated with anyone. So I feel better having—being more precise.

Is there anything that we can learn from the growth in future Medicaid funding by looking at the recent cross-growth in the private sector? The private sector appears to be growing at a lesser rate than the public sector. Is that a significant factor in terms of your calculations?

Mr. PARRELLA. Well, I would say that in our State, private sector purchasers of insurance are abandoning, to a large extent, fee-for-service reimbursement models for the major corporations that are based in our State. They are overwhelmingly going to managed care delivery models as a way of trying to contain costs. And I think that the leverage that they are seeking is the same leverage that John alluded to in his remarks about purchasing power for the State, and they are able to do that.

I think one of the things that was surprising to us was that historically our rates have been extremely low compared to rates that

are paid for similar services in the private sector. But as the private sector has aggressively pursued discounts on rates for medical services as part of the purchase of consortiums of care, they are getting down to a range where they are paying rates which are not all that dissimilar in some instances from what we had been paying in a fee-for-service environment, which is one of the things that leads us to think that we could do better as a purchaser than where we have been historically.

Mr. PETRABORG. I would only add to that example, I think most of us are familiar with, having to do with hospital utilization over the last few years, kind of the way purchasing has moved toward shorter stays and services outside of that hospital. We can apply that same kind of perspective to the way we are purchasing services for nursing care, nursing home care and services to the disabled. I believe we have a lot of room for maintaining service and controlling costs.

Mr. SHAYS. John Petraborg and David Parrella, thank you both for coming. It is a nice way to introduce this issue to the committee. Thank you very much for coming. I appreciate your testimony.

I now would invite Dr. Bruce Vladeck, Administrator of the Health Care Financing Administration.

Mr. SHAYS. I want to thank you, Mr. Vladeck, for adjusting your schedule. As I said earlier, Henry Waxman has asked us to postpone this hearing slightly. He was in New York and is being somewhat detained by the fog. Frankly, this hearing would be more interesting if he were here, because he is very knowledgeable. I would appreciate hearing his questions as well.

For the record, I recognize that we really are represented by one side of the aisle up here and want to be thoughtful of that in our questions, but we do want to have a meaningful dialog. That would be helpful. I know you to be a very devoted public servant, and I appreciate your being here and welcome your testimony.

STATEMENT OF BRUCE VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you, Mr. Chairman. I do appreciate the opportunity to be here today and all of the flexibilities about schedules that were associated with it.

In light of where we are in this debate and the nature of the subject—I know your concerns about dialog—I am going to try and keep my prepared statement very brief and to organize it essentially around three charts, copies of which we are trying to get up here, but which I believe are also in the back of your full written statements.

Medicaid is in the process of becoming, in one sense, the largest health insurance program in the United States of America, now covering 36 million vulnerable Americans through partnership between the Federal Government and the States. Within the current program structure, States have substantial flexibility to design their programs to meet their unique needs, and the State and Federal Government have been working to implement more flexibility. We have used our current waiver authority to enable States to pursue innovative approaches to the provision of health care coverage to special populations and to the redesign of delivery systems.

Further, as you know, the President has proposed a set of new reforms to provide States with still further flexibility while maintaining coverage of vulnerable populations, increasing the control of Medicaid costs and contributing savings to the Federal budget.

Mr. Chairman, one of the issues that came up with the prior panel had to do with the rate of growth in Medicaid expenditures on a per-enrollee basis. And the chart that is on your right—again, it is table 1, I believe, or chart 1 in your written materials—shows that except for one particular glitch in the period between 1988 and 1991, Medicaid rates per beneficiary have traditionally over the life of the program grown at a rate lower than or roughly equivalent to the rates per individual of private health insurance costs, notwithstanding the fact that, as was also noted and as we will get to, a large share of Medicaid expenditures are devoted to folks who are inherently more expensive to care for than are folks covered by private health insurance. That is why there is such a disproportion between the share of the covered individuals in Medicaid who are elderly or disabled and the proportion of expenses associated with the elderly and disabled.

A principal driver of Medicaid cost increases over the last number of years, almost 40 percent, the contributor of almost 40 percent of projected increases in Medicaid costs under CBO projections for the balance of this decade has to do with the continued growth in the number of people eligible for the program.

Since 1988, according to estimates of the Urban Institute, the total enrollment in the Medicaid program has increased somewhere in excess of 5 million persons. At the same time, I might note parenthetically, the number of people in the United States with private health insurance in this same period of time has fallen by somewhat more than 7 million people. So the question is not just a cross-sectional one of how we will operate the Medicaid program at the moment, but how States are to have adequate flexibility in an era of constrained spending in order to meet the needs of a growing number of low-income and disabled persons for health care.

We believe Medicaid is the critical safety net for a variety of populations. Not only does it cover preventive care for low and moderate income pregnant women and children and long-term care for low income seniors and persons with disabilities, as you know, but it is, as was noted in the previous panel, the principal provider of long-term care not only for the elderly but for the seriously disabled of all kinds, including the mentally retarded and developmentally disabled. It is the primary source of financing for services for people with HIV in the United States, accounting for somewhere between 40 and 50 percent of all health care expenditures for the HIV infected. It is now the primary source of financing for public mental health services in the United States, exceeding any other source of Federal or State revenue, and is the safety net for all middle income families whose parents or adult children are in need of chronic expensive services of one sort or another.

Again, as we have discussed, while the elderly and disabled account for roughly half of Medicaid recipients, they account for more than 70 percent of Medicaid spending.

What is interesting, in light of the earlier conversation, is in the last decade the greatest source of growth in Medicaid expenditures has not been on behalf of the elderly. It has been on behalf of the nonelderly disabled, whose numbers have increased and for whom a variety of services have increasingly been financed through the Medicaid program rather than other sources of one sort or another.

As you know, under current law there are certain populations that States are required to cover if they participate in the Medicaid program, and certain services they are required to offer if they participate in the Medicaid program. There are also additional populations that States may choose to cover at State option and additional services that States may choose to cover at State option. In 1993, only 38 percent of all Medicaid expenditures were on behalf of mandatory services for mandatory populations. If you exclude disproportionate share dollars——

Mr. SHAYS. Say that over again. It went by me.

Mr. VLADECK. OK.

Mr. SHAYS. Maybe what you could do, because that is a helpful chart, if you would put the other chart down below, the one that was just up, just put it down below since we may make reference to it.

Mr. VLADECK. We talked, the previous witnesses talked, I think quite appropriately, about some of the complications of Medicaid eligibility, but there are—the overwhelming proportion of Medicaid eligibles are eligible by virtue of being recipients of cash assistance, either AFDC or SSI. States may, at their option, cover a variety of other folks in the Medicaid program. Similarly, we require States that participate in Medicaid to cover 11 basic services in the program, but we permit them to cover 20 some odd additional services at State option. As the gentleman from Connecticut noted, Connecticut covers most of those.

So that in fact if you exclude, which is sort of the next line, State payments, disproportionate share payments that States make as part of their Medicaid program—which nationally are about 12 to 14 percent of all Medicaid expenditures and are also entirely optional on the part of the States—but even if you exclude them, if you look at the lower of those two tables, slightly under 44 percent of all State Medicaid expenditures are on behalf of services they are required to cover, for people they are required to cover, in order to participate in the Medicaid program.

Another 35 percent of State expenditures are on behalf of individuals who the States have required, who the States have chosen to cover over and above that which is minimally required in order for the States to receive Federal financial participation in the Medicaid program.

To flip the chart the other way, 45 percent of Medicaid expenditures are on services that States are permitted but not required to provide in order to receive Federal matching payments under the Medicaid program.

The point of this chart, of course, is to suggest in some basic structural ways the extent of flexibility that is currently available to States under current law, even though we in the administration believe there are important ways in which that flexibility ought to be expanded.

The fundamental nature of the partnership between the Federal Government and the States that has existed in the Medicaid program for the last 30 years, in which in effect the Federal Government says if the State chooses to meet a set of minimum requirements about coverage and benefits, we will provide a Federal match of between 50 and 83 percent of the dollars associated with that activity and, in addition, we will match, at the same rate, a very broad range of additional expenditures the State may, at its option and its discretion, choose to make.

This has permitted States to develop 57—if you count the territories, the District of Columbia—very considerably different Medicaid programs which vary from one to another on almost any dimension one could try to name. But it also provides the States with a considerable degree of automatic protection. To the extent to which economic circumstances of one sort or another require or cause an expansion in coverage or an expansion in the need for service, Federal matching payments are automatically available within the very broad confines of the existing program.

We believe that the conference agreement would curtail this Federal financial responsibility by putting an absolute ceiling on the willingness of the Federal Government to match State payments, which would throw the partnership out of balance in a fundamental way, and which makes sense as a matter of arithmetic only if the basic guarantee of coverage for low-income elderly and disabled persons that is now the core of the Medicaid program were abandoned at the same time.

Most simply, we just do not believe that the Medigrant program, as contained in the balanced budget bill, provides nearly enough funding to continue to provide existing levels of coverage to existing beneficiaries, even with greater program efficiencies, and certainly not to accommodate the growth that might come about as a result of economic recession or just continued increase in the number of low-income people in this society.

To make matters worse, the provisions in the conference agreement which reduce the extent of required State matching for something on the order of a dozen States will, we believe, provide those States with a very strong incentive to reduce the level of their contributions to Medicaid. If you add the projections of what the States would reduce in terms of their spending as permitted under the formula in the reconciliation bill with the reductions in Federal outlays, we believe that amount would total close to $400 billion over 7 years, an amount with which it would just not be possible to continue coverage of most of the folks who are now being covered.

We believe at the same time that we can protect access to high-quality health care while providing States with additional flexibility, as is outlined in the President's proposal. We would continue the basic Federal partnership with the single change of limiting the growth in per-person spending by the major categories of persons covered. If States had to expand enrollment as a result of population change or economic circumstances, more than otherwise would have been expected, they would receive additional Federal funds in order to cover those folks.

Federal matching funds would increase as the State population grew, as enrollment grew. There would not be a shift from the Federal Government to the State necessary to maintain coverage, which we believe would in that instance clearly constitute an unfunded mandate. In fact, what a block grant does in effect is transfer all of the financial risk of operation of the Medicaid program to the States who can be expected, under their obligations to balance their budget and meet competing priorities, to shift that risk further downstream onto the poorest and most vulnerable members of our society if they are not to incur significant additional costs, as some of the later witnesses will expect.

Nonetheless, we believe that States ought to have considerably more flexibility in operating their Medicaid programs. We have been in almost continuous discussion with the National Governors Association, the State Medicaid Directors Association, and other representatives of State governments since this administration began. They have made a number of proposals to us, and we have incorporated a large number of them in the President's proposal.

In light of the earlier discussion, I would particularly emphasize three of those. First, the President's proposal would eliminate the so-called Boren amendment, the requirements associated with how States pay institutional providers—hospitals and nursing homes—and the legal liability that has evolved for States under that requirement. We would provide States with substantially more flexibility to develop a variety of managed care arrangements and to mandate the participation of Medicaid enrollees in those networks, and we would make it substantially easier in administrative terms for States to move a larger and larger share of their long-term care systems, both for the elderly and the disabled, to community-based services teams out of an institutional focus.

These can all be done while maintaining the safety net for everyone who is currently eligible for coverage or who is likely to be eligible in the future, and while constraining the rate of cost growth for both the Federal Government and the States.

We believe it is possible to moderate the growth of costs in the Medicaid program. We believe it can be done without jeopardizing the guarantee of coverage as long as the basic financial partnership between the Federal and State government remains in place and the incentives on States forced to economize and seeking to economize are in the direction of greater efficiency or reductions in payments to providers, rather than reduction in coverage.

We believe that that is what the President's proposal would achieve and that it is necessary to continue in that vein in order to protect this essential and irreplaceable safety net for the most vulnerable members of our population.

I appreciate, again, the opportunity, Mr. Chairman, to appear. Of course, I am happy to respond to any questions.

[The prepared statement of Mr. Vladeck follows:]

STATEMENT OF

BRUCE C. VLADECK
ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

ON
UNFUNDED MANDATES IN MEDICAID

BEFORE THE SUBCOMMITTEE ON
HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS

HOUSE COMMITTEE ON GOVERNMENT REFORM
AND OVERSIGHT

JANUARY 18, 1996

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Introduction

Medicaid provides health coverage for 36.1 million Americans -- children, pregnant women, senior citizens, individuals with disabilities and others -- through a partnership between the Federal government and the States that provides States with substantial flexibility in designing their Medicaid programs.

Under the current program structure, States and the Federal government have been working to implement more flexibility in the Medicaid program. HCFA has used current waiver and demonstration authority to enable States to pursue a number of innovative approaches to provide health coverage to special populations and to redesign provider delivery systems.

Furthermore, the President has proposed important new reforms that will maintain coverage of vulnerable populations, increase control of Medicaid costs, contribute savings to the Federal budget, and provide States with additional programmatic flexibility.

In fact, Medicaid program spending has grown less rapidly than spending in the private sector on a per person basis, except for the period between 1989 and 1992 (Chart 1)[1]. Combined efforts by

[1]The higher growth rates during this time were caused by several factors, including a national recession, States' use of statutory loopholes to increase Federal payments without increases in medical services, and increased provider payments.

the Executive Branch, Congress and the States have kept program costs under control while maintaining the Medicaid program as an important source -- often the only source -- of coverage for low-income Americans. This Administration's proposals to further control spending continue the commitment to guaranteeing these individuals access to a meaningful benefits package. The President's proposal does not shift Federal responsibilities to the States, it is not an unfunded mandate, and it provides significant increases in States' flexibility to manage their Medicaid programs.

Medicaid is a Critical Safety Net

Medicaid is the primary source of coverage for Americans with diverse health care needs. It covers preventive care for low-and moderate-income pregnant women and children and long-term care for low-income senior citizens and persons with disabilities. It also provides a variety of rehabilitative services and adaptive technologies for persons with disabilities, chronic care for individuals with special needs, and supplemental coverage for low-income Medicare beneficiaries.

Benefits

Generally, Medicaid acute-care coverage mirrors the employer-based coverage available to most Americans, but for senior

citizens and individuals with disabilities Medicaid also provides long-term care benefits that are rarely available or affordable through other sources. Because Medicaid covers these services, the program ultimately helps a large number of working American families care for their chronically ill family members. Indeed, 68 percent of all nursing home residents rely on Medicaid to help pay for some of their care.

Many senior citizens have complex health problems or need long-term care. In 1993, spending on services for elderly and disabled individuals constituted almost 70 percent of all Medicaid spending, excluding payments to disproportionate share hospitals (DSH). Approximately half of these dollars was spent on long-term care in nursing homes. Without Federal Medicaid funding, the costs of caring for many of these individuals -- the elderly, chronically ill, disabled and mentally ill -- would fall entirely on States, local communities and families. The remaining thirty percent of Medicaid spending pays for care -- primarily hospital and physician services -- of low-income adults and children (Chart 2).

It is important to note that States are free to cover additional populations and services beyond those required under Federal guidelines. A few optional benefits, such as prescription drugs and clinic services, are covered by almost all of the States.

States can choose to offer a wide variety of other medical services, and they can and do change their benefit packages.

States use flexibility in eligibility and coverage of services to customize their Medicaid programs to meet their specific needs. In 1993, only 38 percent of all Medicaid benefit and disproportionate share hospital payments was spent on mandatory services provided to mandatorily eligible individuals. States spent nearly 50 percent of their Medicaid funds on optional services and populations they have chosen to cover, while another 13 percent was devoted to disproportionate share hospital payments.

Americans who qualify for Medicaid are guaranteed financing for their essential health services. National standards for coverage of vulnerable populations apply in all States. States provide a full range of services to beneficiaries, from childhood immunizations to nursing home care. Within these parameters, Medicaid has had substantial success serving diverse low-income populations.

Financial Partnership

Medicaid is a voluntary program designed by Congress to be administered by States with matching Federal funding at rates that range from 50 to 80 percent depending on State per capita

income. Today, all 50 States, the Territories, and the District of Columbia have chosen to participate in the Medicaid program and to enter into a financial partnership with the Federal government.

States have used the broad flexibility inherent in the Federal-State relationship to create many optional eligibility, coverage, and financing policies that meet the diverse needs of their people and the State's own financial circumstances.

More importantly, this relationship provides State Medicaid programs with the financial backing of the Federal government. The flow of Federal funds under the current Medicaid entitlement program protects States and beneficiaries during economic downturns and natural disasters, such as earthquakes or hurricanes. When States increase enrollment, the Federal government automatically shares the responsibility of additional costs. The combination of Federal financial participation and an individual entitlement guarantees that the Federal government will consistently share the cost of providing medical care to low-income children, elderly, pregnant women, and individuals with disabilities. Federal financial assistance is provided regardless of changes in program enrollment or in a State's economic situation. The Federal/State partnership inherent in the Medicaid program guarantees the commitment of Federal funds.

Block Grant

The Conference Agreement would curtail Federal financial responsibility by converting Medicaid into a capped block grant formula, throwing the current Federal/State partnership out of balance. The new MediGrant program would end the entitlement to a basic health care safety net for low-and middle-income individuals and families. It would also be seriously underfunded.

The MediGrant proposal would constrain increases in Federal Medicaid spending far below the rate of inflation and the rate of growth in the number of elderly, disabled and low-income people who will need help from the program. Federal Medicaid payments would be an aggregate amount, fixed in law, totally disconnected from State funding needs. This would underfund the Federal portion of the Federal-State partnership and leave States with no protection from enrollment changes. States with growing populations would be at greater financial risk. The arbitrary limits particularly threaten States with rapidly aging populations, since the block grant amounts would not change to reflect the increasing number of high-cost beneficiaries in a State.

Exacerbating the underfunding problem, the Republican block grant formula creates an overwhelming incentive for States to reduce

their contributions to Medicaid. The formula would lower the amount of State expenditures required to receive Federal matching funds. State spending beyond the block grant amount would not be matched at all. The Center on Budget and Policy Priorities has estimated total Medicaid spending reductions - Federal and State - could exceed $400 billion over seven years.

While both Federal and State support for low-income individuals and families would be dramatically reduced under the Conference agreement, the medical needs of this population would not go away. The cost of caring for the uninsured and low-income Americans could fall to local-level public health care systems and may shift costs to the privately insured and their employers. Worse, millions of needy people could opt to forgo necessary care altogether or potentially increase the use of costly emergency services.

The Republican plan would also eliminate the individual entitlement to health care under Medicaid. Vestiges of statutory language guaranteeing coverage for some people are undermined by a lack of definitions for eligibility criteria and have no specific set of meaningful health benefits. The set-asides in the Republican plan offer little protection for vulnerable populations.

In addition, the Republican block grant does not provide meaningful assurances that Federal and State tax dollars will be appropriately spent. The Conference Agreement eliminates some Federal enforcement provisions to guard against waste or abuse of American Federal tax dollars. The taxpayers deserve appropriate Federal standards and oversight in the Medicaid program.

The President's Proposal

The Administration opposes the Republican Medicaid proposal as excessive, harmful and unnecessary. The President has proposed an alternative approach that would protect health care access and high quality of care while providing States with additional flexibility in their programs and controlling costs and yielding savings for deficit reduction.

The President's Medicaid per capita cap proposal would continue the shared Federal-State financial partnership and maintain the entitlement to a meaningful set of health benefits for low-income children, pregnant women, seniors, and individuals with disabilities.

States would receive Federal matching funds up to per person spending limits for any current or new enrollees. This plan would maintain the Federal financial commitment even if States have to expand enrollment. Under a period of economic recession,

increased enrollment in a State would automatically result in additional Federal funds for States. Under a per capita approach, Federal dollars would be specifically linked to the number and casemix of enrollees. The Center on Budget and Policy Priorities estimates that a recession, depending on its severity, could increase Medicaid costs due to increased enrollment by between $8 billion and $29 billion. Under the per capita approach, Federal funds would automatically be available to match State spending for each new enrollee.

Cost Shift -- Opponents of the President's plan charge that the per capita cap would result in a cost-shift from the Federal government to the States. That accusation is wrong. The President's proposal provides new State flexibility under the current partnership, not new mandates. The President's proposal maintains the Federal/State financial partnership and the Federal government's financial commitment to the States and to beneficiaries -- which is the heart of the Medicaid program.

Under the per capita cap, States would continue to receive Federal matching funds for individuals States need to enroll in the Medicaid program. Federal matching funds would increase as the States' population expands and enrollment grows. Federal matching funds under the per capita cap proposal would be dynamic and responsive to States needs.

It is the block grant that would shift costs and leave States at risk -- particularly in the event of economic downturns. Under a block grant, Federal matching funds do not change -- regardless of changes in the size of the States' Medicaid populations.

Unfunded Mandate -- Opponents charge that the per capita cap proposal is an "unfunded mandate" on the States. This accusation is also wrong. In fact, under a per capita cap methodology, Federal funding would expand as the States' needs expand and enrollment grows. The per capita cap would reduce Federal spending without putting the States at undue financial risk.

However, the Republicans' block grant proposal would underfund the Federal/State partnership, leaving the States with no protection from enrollment changes. States with growing populations would be at greater financial risk. The block grant methodology does not reflect the number of high-cost beneficiaries in a State. Consequently, the arbitrary limits particularly threaten States with rapidly aging populations.

Flexibility -- Opponents also charge that the per capita cap proposal does not provide enough State flexibility. The President's proposal enhances State flexibility -- but not to the point of jeopardizing beneficiary access to services or their quality of care. The President's proposal is designed to provide States increased flexibility to manage their Medicaid programs.

At the same time it retains the beneficiary entitlement to benefits.

The President's proposal incorporates many flexibility changes States have been advocating through the National Governors Association, the State Medicaid Directors Association, the American Public Welfare Association and other groups. These changes would provide States greater flexibility to design and operate their programs, thereby permitting them to improve program management to help meet the Federal per capita payment limits. These flexibility provisions could also produce savings independent of the Federal payment limits in cases where State spending is projected to be under the per person growth limits.

The President's proposal provides:

Greater State control over program efficiency and costs:

- Eligibility simplification and expansion would provide States the option of covering individuals with incomes up to 150 percent of poverty, subject to a budget neutrality adjustment.

- States would be able to require enrollment in managed care without waivers.

- States would be able to continue innovations in provider payment methods without Federal requirements regarding hospital and nursing home payments.

- States would no longer have to reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) on a cost basis.

- States would have greater control over long-term care costs because they would be able to implement home and community-based services programs without Federal waivers.

Enhance flexibility for States to establish managed care networks:

- States would be able to establish provider networks (including primary care case management (PCCM) programs) without needing waivers.

- States would be able to contract with capitated health plans without regard to Federal enrollment requirements (i.e., the current rule requiring Medicaid capitated plans to have 25 percent commercial enrollment would be repealed).

- States would be able to restrict Medicaid beneficiaries in a rural area to a single HMO if only one HMO were available.

State relief from administrative requirements regarding provider qualifications and long-term care services:

- States would no longer be subject to annual reporting requirements for obstetric and pediatric care.

- States would no longer have to conduct duplicative annual resident assessments for mentally ill and mentally retarded nursing home residents.

- Federal restrictions on training sites for nurse aides would be relaxed.

These flexibility provisions would augment current State authority within Medicaid's Federal-State partnership. This enhanced State flexibility, combined with a per capita cap funding mechanism, would preserve the safety net Medicaid provides while containing costs.

Conclusion

Can savings be achieved in Medicaid? Of course, as long as they are at a moderate level that protects the vulnerable populations who depend on Medicaid. The Administration's per capita cap proposal would do just that within the context of continuing the

entitlement to meaningful benefits and providing substantial new flexibility to the States.

Mr. SHAYS. Thank you. I found your testimony very interesting and helpful. Let me just outline kind of where I am, what I am wrestling with, and I am happy to hear your comments.

I served on the Committee on the Budget for a number of years. I was elected in 1987. I vowed that this country needed to get its financial house in order and have been part of that group within Congress, among which there are some Democrats as well, obviously, as Republicans, who want to get our financial house in order and balance the budget.

When I look at Government spending, I have realized for the last 8 years, I vote on one-third of the budget. I vote on discretionary spending, defense, nondefense, what comes out of the Committee on Appropriations. Two-thirds of the budget is basically on automatic pilot. You fit the entitlement, you get the money.

Then you have the interest rates, which are about 15 percent of the total budget. There is no way conceivable that we can balance our budget unless we slow the growth of entitlements, not cut them, slow the growth, which is—I think the President has acknowledged that as well, because in his program he chooses to save $52 billion over 7 years as opposed to our savings of $133, which we dropped it down to $85, which disappointed me; I would like to stay at $133 or close to it.

Now, we cannot keep the Government on automatic pilot and balance the Federal budget. I would be more than willing, a number of my colleagues would, some would not, to get rid of all the tax cuts and balance the budget in 6 years. What my interest is is to get that 50 percent of the budget that is on automatic pilot and to not have it grow so much.

Now, the other part of the equation for me is that because of the additional add-ons that the Federal Government has done, which some are mandatory and some are optional on the States, we have seen Medicaid grow during certain times, during certain years, recent years, of 20 percent a year. Medicaid/Medicare now constitute 17.6 percent of the entire Federal budget. Medicare and Medicaid are equal to all domestic discretionary spending. Equal to it.

Now, we have continually squeezed discretionary spending. I have sympathy with the President's view that we are squeezing discretionary spending domestic. Where my challenge is, we have to slow the growth of Medicare and Medicaid.

Now looking at your chart, there are parts that are mandatory. In other words, if you choose to be part of Medicare and all Medicaid, and I think it is disingenuous to assume that a State would not, if you choose now, these are the rules. I will just put another bias that I have on the table. In the State level, I saw States doing innovative things. I do not see it on the Federal level. I see the State adding—the Federal Government adding up everybody in this room—gets the number of people, adds up all the shoe sizes and says, there we are, size 8½ fits all. And I would dispute your basic sense that there is flexibility in this. Obviously we would have a debate on that.

What would you call—you have mandatory people and optional people. This is a very helpful chart to have a discussion. I thank you for having it. You have mandatory people; you have optional

people. You have mandatory services; you have optional services. And you have thoughtfully broken that down.

Describe to me the optional people that you call optional. In other words, you can be part of Medicaid but you do not have to have optional people. What would be an optional——

Mr. VLADECK. I think the largest numbers of so-called optional people are in two categories. One are the so-called medically needy. States may, but are not required, to cover folks who would qualify for cash assistance if you ignored that part of their income that they have to spend on medical care. So in other words, if you are a person with even a median income in some States but you have to spend $5,000 or $6,000 a month on medical care because you have a chronic illness of some sort or another, and that $5,000 or $6,000 a month when subtracted from your total income would otherwise make you eligible for AFDC or SSI——

Mr. SHAYS. Give me some other optional people.

Mr. VLADECK. That is the largest group.

The second group of medically needy, States are required to cover AFDC recipients and children up to the age of 13 under 100 percent of the poverty level and pregnant women up to 100 percent of the poverty level.

Mr. SHAYS. That is the AFDC?

Mr. VLADECK. Well, some of them, no, they can, children must be covered up to 100 percent of the poverty level whether their parents receive AFDC or not.

Mr. SHAYS. So working poor?

Mr. VLADECK. States may extend that coverage up to 185 percent of the poverty level. And so there are two very disparate groups in that other people category.

Mr. SHAYS. So your point would be States do not have to do that. Most States do; correct?

Mr. VLADECK. I believe about two-thirds of the States cover some or all of the medically—have some degree of medically needy program. But only about a third of the States cover more than the minimally required low-income mothers and children.

Mr. SHAYS. You described the bulk of the optional people. How about describing the bulk of the optional services?

Mr. VLADECK. A lot of the optional services have to do with particular kinds of providers of services or additional services that are not in the basic Medicaid package. Podiatrists are the ones that we always used to fight about in New York all the time. Dental services for large parts of the Medicaid population are in optional services.

Actually, the most expensive optional service by far is pharmaceutical drug coverage, which is not required to be covered, but most States, I think all the States do. A variety of home and community-based services, long-term care services that are thought to—for institutional care are optional for the States but many States take advantage of them.

Nonmedical transportation is a so-called facilitative service. Physical therapy, occupational therapy on an outpatient basis. There is a list of about 30 such services.

Mr. SHAYS. So basically is it your contention that, am I reading this correctly that if I take mandatory services—what number

there describes the optional people and the optional services? Is it the 45.5 percent?

Mr. VLADECK. The optional people and optional services is that 24 percent of the total, people who the Federal Government does not require the States cover for services, that the State does not require——

Mr. SHAYS. What would define here in your chart the total amount of spending that is optional?

Mr. VLADECK. I guess the total amount of spending that is optional is the total amount that is not in the upper left-hand box. So it would be 56 percent of State Medicaid spending, and the Federal match of it is not mandated by the Federal Medicaid program.

Mr. SHAYS. Not to turn something around but to turn something around, what you described to me is something quite significant. States on their own are choosing to spend 56 percent of all the costs. So why do you have such a concern that States will be irresponsible if we give them discretion?

Mr. VLADECK. States have made that choice, Mr. Chairman, under a deal in which the Federal Government matches them anywhere between $1 for $1 and $3 per $1. If there is no additional Federal dollars associated with a change in State expenditure patterns, you would expect a rational State to behave very differently.

Mr. SHAYS. I am listening to that, and for you that is a satisfactory answer. For me it is not, because I know my State of Connecticut, yes, has to match 50 percent. My point to you is that the bottom line is States have chosen—you cannot have it both ways and say it is optional, and then say they option it and now it is not significant.

It is optional; they option it and they choose to. They do not have to. My State could save a hell of a lot of dollars by choosing not to have that service, but they choose not to.

Mr. VLADECK. Mr. Chairman, I have heard the argument in your State and every other State made by providers every time the State proposes to cut any part of the Medicaid program. They say you are going to save $20 million in the State budget and cost the State $20 million in Federal dollars. I have heard the argument, and every time States have proposed to reduce their outlays on Medicaid, the argument is made that for every $1 the State saves, the beneficiaries of the service and the providers in the system lose between $2 and $4, depending on the State you are in.

The converse of that is it has given the States a greater incentive to expand coverage because of the availability of the open-ended Federal match, absolutely.

Mr. SHAYS. What is interesting is, you take some States that have a 50 percent match and they choose to spend more than some States that get 80 percent Federal dollars, which is kind of an interesting—to me it is at least interesting that even with a greater incentive—let me ask you this now: When I look at nursing care and where States are required to have ombudsmen, is that Federal or State requirement?

Mr. VLADECK. That is Federal.

Mr. SHAYS. Why is it logical and why is it cost-effective and why is it right to have an ombudsman that can say to a nursing home, you had two patients in room A and you had two patients in room

B, and one patient in each room no longer is there. Passed away. Now you have one in each. And the nursing home petitions the advocate to be able to move it. And the advocate says, no, you cannot move that patient. Why is that logical?

Mr. VLADECK. Well, if you were to—what you are referring to is the ability to change a patient's room without the patient's consent. One of the basic principles of the nursing home reforms embodied in 1987, coming out of the report of the Institutes of Medicine, was that merely by virtue of the fact that an individual is a resident of a nursing home, they should not lose their rights as a citizen or their dignity as a human being. And to take someone and say, because you are a nursing home resident we are moving you from this room to that room for the convenience of the facility, without your consent, struck a number of us as a violation of the basic dignity of the individual.

Mr. SHAYS. You have just illustrated to me why I want the States to have this decision. You on high basically decide in a sense that a nursing home cannot save the taxpayers money and be able to put those two individuals into one room; the room looks the same, is the same. It is maybe one room down. But instead, that nursing home now has two patients, each having their own room. It is logical that patient may want to stay there and not—and have the room all to themselves. But it sure is not cost-effective.

Mr. VLADECK. Mr. Chairman, there is nothing in the rules, Federal or State, that permits, that prevents the facility from bringing another patient into each of those rooms.

Mr. SHAYS. Right. But maybe they cannot do it for a week or two or three.

Mr. VLADECK. And the decision was made, and I would defend it. And let me generalize from your comment on why we think it is important to have a Federal role. We believe that the mere fact that an individual, because of illness or poverty requires Federal and State support for the receipt of medical care, should not require them to lose their rights or their dignity as a citizen of this country in the receipt of medical care. It should not give them less freedom to get care or to be treated like a citizen than anyone else who enters the medical care system.

Mr. SHAYS. I agree with that. But you make a quantum leap, in my judgment. I acknowledge to you, this is just one, but it is just one replete with a whole host of others. I believe you believe that. And you believe basically the Federal Government should be able to have a system that prevents efficiencies and that basically costs the taxpayers a hell of a lot of dollars.

Mr. VLADECK. No, sir. I have not defended everything in that book. I think that is a misstatement of the position of the administration. We believe that large parts of that book ought to be repealed.

Mr. SHAYS. I do not want to put words in your mouth. So if that is the case, it appears to me that that is what is being said. What is your point?

Mr. VLADECK. Let me be very explicit. We believe that large parts of that book, as they relate to requirements on provider payment methodologies, ought to be eliminated; that large parts of that book as they limit the ability of States to engage in home com-

munity-based care or in managed care ought to be eliminated; that the eligibility process ought to be considerably simplified, which is where most of the regulations by page and by volume in the Medicaid system have to do with this eligibility, and we agree strenuously that that should be radically simplified.

At the same time, there are parts of the requirements in that book that we believe must be maintained in order to protect the rights and the dignity of the beneficiaries of the program. And one part of that about which I will confess I feel particularly strongly, because of my own background, are the Federal requirements about quality of care and quality of life in nursing homes.

Mr. SHAYS. Quality of care, is that defined by the number of nurses versus the number of patients?

Mr. VLADECK. As a matter of fact, there is no Federal standard, quantitative standard on the relationship of the number of nurses to the number of patients. There is a standard that gives individual facilities and States a considerable amount of discretion in adjusting their staffing, nurse staffing to meet patterns of particular practice or particular needs of residents.

Mr. SHAYS. It is your testimony that there is no Federal requirement to have a certain level of staffing at nursing homes?

Mr. VLADECK. There is a Federal requirement to have an adequate level of staffing. There is not a quantitative requirement at the Federal level that says for each resident there shall be X number of nurses or of nursing hours, other than the minimum of one R.N.

Mr. SHAYS. One R.N. For what?

Mr. VLADECK. Per shift, per facility.

Mr. SHAYS. OK. It could have 300 patients with one R.N.?

Mr. VLADECK. I believe so; yes, sir.

Mr. SHAYS. Mr. Souder.

Mr. SOUDER. My initial question is on the chart with the yellow on it, on the mandatory services and mandatory people. Has that 43.5 percent stayed relatively constant? Is this a new set of data? Has that been increasing?

Mr. VLADECK. That is a very good question that I do not know the answer to and will try to get it to you in the next few days. My impression is it has probably been decreasing. But I honestly, that is a guess and I would rather, if you will permit us by early next week, get you some real, a quantitative answer to that.

[The information referred to follows:]

Hearing on Medicaid as an Unfunded Mandate
Before the Subcommittee on Human Resources and Intergovernmental Relations
of the House Committee on Government Reform and Oversight
January 18, 1996

Materials Provided for the Record by
Bruce Vladeck, Administrator, Health Care Financing Administration

Mr. Souder: On the chart showing the mandatory services and mandatory people, has that 43.5 percent (expenditures for mandatory services for mandatory recipients) stayed relatively constant? Has that been increasing?

The attached chart shows Medicaid spending distributions for 1993, 1994, and spending distribution estimates for 1995 mid-session review. The percentage of Medicaid spending incurred by mandatory eligibles for mandatory services has remained relatively stable over this period.

Medicaid Spending Distributions
($ in millions)

DRAFT

1993 Summary Data

Services	Eligibility Categories Mandatory	Optional	Totals
Mandatory	$47,885	$12,052	$59,937
Optional	$23,681	$26,358	$50,039
Totals	$71,566	$38,410	$109,976

Services	Eligibility Categories Mandatory	Optional	Totals
Mandatory	43.5%	11.0%	54.5%
Optional	21.5%	24.0%	45.5%
Totals	65.1%	34.9%	100.0%

1994 Summary Data

Services	Eligibility Categories Mandatory	Optional	Totals
Mandatory	$52,282	$14,812	$67,093
Optional	$27,242	$25,661	$52,903
Totals	$79,523	$40,473	$119,996

Services	Eligibility Categories Mandatory	Optional	Totals
Mandatory	43.6%	12.3%	55.9%
Optional	22.7%	21.4%	44.1%
Totals	66.3%	33.7%	100.0%

1995 Mid-Session Review estimates

Services	Eligibility Categories Mandatory	Optional	Totals
Mandatory	$57,409	$15,262	$72,671
Optional	$29,910	$26,948	$56,858
Totals	$87,318	$42,210	$129,528

Services	Eligibility Categories Mandatory	Optional	Totals
Mandatory	44.3%	11.8%	56.1%
Optional	23.1%	20.8%	43.9%
Totals	67.4%	32.6%	100.0%

Growth Rates	93-94	94-95	93-95 ACRG
Mandatory/Mandatory	9.2%	9.8%	9.5%
All other Optional	9.1%	6.5%	7.8%

Total Expenditures for Mandatory and Optional Medicaid Services and Populations: FY 1993

(Dollars in Millions)

	Mandatory Services	Optional Services	TOTAL
Mandatory People	47,885	23,681	71,566
Optional People	12,052	26,358	38,409
TOTAL	59,936	50,039	109,975

As A Percent of Total

	Mandatory Services	Optional Services	TOTAL
Mandatory People	43.5%	21.5%	65.1%
Optional People	11.0%	24.0%	34.9%
TOTAL	54.5%	45.5%	100.0%

Excludes DSH, collections and adjustments

Mr. SOUDER. I don't want to belabor an individual point. As you know, we have been in touch with you and Indiana has been in touch with you on their concern. I would rather use it as an illustrative question, that in this question of flexibility, we had a number of things that the earlier witnesses had raised, I will ask in more detail.

I know that Mr. Parrella from Connecticut had said that he was concerned about the second round of questions that came and delayed the program by about 4 or 5 months and their ability for funding. In Indiana, the particular question relates to a number of our urban hospitals where a separate hospital fee was assessed and it is still being debated, as of a December meeting, I guess, for 1993 and 1994 reimbursement. Because the question was—is—if it had been general broad-based revenue, it would have been reimbursable, but because it was a hospital tax, it was not.

For example, we have one hospital in Fort Wayne that mostly takes care of the lower-income people. It seems to be rather a narrow definition. If the State had taken that money under their general revenue fund and done it, it would have been eligible. But since they did it a direct way, it was not.

Why would it be that narrow? Is it a financially driven concern at the Federal level? It seems like an awful narrow thing to have not granted a waiver over.

Mr. VLADECK. Mr. Souder, all I can tell you is that the particular development and refinement of a variety of provider tax arrangements, as well as other ways of raising disproportionate share funds for hospitals, are really the cause of that spike in the Medicaid expenditures in the 1988 through 1991 period. As a result of which, the previous administration proposed and had enacted legislation to limit the ability of States to raise Medicaid dollars through those tax arrangements. Frankly, sir——

Mr. SOUDER. I want to reinforce that because I was on Senator Coats' staff at the time, and we were going around with the Bush administration as well.

Mr. VLADECK. It is a very complicated statute. The previous administration, who also issued proposed regulations very late in 1992 to implement that statute—the States felt very strongly that those regulations were too rigid and did not provide the States with enough discretion. When this administration came into office, we undertook to rewrite the regulations in a consultative process with the National Governors Association, representing the States. It is still a very complicated set of rules.

As the instance of Indiana illustrates, we are in the first generation of seeking to apply these very complicated rules to some very complicated situations. We are trying to be as painstaking and as careful as we can not to take money away from providers who deserve it when we can, appropriately. We do have this complicated statute that we are obligated to enforce, and we are just trying to work our way through it.

We would support—it is not, I don't believe, in any of the—well, obviously it is not relevant under a block grant. It is not in the President's bill. We would support some efforts to simplify that, and in fact much of the need for the 1991 statute was supplanted by the further limitations on disproportionate share payments en-

acted as part of OBRA 1993. And none of us yet, frankly, have really looked at the extent to which the OBRA 1993 requirements would permit us to simplify the 1991 requirements, but we would simply be willing to do that.

Mr. SOUDER. It becomes very critical because these hospitals are serving the portion of the population that is getting squeezed in this chart here, basically low-income families and children who partly are being squeezed in Indiana because of what amounted to an unfunded Federal mandate on disability; because the Federal disability law broadened it from what the Indiana disability law was, transferred Indiana funds. They tried to address that to try to be able to cover low-income kids. We have a number of major hospitals in our State that are constantly on the margin as to whether they are going to close. And this funding becomes very critical, because while you are sorting through and saying this is very difficult, we are getting squeezed at both ends of the unfunded mandates changes, the State forced allocation. Then they tried to address that question, and that isn't being waivered, when they thought it was going to be waiverable. That is why we are pushing hard on that.

Mr. VLADECK. I understand that, sir. With all respect, and I am really not as familiar as I probably ought to be about Indiana, but there are a number of States which are financing disproportionate—and I do not believe this is the case in Indiana—but which are financing disproportionate share hospital programs without any State revenues whatsoever, essentially with Federal dollars matching hospital dollars. And to the extent that implementation of the 1991 or 1993 laws creates difficulty for those hospitals, we find ourselves in a very hard place because——

Mr. SOUDER. If they had a hospital fee that went to the general revenue fund and then that money came out of general revenue, would that not be eligible?

Mr. VLADECK. That is correct. But as you are well aware, State governments in the last decade, for a variety of reasons, in order to support these institutions, including many that were traditionally supported by county revenues, tax revenues, for example, found a way to use Federal funds to do it without State or county tax levees going to them. It has created some real problems and we are going to try to work them through as best we can to protect the institutions.

Mr. SOUDER. I understand that. I view a hospital tax as a State and local tax of a different form. I want to revisit, because it is a fundamental—let me ask you an angle off the State question first. You raised a question of what if there was a recession or a downtime and there was not a Federal program to protect. How do you feel about—this has come up in other forms of our block granting program—Senator Lugar from Indiana has expressed it in relationship to school lunches and some of the food stamp programs, because Indiana from time to time has been known to be automobile recession prone—how would you feel about some sort of a fallback kind of rainy day protection, that if you have a trigger that the State then would partially reimburse when it went up in a boom time?

Mr. VLADECK. My real answer is that I do not know enough about that to give you a fully informed answer. My understanding is, which is not a very sophisticated one, that there is such a mechanism in the unemployment insurance system.

Mr. SOUDER. Right.

Mr. VLADECK. And that I was a resident or involved in government in the State of New Jersey at a time where the bankruptcy of that and the requirement of borrowing from the Federal thing created enormous problems for the State. The State now has the opposite political problem of having probably a very large surplus, which is very difficult for officials to keep their hands off of.

I guess my basic answer is, I think there are a variety of ways to protect the States. The bottom line from our perspective is to protect the individuals. It seems to us the best way to protect the individuals is to combine a guarantee to the individual of coverage along with mechanisms that adjust for changing needs of the State.

Mr. SOUDER. This subject can get tense quickly, and I do not want to get into that. But there is a philosophical question that is——

Mr. SHAYS. This is what makes the hearing interesting.

Mr. SOUDER. Not me. I am noncontroversial.

My concern is that in some of the earlier questions, is that while the intent is to be protective of individuals, it really sounds pejorative to the people in the States that they are not. And that this is true in a lot of issues—of only the government, Federal Government can protect the disabled; they are the only ones who can protect the frail and elderly; they are the only ones who can protect minorities.

I am not interested in defending our Governor from Indiana. He is not one of my favorite people. He may run against my former boss. But I think it is a little bit of a slight to imply that he does not have as much concern for senior citizens in Indiana as the Federal Government does, or that he for some reason is going to not meet the needs. You even implied at one point in your testimony that they would cut back if given flexibility to cut back. That is not only saying that they would not cover, but they would actually reduce services if they had the option.

Then you added the additional interesting comment that it was because they have budget needs and priorities. So do we. We are the ones in debt. Indiana has a constitutional amendment to keep them from going in debt so they have to do it that way. We are here trying to figure out how in 7 years from now we can get to an annual balanced budget, let alone have this overriding interest.

Why do you think that their budget needs and priorities are going to take priority over our budget needs and priorities? And second, what makes you think, for example, the nursing homes—my friend Bob Alderman, who is a State legislator, has worked real hard on nursing home protection for seniors in Indiana. Why do you think that the people of Indiana and other States are less caring than people in Washington? That is the implication, even though I do not think it is personal that way, certainly not from Democrat to Democrat in our State.

Mr. VLADECK. I think that is a very good point. I must, again if I may, sort of add a bit of a personal dimension to it, which is that

for another couple of months I guess I still will have spent more of my career as a State government official than as a Federal official. So I am very sympathetic to what you say about folks who work in State government. I guess the answer I would give you is twofold.

In a sense, if what we see as a set of minimum protections that need to be established at the Federal level are things the States would do anyway, then the Federal requirement is not a burden on the State if the State were to do it anyway. It is like, you know, telling my kids that they have to finish the pizza. I mean, they will complain probably that I am being, I am telling them what to do again, but they are going to eat it anyway.

If States are going to cover all these folks and provide all these services and protect the dignity of nursing home residents, then Federal requirements that they do it should not be an additional burden on the States.

The second thing is, frankly and unfortunately—and I recognize that the world changes in a variety of ways—but one of the reasons we expressed some of the concerns we do about what States would do under a block grant situation, or in the absence of some of the requirements of the Federal law, was the historical record. And there is a considerable historical record in many of these areas of including during the history of the Medicaid program, and certainly prior to the history of the Medicaid program—many of them have to do with issues that are still very relevant today.

Let me just give one example in that regard. One of the things we have had very extensive discussions with the Governors about and with Members of Congress of both parties as we have proceeded with these negotiations over the last couple months, and Mr. Shays, an issue that has a very interesting resonance in Connecticut, has to do with the requirement in the Medicaid law that if a benefit is provided to any group within the Medicaid program by a State, the same—the State may limit the availability, may limit the number of hospital days that are provided, may limit the number of physicians' visits, may limit the amount of prescriptions, but it has to have the same rules statewide.

I think Mr. Parrella raised questions about that so-called statewideness requirement for its limitations on the flexibility in the State of Connecticut to operate their program.

The fact of the matter is that among the folks who receive Medicaid coverage around the country are somewhere between half a million and three quarters of a million Native Americans who tend in most States, for very obvious historical reasons, to be concentrated in very limited areas of those States. As recently as this year, we have had comments from people who run Medicaid programs that are forced to cut back, if they were not under statewide obligations, because of the politics of the relationship between the Federal Government and the States and the tribes. They would give the responsibility for providing health services to the tribes back to the Federal Government.

Now, statewideness actually comes in the first instance from the fact that the Medicaid law was first enacted the year after the civil rights was enacted. And those concerns have taken on different forms. The world has changed. In many ways the States are much

more sophisticated, and certainly their professionalism of both their legislators and their administrative agencies is enormously greater than it was 30 years ago in a variety of ways. But I think some of the continuing interest from the point of view of the Federal Government in these issues remains.

One last issue, if I might, and that tends, I think, to get a little bit overlooked in this regard. We are talking—and it is one of the odd things about sitting where I sit relative to these debates—we are talking, as the chairman noted, about a considerable fraction of the Federal budget here. We are talking this fiscal year, now that we have a continuing resolution for these payments for this part of the year, of just under $100 billion Federal. And what is remarkable to me is the extent to which the Congress of the United States is prepared to send out to the States $100 billion a year with only one book's worth of requirements and regulations, because the prudent administration——

Mr. SHAYS. This is the summary. It is a summary.

Mr. VLADECK [continuing]. The prudent administration of Federal funds—we are talking about a lot of money here, and a lot of the limitations on State flexibility are there as limitations of Federal financial liability.

Anyway, that is a third observation relative to your question.

Mr. SOUDER. If I can make this comment, and then I will yield back. I understand a lot of the historical examples that led to the type of attitude that you said, and we still, obviously, in most States have downstate versus upstate, or out-of-Chicago versus Chicago, or you have all kinds of variations like that.

While I understand that in a sense of historic sense, I still do not agree with the basic premise that just because something happened before that it is necessarily going to happen again. I think that the mere nature that the Federal Government was involved has changed the debate in the States on any issue that the Federal Government got involved, whether it is civil rights, education and any other. The bottom line is that when all was said and done, what you said was, is that you felt that the States would have weaker standards and that they would—Governors and people in those States would not protect their most vulnerable. Those are the same people that elected this Congress and this President. When you make a judgment about their willingness to defend, if that is a problem in our society, it is a problem that is going to go through the whole system, because you have in effect said the American people in their States are not interested in protecting as much as we are here in Washington. Even though you gave all the reasons for it, that was your ultimate conclusion, that there is a danger in doing that.

While I understand there is some risk and we have to watch the funds—and it is not revenue sharing, it is block granting—so we have the right, as long as we are raising the revenue, to watch that, to put conditions in. I think, personally, they will exercise their responsibility. I know that is a difference.

Mr. SHAYS. One of the astounding things for me was to come to grips with this subcommittee overseeing HHS; and when it includes Social Security, we realized that the combined budget of HHS and Social Security was larger than the gross domestic prod-

uct of Canada. And here we are trying to regulate it. I think it is humanly impossible for HCFA to take on this task.

I am going to concede a few points. One of the points I am going to concede is that—and I am directly responsible because I am the task force chairman of Medicare and Medicaid on the Committee on the Budget. We earmarked savings numbers and then told the authorizing committees: We would like you to allow the growth to go to this point, not to this point.

The number we got from Medicare, in my judgment, works tremendously well. I happen to believe that no increase in copayment, deduction and so on, amount of money allowing choice and so on, we would disagree with this. But where I concede to you is that if any money were to be added, Medicare and Medicaid, it should be in the Medicaid one. We allow a 7.2 percent growth in Medicare; we do not allow for the same growth in Medicaid.

One of the points that I am going to parenthetically say to you is that in the course of the President staking out his territory of quote unquote protecting Medicare and Medicaid, what I hope these negotiators put more money into the Medicaid than the Medicare, because I do not think we need to put more money into Medicare. Now we may disagree, but I just want to put that on the record.

What I concede to you is that the number that I helped set, we should have put more money into Medicaid, particularly in the outyear.

Having said that, what I am wrestling with are a whole host of problems here. I don't think HCFA can do the job. That is why I decided the first time you appeared in front of us, I could bring out a litany of crazy things. We do not know how much hospitals are paid. We don't know why they are paid it. We make idiotic billing mistakes of $16 ends up being $16,000. I mean, and on and on; we bill men for giving birth. I mean, and on and on and on.

Now, I don't blame you; I made that decision early on, that what a setup. I think you know HCFA is the brunt of a lot of criticism. My basic contention is that you can't do the job, that it is humanly impossible to regulate from the Federal level such, as you pointed out, such a gigantic amount.

Now, where I can make a concession to you is that I do think there has to be basic requirements. Now, the next issue, though, is: Can we block grant it into basic requirements? I think we can. Or do we still have a quote unquote, a capped entitlement or an entitlement? I do not think we have to go the entitlement route and I think we shouldn't. So there is kind of where we—we had disagreements on numbers and then we have ultimately a disagreement on the program.

Can you describe to me some of the incentives that I have seen come out of the Federal Government in Medicare and Medicaid, incentives, savings of programs money? Where do I see that incentive?

Mr. VLADECK. Well, on Medicaid let me just say, Mr. Chairman, that we try to operate the program in a way that the States do the invading because the States run the program; we oversee it. And we oversee the allocation of money.

Let me give you one particular example, however, in the case of Medicaid, and I am sorry Mr. Waxman is not here for this discussion because this was largely the result of his doing.

Mr. SHAYS. Right.

Mr. VLADECK. The fact of the matter is——

Mr. SHAYS. For the record, I know he is probably in agony right now. Nothing is worse than you think, my God he is down there and I am not there.

I say this sincerely; it would add to—having his presence would be very helpful. So it is unfortunate he is not here.

Mr. VLADECK. The fact of the matter is since he wrote legislation in 1982, I believe to take the first steps in the expansion of home and community-based services for the elderly in Medicaid, about 80 percent in the growth of the number of people receiving long-term care in the Medicaid program has been in home and community-based services.

We talk all the time about how the system is still too dependent on nursing homes and not using enough home and community-based services. We would agree with that. But, in fact, since 1982, the overwhelming proportion of the growth, spurred to a considerable extent by Federal policy and Federal policy changes in that regard, the issue there is even more dramatic for the seriously retarded and developmentally disabled where since 1982 we have gone from a situation in which most of them were institutionalized into a situation in which most of them are in community residences or in the community.

The States, of course, have done that. Many, I might add, under State court order. But in fact it was changes in the Medicaid program that permitted them to do that, that provided them with the financial incentives to do that, that in some way shaped and directed that the institutionalization of that——

Mr. SHAYS. I would give that as an example that I believe in home care, but I believe that that is the area where we are having the biggest abuse—I mean, gigantic abuses; and I can relay a—story after story in my own district of senior citizen homes where you have home health care providers who are coming into the homes basically as companions. I have nursing homes where they will describe that a nursing care physician will come into the nursing home and provide care, see people for 10 minutes and see, you know, 10 people in a very short period of time, collecting sizable dollars.

The big weakness, in my judgment, with our plan is that we didn't take on the home health care industry because they have become a powerful political block. So, I mean, where you would call it invasion, I would say a gigantic danger zone out there, and the States do not have an ability to get a handle on it.

Mr. VLADECK. If I can just say a few words about Medicare. I frankly—and try to keep this as collegial a hearing as possible. There are issues of—periods in which Medicare was substantially more innovative than other periods in its history. But the fact is on the back office functions for running a health insurance company Medicare is so far ahead in terms of automation and the use of automated technologies of any other health insurer, public or private, in the world that the only ones who are even close are our

contractors who have been able to piggyback on our electronic data transmission systems and our electronic remittance systems and so forth.

Mr. SHAYS. Could we pursue that just a little bit? Because I have a hard time. We are examining what we are doing with our automated system. Why can't you tell me what a hospital gets?

Mr. VLADECK. I can tell you what it gets in the Medicare program. I absolutely can.

Mr. SHAYS. How many weeks later?

Mr. VLADECK. I can tell you generally the next day, if you want last year's information. If you want current year's information, I can only tell you what they have accrued. I can't tell you what they will eventually be paid.

Mr. SHAYS. No, you can't tell me what they are eventually going to be paid. But bottom line is, when we have had our hearing, and we will have a hearing on this, with all due respect, the system is broken down. We have nine different units, nine different areas. These areas all use different coding. They do not use the same coding. So when we bill from one district to another, from one area to another, they don't mean the same thing.

We could get into a big story about this one. It is interesting that the two issues you are bringing up, home care, I am thinking danger zone. You are bringing up the automated system, and I think the system is basically breaking down. We are having a postponement of when the new system gets on line. It is not keeping up to schedule. I do not think that is anything to be too excited about.

Mr. VLADECK. I don't know what that last issue is referring to, sir. I would say that none of the invasions that have ever occurred in the Medicare or Medicaid program have been perfect. But the fact of the matter is that invasions everywhere are rarely perfect. We could cite lots of State level or private sector invasions that in the aggregate have done good things that there are problems with. I think at this point it becomes just sort of a silly kind of debate.

Mr. SHAYS. Well, it is not silly. The one thing that is true is you can't be blamed for the system not working. That is the one thing true. You are in charge; but you are in charge, in my judgment, of a system almost impossible to operate. We spend so much. We have such large billings. We have a disjointed system of keeping track. We do not use the same codes. That is fact. That is not——

Mr. VLADECK. I don't know what you are referring to.

Mr. SHAYS. You don't know the fact that when we bill from area to area that we use different codes?

Mr. VLADECK. We use the same codes, sir.

Mr. SHAYS. The computer system——

Mr. VLADECK. The computer system uses nine different sets of software, that is correct, but the billing codes are the same.

Mr. SHAYS. Why the different sets of software?

Mr. VLADECK. Because we have not replaced—we have not put a unified system in place yet.

Mr. SHAYS. Well, that is kind of where I am headed. This isn't the gist of the hearing, but it is just to give you a sense of where my mind is.

The other area where I have this question mark, one of the challenges that we think we have with the system is, as you rightfully

point out, even my State, when it spends 50 cents, it gets $1. Some States, when they spend 20 cents, they get $1. And there is a danger that States have in not fully grasping that some of this money that is getting wasted, because it is not their dollar, isn't worth focusing in on.

So one of the interests that we have is to have the State feel the impact when it does make a savings. In other words, when it makes a savings, it doesn't save 50 cents on the dollar. When it makes a savings, it saves 100 percent. When it finds waste, fraud and abuse, it makes it 100 percent.

So that is another part of this logic of saying, you know, three different people are responsible. Let us have one party responsible for the savings and the management and let that party realize the full benefit from it.

It is the problem of, since it is a Federal dollar, who cares. Now we want to make it a State dollar, and we want them to care a lot more, and we think they will. What is wrong with that logic?

Mr. VLADECK. Well, there is the notion of two people instead of one. It seems to me the entire constitutional theory of the United States is one of checks and balances. That is what we have in the existing Medicaid system, and that is what you largely remove in a block grant, whether it is a block grant for Medicaid or a block grant for community development or a block grant for anything else.

It is true that a system of checks and balances, just as that between the executive and the legislative branch, produces a degree of cumbersomeness and time-consuming and paperwork that our colleagues in parliamentary systems or colleagues in unitary countries do not have to deal with. But, sure, if there are 100 percent Federal dollars, if they become 100 percent State dollars, it is true that the States may be more careful with them.

It's also true that they may choose, as States tried in the early 1990's, to spend Federal Medicaid dollars on highways and State university construction rather than health services for poor people.

And I think, from the point of view of a Federal official, it's very important to me that every one of those dollars—and, of course, I don't personally oversee every dollar, sir, but I do believe that the size of the system is not our major administrative problem. The fact is, if the States get $97 billion, Federal taxpayer dollars, to provide health services for low-income people, I think we as Federal officials, whether in the executive or legislative branch, have the responsibility to see that those dollars are spent on health services and low-income people.

Mr. SHAYS. Before we go to Mr. Souder, let me just ask you this: putting aside the block grant issue, with our Medicare, Medicaid health care anti-fraud bill, we are making health care fraud a Federal offense. You don't have to get someone basically for wire or mail fraud. You can get them for medical fraud. Does the administration agree with that thrust in our legislation?

Mr. VLADECK. I believe we have, sir. Yes.

Mr. SHAYS. Thank you.

Mr. Souder.

Mr. SOUDER. I am not a big is beautiful fan.

Mr. SHAYS. You are not a what?

Mr. SOUDER. I am not a big is beautiful fan. I believe the country is moving toward decentralization. I understand that you need some standards and checks and balances, but I had a very particular question.

In the 27 percent of the recipients who are in the aged, blind and disabled category that get 69 percent of the money, I also thought I heard you say that the money for the elderly hasn't changed much.

Mr. VLADECK. As a share, sir, as a proportion.

Mr. SOUDER. So that, presumably, the—that growth has been in the disabled area?

Mr. VLADECK. Yes, sir.

Mr. SOUDER. And you said that was partly because they were getting the money from other sources?

Mr. VLADECK. Yes.

Mr. SOUDER. What would some of the other sources be?

Mr. VLADECK. Well, just for example and you made reference—and I think this is an issue where the States have a real beef about mandates and where in the context of other legislation the administration has tried to work with the Congress—there was a very substantial expansion de facto in the definition of disability in the 1980's in the areas of mental illness and substance abuse as the primary or corollary causes of disability.

What that has meant, in many States, is that many chronically mentally ill people or chronic substance abusers or both, because there are many who are both, who are traditionally treated entirely in State-run and State-financed services and institutions, although there used to be more Federal funding until it was block granted and cut for those services, are now covered by Medicaid. They are eligible for Medicaid, and those mental health and substance abuse services are now being paid for under Medicaid programs.

And that's probably—the single biggest piece of that—I mean, Medicaid is so big and so complex there's a lot of pieces, but of that growth in the outlays for the disabled, for the nonelderly disabled, that's probably the biggest single piece in the 1980's.

Mr. SOUDER. You are saying some of the squeeze on low income children and seniors is because of drug abusers?

Mr. VLADECK. I'm saying it's because of the—well, I would say it differently. I would say it's because the Federalization of the expense for treatment of the chronically mentally ill and drug abusers in what had previously been fully State or State and county funded service programs.

The other piece of that, just to finish up, in some States, my own, New York, it's been a big issue. In other States, it's been a much smaller issue, has been that's where most—the plurality—not the majority but the plurality—of all services in the United States for people with AIDS and HIV infection is in that box. And, of course, that's an 1980's phenomenon in terms of the growth of those numbers.

Mr. SOUDER. I think there are a number of issues like that, and probably many of these would range in the optional areas you earlier raised—dental services. My wife is an occupational therapist. I think there are a lot of things that may indeed be meritorious, but that's where the flexibility at the States and a lot of that bur-

den should fall and that there may be other ways—as we move through a lot of these things in the future, we can work out some relationships where I think the Federal Government has moved way too far and even if everything isn't block granted there may be some kind of rainy day fund to protect the highest risk in the health areas. But there's a lot of ranges. I think it's a matter of some decision at the States and how they want to deal with alcohol and drug abuse, too. I don't think that should necessarily be a national mandate.

Mr. VLADECK. Well, again, I think we—if you start from the presumption of the basic, you know, that upper left hand corner, sir, is one way of describing it. There are a lot of ways to give the States greater flexibility, both in administration of that part of the program and in the way they run the rest of the program.

Mr. SHAYS. Mr. Vladeck, I just have two general questions. I know you need to get on your way, and we are going to get you on your way a little earlier than your bottom line final requirement was.

Mr. VLADECK. I appreciate that.

Mr. SHAYS. Thank you.

You had mentioned to me, talking about Connecticut as an example of a repeals requirement, that all communities in a State receive comparable benefits, that whole issue.

Let me just introduce the other side of the story. The Federal Government on high's decision that the State has to offer the same level of service everywhere prevents a State, particularly a State like Illinois, a larger State—it basically says that it can't offer an innovative program, let's say in the Chicago area, because it's not provided in southern Illinois, because it's not a comparable service. And, to me, this is kind of the illustration of why I would like the Federal Government out of it. Because if people live in Chicago and you can provide a better service because it's available, why should we do it? Why should we basically downgrade the benefit to Chicago because it's not available, say, in southern Illinois?

Mr. VLADECK. The State is not required to make it available, sir. If there's one super-duper children's specialist in the State of Illinois and he practices at Children's Hospital in Chicago, the State is—and he's the only one that does that operation——

Mr. SHAYS. I'm not talking about the super-duper.

Mr. VLADECK. Well, let's—but I think if you look at the practical issues, if we are talking about tailoring home and community-based services to the particular needs of communities and some communities—in rural communities, you can run a decent, long-term care program without providing people with transportation. In the city of Chicago, you may be able to rely on public transportation. That flexibility is permitted.

But what's not permitted under current law is to say that in down-State Illinois we are going to provide Medicaid beneficiaries with dental care and we are not going to provide it to the Medicaid beneficiaries in the State of Chicago—in the city of Chicago—and we think there's a good historical basis for that requirement.

Mr. SHAYS. I know there has been a historical basis, but the—thank God, we don't do everything on a historical basis.

But what I'm thinking of is in terms of the whole concept of introducing managed care, and the ability of a community to provide managed care in one area that they may not be able to provide in it some other parts of the State.

Mr. VLADECK. We do not require that States that do managed care in one community do it all everywhere.

Mr. SHAYS. No, no. But there you give waivers.

Mr. VLADECK. We have proposed in our legislation that it does not require waivers.

Mr. SHAYS. And one of the obscene things, as far as I am concerned, is that a State even has to go to the Federal Government on bended knee to ask to do—to be able to do managed care. I mean, managed care is a pretty basic kind of program.

Mr. VLADECK. It doesn't have to come to the Federal Government to ask to do managed care if it limits enrollment to voluntary enrollment on past beneficiaries. If it wants to require beneficiaries to enroll in managed care, then under current law it requires a waiver from the Federal Government, and we have proposed eliminating that and permitting mandatory managed care without such a waiver.

Mr. SHAYS. OK. You know what? In some ways, I think you have the same challenge on Medicaid that we have now with our budget. We don't have a budget and so we are having to decide what government programs we keep running, and we are having to work night and day to say, we want this one to run but maybe not this one.

And that's kind of an archaic system, but it's the best we've got on the table right now. And you all are having to decide what are all these things in this book that we can drop soon enough before some of us, you know, point out another problem with it. It would be a lot simpler, I think, to scrap the thing and to just be logical about, yes, managed care, for instance, do it, and not have to ask permission.

I understand the distinction you make, requiring or not requiring. I happen to believe that the Federal—if the American people are paying the bill, they should have some requirement. No welfare recipient is forced to join a health care system that is provided totally and completely by the taxpayer.

I think the taxpayers have a right to say: You know what? If you want free health care, you are going to do it in a program that we think is good, cost-effective and saves money at the time. And there we would have another disagreement.

Mr. VLADECK. No, I would agree with you, sir.

Mr. SHAYS. OK. So you would agree that the State should be allowed to?

Mr. VLADECK. Yes, sir. That's part of the President's proposal.

Mr. SHAYS. OK. But I thought you said the Federal law was we have to——

Mr. VLADECK. The existing law.

Mr. SHAYS. I thank you very much for being here.

Mr. VLADECK. Thank you, sir.

Mr. SHAYS. I welcome our next witnesses. You have been a wonderful——

Mr. VLADECK. I will try to get you that additional information as soon as I can.

Mr. SOUDER. Thank you.

Mr. SHAYS. Again, Mr. Vladeck, thank you for trying to arrange the schedules of others.

We are all set. I just want to make sure—I have had the opportunity to have read Mr. Waxman's statement. It was very interesting—and Mr. Town's. And, without objection, all records will be—their statements will be in the record; and obviously any—the full statements of our witnesses, without objection, will be as well.

[The prepared statements of Hon. Henry A. Waxman and Hon. Edolphus Towns follow:]

Remarks of Honorable Henry A. Waxman
Subcommittee on Human Resources and Intergovernmental Relations
Hearing on "Unfunded Mandates" in Medicaid
January 18, 1996

The title of today's hearing -- "Unfunded Mandates in Medicaid" -- reminds of Alice's encounter with Humpty Dumpty in Through the Looking Glass. Alice is trying to figure out what Humpty is talking about, and Humpty informs her that, "When I use a word, it means just what I choose it to mean."

The simple truth is that there are no "unfunded mandates" in Medicaid. Anyone who asserts that there are either misunderstands the program or has taken up Humpty Dumpty's world view.

According to Webster's New World Dictionary, a "mandate" is "an authoritative order or command." "Unfunded" means "not funded."

There is not a single "authoritative order or command" that is "not funded" in Title XIX of the Social Security Act, which establishes the Medicaid program.

First, Medicaid is a voluntary program. No State is required to participate. No hospital, physician, nursing home, or other provider is required to participate. No citizen is required to participate.

Title XIX does not -- does not -- "order or command" the States to provide basic health and long-term care coverage to their low-income citizens. Every single State has the constitutional and statutory right to drop out of the Medicaid program today.

So much for the so-called "mandate." Now let's turn to the "unfunded."

The Congressional Budget Office projects that the Federal government will send $97.2 billion in Federal Medicaid matching funds to the States. That's about 57 percent of the total amount that is projected to be spent on basic health and long-term care services under Medicaid by all the States and the Federal government combined.

In other words, the Federal government is paying more than half the costs of the program. The dictionary might characterize this as "predominantly funded." However, it is a clear misuse of the English language to call this arrangement "unfunded."

So Medicaid is neither a "mandate" nor is it "unfunded."

Which brings us to the world according to Humpty Dumpty, where words mean what we choose them to mean. We now have, as part of the Republican Contract on America, a law which solves this inconvenient English language problem by arbitrarily

defining certain changes in Medicaid as "Federal intergovernmental mandates."

Obviously, there is a political agenda at work here -- an agenda to repeal Medicaid and its guarantee of basic health coverage for 36 million Americans, and to replace it with what is, for all intents and purposes, Federal revenue-sharing to the States.

Medicaid is the program under which, for the past 30 years, the Federal government has shared with the States in the cost of hospital, physician, nursing home, and other basic health and long-term care services for vulnerable Americans.

States are not -- repeat not -- "mandated" to provide any of these services by either the Constitution or Title XIX of the Social Security Act.

However, if the States want the Federal government to share with them in the cost of these basic health and long-term care services, they must meet certain terms and conditions.

For example, if States want Federal Medicaid matching funds, they must spend some of their own money providing coverage for medically necessary hospital, physician, nursing home, and other specified services to certain populations, such as pregnant women with incomes below 133 percent of the poverty line.

If States offer the required coverage to the specified populations, States may also receive Federal matching funds for spending on other services, such as prescription drugs, and other populations, such as elderly individuals with high, recurring medical expenses.

Despite all the rhetoric about "unfunded mandates," the fact is that majority of Federal Medicaid dollars are spent on services and populations that States are not required to cover in order to participate in the program.

More precisely, in 1993, only 38 percent of all Medicaid funds were spent on required services for required populations that States must cover in order to receive any Federal Medicaid matching funds at all. Most of the rest -- 50 percent -- were spent on populations or services for which the States may receive Federal matching funds if they choose to but are not required to cover as a condition of receipt of Federal Medicaid funding. The remaining 13 percent were spent on payments to disproportionate share hospitals, some of which were redirected by some States to help finance other State activities.

Again, this means that well over half of the $97 billion that the Federal government will send to the States in Medicaid matching payments this year are for populations or services that the States are not required to cover as a condition of receiving Federal Medicaid funds.

I seriously doubt Mr. Webster would characterize this as either a "mandate" or "unfunded."

Yet here we are today, about to hear from witnesses attacking the program -- and Administration efforts to reform it in the context of deficit reduction -- as an "unfunded mandate."

It is particularly ironic that some of these same witnesses who view the President's plan as an "unfunded mandate" will be supporting the vetoed Republican plan to repeal the Medicaid program and to slash Federal matching payments to the States by 17 percent, or $163 billion, below what CBO estimates will be the cost of maintaining current coverage over the next 7 years. In the year 2002, the reduction in Federal payments will be over 28 percent below the cost of maintaining current coverage.

Apparently, proponents of the Republican Medicaid repeal don't mind taking huge amounts of Federal money from the States so long as they also remove any duties that the States might have to undertake in order to receive the Federal funds -- duties such as guaranteeing basic health coverage to low-income children, paying providers reasonable amounts for the care they deliver, and contributing some of their own funds toward the cost of the program.

Of course, the States, faced with this massive reduction in Federal funds, will have no practical choice but to cut back on eligibility, on benefits, and on payments to providers. That's why the Republican Medicaid repeal gives States the authority to do what needs to be done to ration care.

To get a sense of what lies ahead under the Republican approach, take a look at the survey that Virginia's Medicaid agency has already sent out asking its residents to rank who among them should have priority in coverage.

Here are the choices: all children; persons with disabilities; elderly; homeless; Medicare recipients; nursing home residents; pregnant women; prisoners; public assistance recipients; unemployed; working poor; young children; SSI recipients; and "other."

Why are Virginia and other States going to have to choose among these populations under the Republican repeal? A study released just last month by the Kaiser Commission on the Future of Medicaid gives us some idea.

The study, which was prepared for the Commission by the Urban Institute, finds that, under the vetoed Republican plan, not only will Federal Medicaid spending drop by $163 billion over the next 7 years, but State spending could fall by an <u>additional</u> $240 billion.

As a result, total Federal and State spending on health and long-term care services for vulnerable Americans could fall by over $400 billion over the next 7 years under the vetoed Republican plan. That translates to a cut of 25 percent over the next 7 years, and 35 percent in the year 2002 alone.

Now that is how to "unfund" a program.

Obviously, what this "unfunding," Republican-style, will mean in most States is cutbacks in eligibility, benefits, and payments to providers -- cutbacks that will increase in severity year after year after year.

In contrast, the President's per capita cap proposal responds to the pleas of those who want more cost discipline in Medicaid without terminating the guarantee of basic health and long-term care to 36 million Americans. Under the President's approach, States would have both the incentives and the tools to manage Medicaid more efficiently, and the Federal government would maintain its commitment to sharing in the costs of providing basic health and long-term care coverage to vulnerable Americans. This continuing Federal commitment is particularly critical when States face cost increases for reasons beyond their control, including recessions, regional economic downturns, natural disasters, and outbreaks of contagious disease.

The policy differences between the President's approach and the Republican Medicaid repeal could not be more fundamental. They are the difference between guaranteed basic coverage and rationing of basic care to 36 million Americans.

Mr. Chairman, I look forward to the testimony of our witnesses this morning. This hearing should be extremely useful in helping both the press and the public understand that the Medicaid program is neither a "mandate" nor "unfunded, " and that the differences between the Republican and Democratic approaches to Medicaid are profound.

EDOLPHUS "ED" TOWNS
MEMBER OF CONGRESS
10TH DISTRICT, NEW YORK

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COMMERCE, CONSUMER PROTECTION, AND COMPETITIVENESS

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"UNFUNDED MANDATES AND THE MEDICAID PROGRAM"

Opening Statement by the Honorable Ed Towns

HEARING BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

AND INTERGOVERNMENTAL RELATIONS

January 18, 1996

TODAY'S HEARING RAISES IMPORTANT ISSUES ABOUT WHETHER THE PROPOSED REFORMS IN THE MEDICAID PROGRAM WILL ENABLE AMERICA'S NEEDIEST CITIZEN, THE LOW-INCOME ELDERLY AND POOR CHILDREN TO RECEIVE THE SAME QUALITY OF CARE THAT THEY CURRENTLY RECEIVE.

THE MEDICAID PROGRAM IS A MEDICAL ASSISTANCE PROGRAM JOINTLY FINANCED BY STATES AND THE FEDERAL GOVERNMENT FOR ELIGIBLE LOW-INCOME INDIVIDUALS. MEDICAID COVERS HEALTH CARE EXPENSES FOR

RECIPIENTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) AND MOST STATES COVER THE NEEDY ELDERLY, BLIND, AND DISABLED RECEIVING CASH ASSISTANCE UNDER THE SUPPLEMENTAL SECURITY INCOME PROGRAM (SSI).

TOTAL OUTLAYS FOR MEDICAID IN FY 95 WERE ABOUT $156 BILLION. FEDERAL OUTLAYS WERE $89 BILLION; STATE OUTLAYS WERE AT $67 BILLION. CHILDREN AND ADULTS IN FAMILIES WITH DEPENDENTS MAKE UP OVER 70 PERCENT OF THE MEDICAID POPULATION BUT ACCOUNT

FOR ONLY 30 PERCENT OF THE SPENDING. THE AGED, BLIND, AND DISABLED, ABOUT 30 PERCENT OF MEDICAID RECIPIENTS, ACCOUNT FOR 68 PERCENT OF SPENDING. ABOUT HALF OF THAT 68 PERCENT IS FOR LONG TERM CARE.

PROPOSED REFORMS OFFER VERY LIMITED GUARANTEES THAT THESE CURRENT RECIPIENTS WILL CONTINUE TO RECEIVE HEALTH COVERAGE UNDER THE MEDICAID PROGRAM. FOR EXAMPLE, THE PROPOSED REFORMS PASSED BY THE CONGRESS WOULD REPEAL ANY NATIONAL STANDARDS OF CARE AND REQUIRE

THAT THE STATE ENSURE COVERAGE FOR ONLY THREE POPULATION GROUPS: FAMILIES WITH INCOME UNDER 185% OF POVERTY THAT INCLUDE A CHILD UNDER 19 OR A PREGNANT WOMEN; LOW INCOME ELDERLY PERSONS OVER 65, AND LOW INCOME DISABLED PERSONS.

THE REFORMS INCLUDED IN THE BUDGET RESOLUTION ALSO REDUCE DIFFERENCES IN PAYMENTS TO STATES OVER A SEVEN YEAR PERIOD. STATES WITH HIGHER THAN AVERAGE MEDICAID EXPENDITURES LIKE MY HOME STATE OF NEW YORK WILL BE INDEXED AT A LOWER

GROWTH RATE. THIS PLAN, THUS, PLACES A STATE LIKE NEW YORK AT THE SAME GROWTH RATE AS ALASKA, WYOMING AND THE DISTRICT OF COLUMBIA.

WHILE SOME WOULD ARGUE THAT MEDICAID IS BEING RESTRUCTURED, IN THE BUDGET RECONCILIATION PROPOSAL, THE FACT IS THAT $133 BILLION IS ELIMINATED FROM THE MEDICAID PROGRAM. RESTRUCTURING ADVOCATES ARGUE THAT THE ELIMINATION OF "UNFUNDED MANDATES" WILL GIVE STATES THE DESIRED FLEXIBILITY TO ABSORB THIS $133

BILLION CUT THROUGH INCREASED EFFICIENCY AND MANAGED CARE APPROACHES. EVEN STATES LIKE ARIZONA AND TENNESSEE, WHERE THE ENTIRE MEDICAID POPULATION HAS BEEN PLACED IN MANAGED CARE PROGRAMS, WILL LOSE 10 TO 16 PERCENT OF THEIR FEDERAL MEDICAID DOLLARS UNDER THE BUDGET RECONCILIATION PLAN. THIS DECREASE IN AVAILABLE FUNDS WILL FREE STATES TO EITHER REDUCE THE QUALITY OF CARE PROVIDED OR DECREASE THE NUMBER OF PEOPLE SERVED BY MEDICAID. EITHER WAY,

HEALTH CARE FOR THE POOR OF THIS NATION WILL BE REDUCED.

THAT IS WHY THE ADMINISTRATION'S PROPOSAL FOR A PER CAPITA CAP THAT RESULTS IN ONLY A $54 BILLION REDUCTION IS A FAR MORE REASONABLE AND COMPASSIONATE APPROACH. STATES WOULD BE GIVEN INCREASED FLEXIBILITY IN DETERMINING WHAT BENEFITS TO COVER AS WELL AS THE ABILITY TO DEVELOP MANAGED CARE PLANS THAT MEET THE NEEDS OF INDIVIDUAL STATES. MOST IMPORTANTLY FOR STATES LIKE NEW YORK,

THE PRESIDENT'S PLAN WOULD PROVIDE FOR A GRADUAL REDUCTION AND RE-TARGETING OF THE $16.9 BILLION IN DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS THAT SERVE THE POOR AND DISADVANTAGED.

UNFORTUNATELY, AS THIS HEARING COMMENCES, BUDGET NEGOTIATIONS BETWEEN THE CONGRESSIONAL LEADERSHIP AND THE ADMINISTRATION HAVE BROKEN OFF. THE FUTURE OF HEALTH CARE FOR AMERICA'S POOR IS NOW LEFT TO THE NEXT ACT IN THE POLITICAL DRAMA THAT IS NOW UNFOLDING ON

OUR NATIONAL STAGE. I CAN ONLY HOPE THAT IN THE FINAL ANALYSIS, WE WILL HAVE A MEDICAID PROGRAM WHICH ENSURES SOME VIABILITY FOR HOSPITALS THAT SERVE THE POOR AND UNINSURED AS WELL AS GUARANTEEING A MINIMAL LEVEL OF CARE FOR OUR NEEDIEST CITIZENS.

Mr. SHAYS. Our third panel is comprised of one individual, William Scanlon, who is the Associate Director of Health Finance Issues, General Accounting Office, the GAO office.

Let me—if you would stay standing and swear you in.

Mr. SCANLON. We have here Richard Jensen as well, who is a Medicaid specialist.

Mr. SHAYS. Richard, wonderful to have you here.

If both of you would stay standing and raise your right hand.

[Witnesses sworn.]

STATMENT OF WILLIAM J. SCANLON, ASSOCIATE DIRECTOR OF HEALTH FINANCING ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY RICHARD JENSEN, MEDICAID SPECIALIST

Mr. SCANLON. Mr. Chairman——

Mr. SHAYS. Thank you. Thank you for your testimony.

Mr. SCANLON. Mr. Chairman, we are very pleased to be here today as the subcommittee considers the issue of mandates in the Medicaid program, and we are happy to report on work that we have done on Medicaid programs in various States over recent months.

Between 1984 and 1993, the Congress enacted a series of provisions that mandated coverage, primarily for low income pregnant women, children and Medicare beneficiaries, and allowed States to cover other groups at their discretion. These provisions have been detailed in an appendix to my written statement.

During the decade, Medicaid enrollment increased more than 50 percent as 11 million persons were added to the rolls. At the same time, the Federal coverage mandates and State optional coverage decisions led to considerably greater uniformity across States in the proportion of low income individuals covered by Medicaid. These mandates, however, also contributed to sharp increases in Medicaid spending. In the last decade, Medicaid spending more than tripled and grew faster than most major items in the Federal budget, including Medicare.

Enrollment mandates, however, were not the sole contributor to the rise in Medicaid spending. Depending upon the time period you examined, other factors such as medical price inflation, utilization growth and increases in eligibles due to a national recession contributed significantly as well.

From 1988 through 1991, higher enrollment, inflation and increased use of services each accounted for about a third of the expenditure growth. In 1991 and 1992, however, it was States' use of Disproportionate Share Hospital [DSH] payments—those supplemental payments to hospitals that serve a large number of Medicaid and other low income patients—that were the important cost driver. In 2 years, DSH payments grew from just under $1 billion to over $17 billion and represented about $1 out of every $7 Medicaid spent on medical services.

Today, in response to these rising costs, many States have or are seeking flexibility to control Medicaid spending through greater use of managed care. Their program restructuring efforts mirror private health payers' growing reliance on managed care plans to pro-

vide care at a hopefully lower cost by controlling the price and use of services.

Medicaid, however, still lags well behind the private sector in the use of managed care.

The Medicaid statute, adopted at a time when fee-for-service medicine was predominate, limits States' ability to use managed care. States can enroll their Medicaid beneficiaries, as was discussed, in managed care only by seeking waivers of program rules; and to make the most extensive use of managed care, a State must seek a section 1115 waiver to operate their program as a demonstration or experiment.

Section 1115 waivers provide States the ability to contract with a broader range of managed care organizations, including those that enroll few or no private patients. Usually, to serve Medicaid beneficiaries, 25 percent of a managed care organizations's enrollment must be private, paying patients, as the plan's ability to attract private patients has been seen as one assurance of quality.

Similarly, section 1115 waivers also permit States to require beneficiaries to remain enrolled in managed care for up to a year rather than 30 days, which is usually required by Medicaid. The freedom of beneficiaries to disenroll at will has also been seen as an indirect assurance of quality of care.

While HCFA has agreed to waive some of the traditional quality assurance provisions, the terms and conditions of section 1115 waivers require States to operate alternative quality assurance systems. Beneficiary protections are essential in our view because of the financial incentives to underserve in managed care plans that are paid and are themselves paying providers on a per capita rather than a per service basis.

Almost half the States are currently engaged in or planning a transformation of their programs and we believe an important lesson has emerged from our observations of these State experiences. That is, while broader use of managed care holds the promise of better cost containment and access for Medicaid beneficiaries, it also presents considerable planning and implementation challenges.

In my written statement, we provide information on the experiences of three States that we have examined: Arizona, Tennessee and Oregon. Let me focus briefly on Arizona.

Today, Arizona's program includes the development and use of competitive market forces to select health care providers and determine capitation rates. Its effective use of competitive bidding has resulted in considerable savings to both the State and Federal Governments. In addition, it has developed the data collection and analysis capabilities needed to monitor plans provision of services and financial performance.

These accomplishments, however, did not occur overnight. Arizona encountered early implementation difficulties, but has been expanding and refining its program management efforts since it began its managed care program in 1982. The maturity of Arizona's program today, especially its oversight mechanisms, reflects the substantial preparation and development efforts that the State invested over many years.

In conclusion, I would note that, consistent with the interests of the Congress in containing Federal spending, States believe they need greater flexibility to manage their respective Medicaid programs, flexibility available today only by seeking Federal permission with a waiver. If States are granted more direct control to aggressively pursue managed care strategies, the importance of adequate implementation, planning and continuous oversight of managed care systems to protect both Medicaid beneficiaries from inappropriate denial of services and Federal dollars from payment abuses must not be overlooked.

Mr. Chairman, I would be happy to answer any questions that the subcommittee members may have.

Mr. SHAYS. Thank you, Mr. Scanlon.

[The prepared statement of Mr. Scanlon follows:]

United States General Accounting Office

GAO

Testimony

Before the Human Resources and Intergovernmental Relations Subcommittee, Committee on Government Reform and Oversight, House of Representatives

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MEDICAID

Spending Pressures Spur States Toward Program Restructuring

Statement of William J. Scanlon, Director
Health Systems Issues
Health, Education, and Human Services Division

GAO/T-HEHS-96-75

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to testify on how states have addressed rising Medicaid costs brought on by federal mandates and other factors. Since 1984, the Congress has mandated eligibility expansion to certain low-income groups and allowed coverage of others at state option.[1] From the time these mandates began to take effect, Medicaid costs have more than tripled and the number of beneficiaries increased by over 50 percent, to 39 million. Medicaid's current costs exceed $141 billion, and its growth outpaces that of most major items in the federal budget, including Medicare. Without modification, spending is likely to double in the next 5 to 7 years.

In response to these escalating costs, many states are in the process of restructuring their Medicaid programs by seeking section 1115 waivers from the Health Care Financing Administration (HCFA), which oversees the Medicaid program. Named for section 1115(a) of the Social Security Act, these waivers free states from certain Medicaid restrictions on the use of managed care delivery systems. They also allow states to expand Medicaid-financed coverage to individuals not normally eligible for Medicaid.

My statement today will focus on (1) federal mandates and other factors that have led to Medicaid cost growth, (2) states' use of section 1115 waivers for managed care programs to address rising Medicaid costs, and (3) lessons for adequate program planning and oversight from states' experiences implementing managed care programs. My comments are based on recent GAO work on these issues. (See app. II for a list of related GAO products.)

In brief, several factors, including federal mandates that expand eligibility, medical price inflation, and creative financing schemes, have contributed to rising Medicaid costs. To contain these costs, 22 states have recently sought waivers from federal regulations that inhibit their ability to operate extensive managed care programs. Some of these states have mandated the enrollment of their acute care populations--primarily for low-income women and children--into managed care programs and have expanded coverage to previously ineligible individuals. Arizona, which runs a Medicaid managed care program under a federal waiver obtained over a decade ago, has lowered Medicaid spending by millions of dollars. It also leads the states in its development of information systems for collecting medical encounter data essential for assessing quality of care.

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[1]See app. I for details of these major federal expansions of Medicaid eligibility and services.

MANDATES, OTHER FACTORS
INCREASE MEDICAID COSTS

Financed jointly by the federal government and the states, Medicaid provides access to health care for two statutorily defined groups of low-income residents--families, primarily women and children; and the aged, blind, and disabled. In reality, Medicaid is not 1, but rather 56 separate programs that differ dramatically across states.[2] Federal statute mandates who is eligible for coverage and the broad categories of services that must be provided. Each state designs and administers its own program by (1) setting certain income and asset eligibility requirements,[3] (2) selecting which optional groups and services to cover, and (3) determining the scope of mandatory and optional services.

Several factors, including federal mandates, have contributed to Medicaid's recent cost explosion. Between 1984 and 1993, the Congress mandated coverage primarily for low-income pregnant women, children, and Medicare beneficiaries and allowed coverage of others at state option. Since these expansions began to be implemented, enrollment has grown by more than 50 percent, to 39 million beneficiaries. At the same time, the mandates and state decisions to cover optional groups led to greater uniformity across states in the proportion of low-income individuals covered by Medicaid.

Enrollment growth resulting from mandates does not, however, fully explain the rise in Medicaid spending. Such factors as medical price inflation, higher provider reimbursements, utilization growth, and an increase in the number of eligibles due to a national recession also played a role. From 1988 through 1991, enrollment, inflation, and increased use of services each accounted for about one-third of the expenditure growth. The most important cost driver in 1991 and 1992, however, was "creative" financing techniques that states adopted to increase supplemental payments to hospitals serving a large number of Medicaid and other low-income patients, thereby partially offsetting costs not covered by Medicaid, state charity care programs, or private insurance. In 2 years, these disproportionate share hospital (DSH) payments grew from just under $1 billion to over $17 billion and represented about $1 out of every $7 Medicaid spent on medical services.

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[2]All 50 states plus the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands have Medicaid programs.

[3]Federal guidelines tie most eligibility categories to the Aid to Families With Dependent Children (AFDC) and the Supplemental Security Income (SSI) programs.

SOME STATES ADDRESS RISING MEDICAID COSTS THROUGH GREATER USE OF MANAGED CARE

States' efforts to obtain the flexibility to implement managed care reflects the growth of managed care in the private sector. Managed care plans have the potential to provide care at lower cost by controlling the price and use of services. In 1993, about 60 percent of individuals with health benefits sponsored by large employers were enrolled in some type of managed care plan--up dramatically from a decade ago. As of June 1994 (the most current date for which data were readily available), 23 percent of Medicaid beneficiaries--primarily women and children--were enrolled in some form of managed care.

Managed care is not new to states' Medicaid programs. Under a section 1915 (b) waiver, available since 1981, states have been able to restrict beneficiaries' freedom to choose any health care provider, a key provision of the traditional Medicaid program. More than 40 states currently enroll some portion of their Medicaid population in managed care. A number of provisions in the Medicaid statute, however, cannot be waived under section 1915(b) and inhibit the implementation of broader managed care programs, particularly those involving plans that are paid with a fixed, or capitated, fee. Consequently, a number of states are turning to demonstration projects permitted by section 1115 waivers.

Section 1115 waivers address states' needs in two ways: they allow states greater flexibility to test cost-containment strategies, such as the more extensive use of capitated managed care, and they allow states to expand program eligibility beyond traditional Medicaid populations. Since 1993, HCFA has approved for implementation 12 statewide demonstration waivers: Oregon, Hawaii, Kentucky, Tennessee, Rhode Island, Florida, Ohio, Massachusetts, Minnesota, Delaware, Vermont, and Oklahoma.[4] Of the 12 approved, 5 states have statewide demonstrations currently operating: Tennessee, Hawaii, Oregon, Rhode Island, and Minnesota. Another 10 states have applications pending with HCFA. In all but a few of the approved and pending waiver applications, states have proposed expanding coverage to previously ineligible groups, such as single adults and childless couples.

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[4]In 1982, Arizona was granted an 1115 waiver to initiate a statewide managed care program. Previously, the state had not participated in Medicaid.

Section 1115 waivers allow states to contract with managed care organizations[5] that enroll few or no private patients. In other words, the "75-25 rule" has been waived. This rule stipulates that, to serve Medicaid beneficiaries, 25 percent of a health plan's total enrollment must consist of private-paying patients. The principle behind this restriction is that a health plan's ability to attract private enrollees can serve as one assurance of quality.

The waivers also permit states to require beneficiaries to remain enrolled in their health plans for longer periods of time than Medicaid typically requires. Allowing beneficiaries to choose to disenroll at will, as normally permitted by Medicaid, makes managed care organizations' planning for financial stability difficult and therefore the enrollment of Medicaid beneficiaries less attractive.

While HCFA has agreed to waive some of the traditional requirements aimed at ensuring managed care quality, the terms and conditions of section 1115 waivers require states to operate quality assurance systems and to collect medical encounter data. Beneficiary protections are essential because of the financial incentive to underserve in managed care plans that are paid, and are themselves paying providers, on a per capita rather than per service basis.

STATES' EXPERIENCE WITH SECTION 1115 MANAGED CARE PROGRAMS SUGGESTS LESSONS FOR PLANNING AND OVERSIGHT

The experiences of at least three states--Arizona, Tennessee, and Oregon--in implementing their section 1115 demonstration programs show the challenges that states are likely to encounter in changing from the traditional Medicaid fee-for-service program. Under Medicaid's traditional delivery system, program administrators primarily determine beneficiary eligibility and act as third-party payers. Under a managed care system, however, considerable advance planning is important as administrators learn to develop market forces and carefully monitor the care provided.

Arizona's experience in implementing a managed care program is instructive. Today, Arizona's program includes the development and use of competitive market forces to select health care providers and determine capitation rates. Its effective use of competitive bidding has resulted in millions of dollars of savings to the state

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[5]Managed care here refers to prepaid plans, some of which operate as health maintenance organizations with "gatekeepers" (providers designated to coordinate the care for individual enrollees) and some as preferred provider organizations, which do not use gatekeepers.

and the federal government. Arizona's bidding process also reduced the state's capitated payments to health plans at a time when other states' per capita costs continued to grow. In addition, the state has invested in data collection and analysis capabilities to monitor cost, profitability, and patient encounter data from each health plan.

But these implementation measures have taken time. Arizona has been expanding and refining its approach since 1982 and, as noted in earlier GAO reports, initially experienced a number of difficulties. In particular, early attempts to contract out the program's administration and data information systems failed. Subsequently, the state assumed the responsibility for administering the program and increased its direct oversight. The maturity of Arizona's Medicaid program today--especially with its oversight mechanisms--reflects the substantial preparation and development efforts that the state invested over many years.

In contrast, Tennessee's Medicaid program has encountered a number of difficulties. In an ambitious attempt to expand its Medicaid program to include a large share of its uninsured, the state shifted its entire program from fee-for-service to managed care on January 1, 1994. The difficulties resulted in part from the state's rapid implementation of the shift. Tennessee began operating its statewide managed care program fewer than 9 months after announcing the plan, despite virtually no experience with managed care in its former Medicaid program and a limited private managed care market compared to the rest of the country. As of the program's "opening day," plans for contracting with provider networks were incomplete, and many of the state's physicians had not yet determined which networks, if any, they might join. Some beneficiaries were initially required to choose a plan without knowing which ones would include their physicians. Systems to process bills were not fully developed, and some providers reported slow or no payments for services during the first months of the waiver. The availability of encounter data, which allow officials to monitor access and quality, is not complete after almost 2 years since program implementation.

Oregon began planning its current section 1115 waiver program, also implemented in 1994, several years previously. It has expanded coverage to over 100,000 new eligibles and is one of the first states to integrate its disabled and elderly populations into managed care. Early planning included holding community meetings and consulting with physicians and hospitals in order to build support from those providers who were likely to participate in the managed care program. The state also developed an array of financial and quality safeguards, including limits on providers' financial risk and client satisfaction and disenrollment surveys. The state is in the process of refining an information system that will effectively collect and analyze medical encounter data important for assessing quality of care provided.

CONCLUDING OBSERVATIONS

About 39 million low-income women, children, elderly, blind, and disabled Americans depend on health care made possible by the Medicaid program. However, the program's rapid spending growth imperils efforts to bring the federal deficit under control. Consistent with the interest of the Congress in containing federal spending, states believe they need the flexibility to manage their respective programs. Such flexibility is available today only by seeking federal permission through a section 1115 waiver. If states are granted more direct control to aggressively pursue managed care strategies, the importance of continuous oversight of managed care systems to protect both Medicaid beneficiaries from inappropriate denial of care and federal dollars from payment abuses should not be overlooked. Finally, the experiences of states with Medicaid managed care programs underscores the importance of adequate planning and appropriate quality assurance systems for a Medicaid program's effective transition to managed care.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Subcommittee members may have.

For more information on this testimony, please call Kathy Allen, Assistant Director, on (202) 512-7059. Other major contributors included Richard Jensen and Hannah Fein.

MAJOR FEDERAL EXPANSIONS OF MEDICAID ELIGIBILITY AND SERVICES (1984-93)

Table I.1: Federal Medicaid Expansion to AFDC Recipients and Related Population

Population affected	Expansion	Mandate/option
DEFRA (Deficit Reduction Act of 1984) (P.L. 98-369)		
Infants[a] and children	Requires coverage of all children born after 9/30/83 who meet state AFDC income and resource standards, regardless of family structure.	Mandate
Pregnant women	Requires coverage from date of medical verification of pregnancy, providing the mother would (1) qualify for AFDC once child was born or (2) qualify for AFDC-UP[b] once child was born, regardless of whether state has AFDC-UP program.	Mandate
Infants	Requires automatic coverage for 1 year after birth if mother already is receiving Medicaid and remains eligible and infant resides with her.	Mandate
AFDC families	Requires limited extension of Medicaid coverage if AFDC eligibility is lost as a result of increased earnings.	Mandate[c]
AFDC families	Extends earned income disregard[d] from 4 to 12 months.	Mandate
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) (P.L. 99-272)		
Pregnant women	Requires coverage if family income and resources are below state AFDC levels, regardless of family structure.	Mandate
Postpartum women	Requires 60-day extension of coverage postpartum if eligibility was pregnancy-related.	Mandate
Pregnant women	Allows provision of enhanced benefits.	Option
Infants and children	Allows extension of DEFRA coverage up to age 5 immediately, instead of requiring phase-in by birth date.	Option

(continued)

Population affected	Expansion	Mandate/option
Adoptive and foster children	Requires coverage even if adoption/foster agreement was entered into in another state.	Mandate
OBRA 1986 (Omnibus Budget Reconciliation Act of 1986) (P.L. 99-509)		
Pregnant women and infants	Creates new optional categorically needy group for those with incomes below poverty line. Women receive pregnancy-related services only.	Option
Pregnant women and infants	Allows assets test to be dropped for this newly defined category of applicants.	Option
Pregnant women	Allows presumptive eligibility for up to 45 days to be determined by qualified provider.	Option
Pregnant women	Allows guarantee of continuous eligibility through postpartum period.	Option
Children	Allows coverage up to age 5 if family income is below poverty line (phased in).	Option
Infants and children	Requires continuation of eligibility (for those who otherwise would become ineligible) if individuals are hospital inpatients when age limit is reached.	Mandate
OBRA 1987 (Omnibus Budget Reconciliation Act of 1987) (P.L. 100-203)		
Pregnant women and infants	Allows coverage if family income is below 185% of poverty line.	Option
Children	Allows immediate extension of OBRA 1986 coverage for children up to age 5 in families with incomes up to the poverty line.	Option
Children	Clarifies that states may provide in-home services for qualified disabled children.	Option
Children	Allows coverage for children aged 5-7 up to state AFDC level (phased in by age).	Option

(continued)

Population affected	Expansion	Mandate/option
Children	Allows coverage for children below age 9 in families with incomes up to the poverty line (phased in by age).	Option
MCCA (Medicare Catastrophic Coverage Act of 1988) (P.L. 100-360)		
Pregnant women and infants	Makes mandatory the OBRA 1986 option of coverage up to the poverty line (phased in by % of poverty line).	Mandate
Family Support Act of 1988 (P.L. 100-485)		
AFDC families	Increases required period of Medicaid coverage if AFDC cash assistance is lost as a result of increased earnings.	Mandate[e]
AFDC families with unemployed parent (AFDC-UP)	Requires coverage if otherwise qualified.	Mandate
OBRA 1989 (Omnibus Budget Reconciliation Act of 1989) (P.L. 101-239)		
Pregnant women and infants	Requires coverage if family income is below 133% of poverty line.	Mandate
Children	Requires coverage up to age 6 if family income is below 133% of poverty line.	Mandate
Children	Requires provision of all Medicaid-allowed treatment to correct problems identified during early and periodic screening, diagnostic, and treatment (EPSDT), even if treatment is not covered otherwise under state's Medicaid plan.	Mandate
Children	Requires interperiodic[f] screenings under EPSDT when medical problem is suspected.	Was an option, now mandated
OBRA 1990 (Omnibus Budget Reconciliation Act of 1990) (P.L. 101-508)		
Children	Requires coverage up to age 18 if family income is below the poverty line (phased in by age).	Mandate
Pregnant women	Makes mandatory the OBRA 1986 option of continuous eligibility through postpartum period.	Mandate

(continued)

Population affected	Expansion	Mandate/option
Pregnant women	Extends period of presumptive eligibility before written application must be submitted.	Mandate
Pregnant women and children	Requires states to receive and process applications at convenient outreach sites.	Mandate
Infants	Requires continuous eligibility if (1) born to Medicaid-eligible mother who would remain eligible if pregnant and (2) remaining in mother's household.	Mandate
OBRA 1993 (Omnibus Budget Reconciliation Act of 1993) (P.L. 103-66)		
Mothers and newborns	Expands scope of required nurse-midwife services to include services outside the maternity cycle that midwives are authorized to perform under state law.	Mandate
Children	Requires state Medicaid programs to establish a program to distribute pediatric vaccines furnished by the federal government.	Mandate

[a]Infants are children up to age 1.

[b]AFDC-UP allows coverage in two-parent families if principal wage-earner is unemployed.

[c]Mandate is for 9 months. State may opt to provide additional 6-month period of coverage.

[d]Certain expenses associated with work are disregarded from income in calculating AFDC eligibility.

[e]Mandate is for 12 months. State may opt to provide additional 6-month period of coverage.

[f]States establish a screening schedule: "Interperiodic" visits are added to the standard schedule if a problem is suspected.

Table I.2: Federal Medicaid Expansion to the Population Receiving SSI

Population affected	Expansion	Mandate/option
DEFRA (Deficit Reduction Act of 1984) (P.L. 98-369)		
SSI recipients	Increases qualifying asset limits for applicants for limited time period (1984-89).	Mandate
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) (P.L. 99-272)		
Children with special needs	Requires coverage regardless of income/resources of adoptive/foster parents.	Mandate
OBRA 1986 (Omnibus Budget Reconciliation Act of 1986) (P.L. 99-509)		
Aged and disabled	Creates new optional categorically needy group for those with incomes below the poverty line under certain resource constraints. Option can be exercised for this group only if exercised also for pregnant women and infants.	Option
Aged and disabled	Allows Medicare buy-in[a] up to the poverty line for qualified Medicare beneficiaries under certain resource constraints.	Option
Severely impaired individuals	Establishes new mandatory categorically needy coverage group for qualified individuals under age 65.	Mandate
Ventilator-dependent individuals	Allows coverage of at-home respiratory care services.	Option
SSI recipients	Makes permanent the previous temporary provision requiring coverage of some former disabled SSI recipients who have returned to work.	Mandate
Employment Opportunities for Disabled Americans Act of 1986 (P.L. 99-643)		
Disabled individuals	Makes permanent a previous demonstration program for individuals able to engage in substantial gainful activity despite severe medical impairments.	Mandate

(continued)

Population affected	Expansion	Mandate/option
OBRA 1987 (Omnibus Budget Reconciliation Act of 1987) (P.L. 100-203)		
Elderly	Allows provision of home and community-based services to those who otherwise would need nursing home care.[b]	Option
Nursing home applicants	Requires states to establish preadmission screening programs for mentally ill and retarded individuals.	Mandate
Nursing home residents	Requires preadmission screening and annual resident review for mentally ill or retarded individuals.	Mandate
MCCA (Medicare Catastrophic Coverage Act of 1988) (P.L. 100-360)		
Elderly and disabled individuals	Makes mandatory for qualified Medicare beneficiaries the OBRA 1986 option of Medicare buy-in for individuals with incomes up to the poverty line (phased in by % of poverty line).	Mandate
OBRA 1990 (Omnibus Budget Reconciliation Act of 1990) (P.L. 101-508)		
Elderly and disabled individuals	Extends the MCCA qualified Medicare beneficiary provision to individuals with incomes up to 120% of poverty line (phased in by % of poverty line).	Mandate
Elderly and disabled individuals	Allows limited program permitting states to provide home and community-based services to functionally disabled individuals, and community-supported living arrangements to mentally retarded/ developmentally disabled individuals.	Option
OBRA 1993 (Omnibus Budget Reconciliation Act of 1993) (P.L. 103-66)		
SSI recipients	Allows states to offer Medicaid coverage to TB-infected individuals who meet the state's income and resource tests.	Option

[a]Medicaid covers Medicare cost-sharing charges: premiums, deductibles, and coinsurance.

[b]This is not automatic. HCFA must grant a waiver to any state wishing to provide these services.

Table I.3: Federal Medicaid Expansion to Other Populations and Service Additions

Population affected	Expansion	Mandate/option
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) (P.L. 99-272)		
Terminally ill individuals	Allows provision of hospice services.	Option
OBRA 1986 (Omnibus Budget Reconciliation Act of 1986) (P.L. 99-509)		
Aliens	Requires provision of emergency services if otherwise eligible (financially and categorically).	Mandate
IRCA (Immigration Reform and Control Act of 1986) (P.L. 99-603)		
Newly legalized aliens	Requires provision of emergency and pregnancy-related services if otherwise eligible. Also requires full coverage for eligible individuals under 18.	Mandate
Anti-Drug Abuse Act of 1986 (P.L. 99-570)		
Homeless	Requires state to provide proof of eligibility for individuals otherwise eligible but having no permanent address.	Mandate
OBRA 1993 (Omnibus Budget Reconciliation Act of 1993) (P.L. 103-66)		
Medicaid beneficiaries	Makes coverage of personal care services outside the home an optional rather than a mandatory service.	Option
Aliens	Clarifies that Medicaid-covered emergency services for aliens do not include care and services related to organ transplant procedures.	Mandate

Mr. SHAYS. Mr. Scanlon, first, thank you for your good work and the good work of your agency. And, second, let me just ask you about the process, the waiver process. What is the basic length of time that's required to get a waiver?

Mr. SCANLON. The length of time has varied considerably. As Mr. Vladeck indicated, the Clinton administration when it came into office indicated some flexibility in the process of approving waivers.

Mr. SHAYS. Right.

Mr. SCANLON. And, in fact, the State of Tennessee submitted a waiver in 1993, and received very rapid approval and began their program approximately 2 months after they received their approval.

From our observations of Tennessee, that rapid implementation ended up being relatively shortsighted and resulted in problems stemming from confusion over exactly how the managed care system was going to operate in the State. This experience seemed to lead to a more careful and a more deliberate consideration of waiver applications on the part of the administration. Our understanding now is that it's taking closer to a year before a waiver is approved.

Mr. SHAYS. The purpose—the reason why States need a waiver is that the Federal Government has various requirements that they no longer want to come under?

Mr. SCANLON. That's correct. There are very important requirements. First, a State cannot mandate that persons enroll in managed care organizations without a waiver. Without a waiver, a State can only make managed care organizations available as a State option and allow people to voluntarily enroll.

The second major requirement that States feel impedes their use of managed care is that you cannot—cannot contract with a managed care organization that has fewer than 25 percent private patients.

Mr. SHAYS. Right. And that last one creates what problems?

Mr. SCANLON. It creates a number of problems. For States that have very limited managed care in the private sector, it means that they are handicapped in that there may be no organizations to contract with where Medicaid won't immediately become the dominant purchaser of services and that Medicaid enrollees will not represent more than 75 percent of the enrollment.

It also means that you are potentially at a disadvantage in terms of dealing with organizations that are not serving the areas of States that are—where Medicaid beneficiaries frequently live, such as inner cities. You could have managed care organizations in a large urban area that are really oriented toward the major businesses of that area and have their services located more in the suburban fringe without enough services in the inner city. If a managed care organization is to organize and attempt to serve the inner city, it may end up with more than 75 Medicaid patients and would, under the existing rules, be prohibited from participating in the program.

Mr. SHAYS. How long have you been in the position? How long have you done research on Medicare or Medicaid? How long have you been involved in that area?

Mr. SCANLON. I have been involved since 1975 in health services research, primarily on Medicaid and somewhat on Medicare.

Mr. SHAYS. What are some of the challenges that we have in the billing system of Medicaid?

Mr. SCANLON. Well——

Mr. SHAYS. I am just talking in terms of being able to catch the waste, the fraud, the abuse and so on. Where do the challenges lie?

Mr. SCANLON. Our challenges have changed considerably over time, in part because of the fact that we have—had a great improvement in the data processing capacity that's available to States. In dealing with a fee-for-service world where claims for services come in from all different types of providers, one has to be concerned about the ability to gather those claims together, match them for an individual and see whether or not the pattern of service use is appropriate. That kind of challenge is now much more feasible to deal with with modern data processing capacity. We at GAO have not looked recently at how much the States have been able to adopt such modern data processing capacity to be able to do that kind of an activity.

When one talks about managed care, you face a different set of challenges with respect to fraud and abuse because the State is no longer the direct payer of each individual service. The State is the payer of a per capita fee to each managed care organization, leaving the managed care organization responsible for delivering the appropriate package of services.

While you are concerned about whether or not they allow providers to bill for abusive or unnecessary services, you are also concerned that the managed care organization makes sure that the package of services being delivered is adequate. We have regarded it as critical that the States put themselves in a position of being able to get sufficient information about the services managed care organizations deliver. This can occur by having the managed care organization report encounter data to the State and that the State having the capacity to analyze them. This has been one of the biggest challenges that States have faced in moving toward more managed care.

As I indicated, Arizona has been reasonably successful in getting such information from their managed care organizations, using it effectively to monitor care, as well as using it in their competitive bidding process.

The other two States which have more recently moved very significantly into managed care, Oregon and Tennessee, have been less successful to date in trying to work with encounter data. Both of those States have 2 years of experience and have yet to have their systems operational and effective to the point of being able to monitor the kinds of care that are being delivered.

Mr. SHAYS. Have you done much work in Medicare?

Mr. SCANLON. I have done a moderate amount.

Mr. SHAYS. OK. What are the differences—what are the challenges in trying to get at the waste and the fraud and the abuse in Medicare versus Medicaid? Is there—are there parallels or are they very different?

Mr. SCANLON. I think there are some parallels. When one is operating in a fee-for-service environment, there's the issue of claims

coming in from multiple providers, and the need to identify an important type of—or the most prevalent types of abuse involving excessive numbers of services or duplicative services.

Medicaid programs typically have had one bill payer for their programs, so all the bills for a Medicaid program are flowing to one contractor who can then process them and presumably put together the profiles to identify abusive practices.

With Medicare, we have had divided responsibility in terms of the payment of bills. We have intermediaries dealing with institutional services, the part A services, and we have carriers dealing with the part B services.

And so you have claims flow to two different types of entities. Sometimes actually, in an area, there will be more than one intermediary involved with different providers. So you have information flowing to different parts of the country to be processed, and the collection of claims information and the profiling to be able to identify abuses is a challenging task.

The Medicare Transaction System is a planned attempt to deal with that issue. The fact that we are moving in that direction is positive. The fact that we are not there is disappointing.

Mr. SHAYS. What concerns would you have with block grants? If you were looking at it as an agency, what becomes your concern if this becomes a block granted program to the States?

Mr. SCANLON. Well, we believe very strongly that for managed care and more vigorous cost control efforts to succeed, we have to be successful in assuring that an adequate level of care is being provided to the population in need.

And from our observation of State experiences, we suggest that it's not necessarily a question of will in terms of how difficult a challenge this is and in terms of how States encountering difficulties in assuring that there is an adequate level of care being provided. It's just a difficult challenge. We, as an agency, would hope is that there be enough assistance and enough attention devoted to the question of how it—how do we overcome the implementation problems that States are going to face and how we continue to monitor to ensure that adequate care is being provided so that we don't have the negative feedback that would occur if care turned out to be inadequate. Then, there could be a backlash against the kind of efficiency gains that we have been trying to achieve.

Mr. SHAYS. So you know you have the efficiency gains. The concern would be whether the needs of the individual would be met. Your comment, though, is well taken. If they weren't, there would be a backlash.

Mr. SCANLON. Correct. We would like there to be efficiency gains as just opposed to pure cost savings. Because cost savings can come from either efficiency gains, which means you are saving money producing an acceptable product, or cost savings can come because we have reduced the amount of services. In effect, you have abused the per capita payment. We have siphoned off too much of the payment into profit and payments for excessive provider incomes.

Mr. SHAYS. That causes me to just followup one last question. I hope I don't think of another one.

Last question: Is it your sense that there is a lot of efficiency gains to be made?

Mr. SCANLON. Given that Medicaid is still predominately a fee-for-service system, I think that there are considerable efficiency gains to be made. We are seeing in the private sector as well as in the States that are moving to managed care with their Medicaid programs, that there is an ability to negotiate additional discounts with providers and that there is an ability to affect the utilization of services.

We don't know how far we can go, and we have to worry about how far it goes in terms of whether we affect the quality of care that's being provided. But it would seem that, given the incentives the fee-for-service system was to overprovide, as we change those incentives, we have the opportunity to gain some efficiencies through more appropriate provision of services.

Mr. SHAYS. And I am going to capture this thought as if it's my own after a few days. Your concept of efficiency gains versus——

Mr. SCANLON. Simple cost savings.

Mr. SHAYS. OK. Cost savings you would define as not necessarily providing the same level of service, thereby saving money. That really helps define the debate. If the administration thinks there are going to be cost savings and that's what ultimately results, then they may be right. If we find that by having the States do it we see significant efficiency gains by doing it, then we would tend to be right. And, obviously, that's where the debate is, a nice way to focus the debate for me. So I thank you.

Mr. Souder.

Mr. SOUDER. I just have a couple of brief questions, and I am sorry if I go over a point that you covered while I was out.

In the computer question, which we have talked about in the Medicare before, too, as well as today, and the Medicaid, is the inability to contract that out due more because of input data plan wide? Is this not something that would overlap with some of what private sector people may do already?

Mr. SCANLON. It's a challenge on both sides, both for the State as well as the managed care organizations. Historically, health maintenance organizations have not had to submit claims for services because they were being paid a capitated fee, and were not being paid on an individual service basis. So there were often no claims records generated for each individual service.

The kind of encounter data or service data that is needed to monitor managed care organizations is the equivalent of getting data on individual services or individual claims. The managed care organizations themselves have to have the capacity to be able to submit such claims, and I think some may currently lack such capacity.

Another issue for the managed care organizations is that they have to submit all that information in a common format so that States can work with it. Having worked with claims data myself in the past, I know that when you are getting data from multiple sources, even though they are purportedly in similar formats, it's often a challenge to get them to be truly compatible and to integrate them for analysis.

With regard to the States, they are in a different position now in terms of what they need to do with those data once they receive them. In the past, they simply had to pay claims, calculate some aggregate statistics so they were able to report to HCFA and be

able to monitor their program in an aggregate way. Now they need to know more about the care that's being delivered. They need to look at the individual and be able to ask questions about the adequacy of care.

How to do that is a challenge that not only the States are facing, but the private sector is, as well. There's promising work going on in this area, both in the academic community and in the provider community, in terms of identifying what could be used as markers of good care. For example, there's a group of markers called ambulatory care, sensitive conditions. For someone that has diabetes, if their diabetes is being well managed they shouldn't necessarily be hospitalized. And so if you see hospitalizations among your diabetic patients, then you know that they may not be getting adequate ambulatory care.

These kind of markers, are in their infancy; and we need to work to develop them so that we have relatively comprehensive measures of the adequacy of care. So it's both an issue of a transition to this new system and trying to deal with the problems of the transition, as well as it's an issue of development of a new science to be able to monitor care.

Mr. SOUDER. One other question. You submitted a list of the major expansions of Medicaid eligibility over this period 1984 to 1993, and when you read the list there's—I mean, no person in government or anybody in politics or any really sensitive individual would ever want to vote against any of these. They all sound really—I mean, somebody who is pregnant—something pregnancy related requires coverage if a family income and resources are below State levels, regardless of family structure, and a lot of things that sound really important. But when you accumulate them together that's how you bankrupt the government.

What my concern was at the beginning here, and maybe you gave this figure, is you said that you thought that 50 percent of the recipients were because of the additions in 1984 to 1993? Is that roughly true?

Mr. SCANLON. There was about a 50 percent increase in the number of recipients during the decade in which all of those were enacted.

Mr. SOUDER. So that could be for several reasons.

Mr. SCANLON. Some of the increase is not due just to those mandates or the optional provisions that are at State discretion. There is also the issue of population growth in that period as well as by the end of that decade we were in the midst of a national recession, and we know that recessions increase unemployment and add considerably to the Medicaid rolls. I have not seen an analysis that tries to separate the effect of the mandates from the recession and from population growth.

Mr. SOUDER. Because some of the mandates may, however, have added costs to those who are already on the rolls, too, is that right?

Mr. SCANLON. That's correct.

Mr. SOUDER. So, in reality, it could be either more or less than 50 depending on the impact of recession versus what they added to people who were already on the rolls?

Mr. SCANLON. Correct. The mandates, we believe, had their biggest impact in terms of the number of recipients. However, the

mandates for the most part added persons to the rolls who were less expensive to serve because they were adding primarily women and children and Medicare eligibles who were being covered only for their Medicare cost sharing.

Mr. SOUDER. So the dollars wouldn't be——

Mr. SCANLON. The dollars would not be the 50 percent number, right.

Mr. SOUDER. Thank you.

Mr. SCANLON. Thank you.

Mr. SHAYS. Mr. Scanlon, thank you very much.

Did you have any point or observation you would like to make?

Mr. JENSEN. No.

Mr. SHAYS. You think your boss did a good job?

Mr. JENSEN. Great job.

Mr. SHAYS. I think he probably did a better job knowing you were by his side.

Mr. SCANLON. Right. A little calmer, I think.

Mr. SHAYS. I appreciate your good work. I appreciate your observations. It was good to have your testimony and thank you very much.

Mr. SCANLON. Thank you.

Mr. SHAYS. We are going to close with panel four: William Beach, visiting fellow, the Heritage Foundation; Philip Dearborn, director of government finance research, Advisory Commission on Intergovernmental Relations; and Judith Feder, professor, Institute for Health Care Research, Georgetown University.

I am sorry. I should have caught you before you sat down. If you would all rise and raise your right hand.

[Witnesses sworn.]

For the record, I would note that all three witnesses have responded in the affirmative.

You are our last panel, but you are equal to the others, and we appreciate it. The nice thing is, I think a good number of you have been here for awhile and you might want to make observations on points that were made before, which is always helpful as well.

STATMENTS OF WILLIAM BEACH, VISITING FELLOW, THE HERITAGE FOUNDATION; PHILIP DEARBORN, DIRECTOR OF GOVERNMENT FINANCE RESEARCH, ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS; AND JUDITH FEDER, INSTITUTE OF HEALTH CARE RESEARCH, GEORGETOWN UNIVERSITY

Mr. SHAYS. So, Mr. Beach, I am being told by staff I have to start with you.

Mr. BEACH. I am accustomed because of the spelling of my last name to being at the top of the list.

Mr. SHAYS. Well, in that sense, Mr. Dearborn, why don't we go with you?

Mr. BEACH. That's fine.

Mr. SHAYS. I want a little variety for you. I don't want you to always have to go first.

Mr. DEARBORN. Mr. Chairman, members of the committee, my name is Philip Dearborn. I am director of government finance re-

search at the Advisory Commission on Intergovernmental Relations.

My testimony today is based on "The Role of Federal Mandates in Intergovernmental Relations," a report required under the Unfunded Mandates Reform Act of 1995. In this report, ACIR reviewed 14 Federal mandates to provide a basis for recommended changes in Federal policies to improve intergovernmental relations. Final recommendations will be submitted to the President and Congress in March of this year. The Medicaid Boren amendment is 1 of the 14 mandates identified by our survey of State and local governments that is reviewed in the preliminary report.

The mandate itself, Boren amendment, requires States to establish reimbursement rates to pay hospitals, nursing facilities and intermediate care facilities for services provided to persons eligible for assistance through the Medicaid program. The mandated Federal criteria provide that State-determined reimbursement rates must be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards.

Now, as the chairman pointed out, the intent of the Boren amendment was to give States a means of controlling cost related to reimbursement claims from providers of Medicaid services. Rather than merely being reimbursement on a cost-related payment requirement for hospitals and nursing home services, the amendment allowed States to pay for services based on predetermined reimbursement rates, giving States a basis for denying reimbursement for costs determined to be in excess of that necessary to provide efficiently and economically delivered services.

However, despite the good intention, the law is seen by many States as more of a burden than a benefit. One problem is the vague, undefined terms used to describe the federally mandated criteria for reimbursement rates, and these include terms such as "reasonable," "adequate," "efficiently" and "economically." And because the intent was to provide flexibility, the Federal Government made a conscious decision not to issue regulations defining the vague terms in the statutory language.

An additional complication is that, while the law requires reimbursement rates to be determined in accordance with methods and standards developed by the State, it also requires the Federal Government to be satisfied with the State-determined rates. To implement this requirement, the Federal Government decided to require State processes for determining rates and the rates themselves be a part of the State Medicaid plans. These plans are then subject to approval by the Secretary of Health and Human Services.

Well, what has happened is the vagueness of the statutory language, combined with the lack of regulatory definitions, has resulted in substantial litigation, with some courts viewing the Boren amendment as a cost-based payment standard in which all costs incurred by the providers must be reimbursed. In these instances, States may be liable for significant sums to cover the retroactive rate increases ordered by the Court for the group of providers involved in the suit. In some cases, these additional payments made

as a result of court-ordered retroactive rate increases are not eligible even for Federal matching payments.

Much of the Boren amendment litigation, however, does not relate to the vagueness of the statutory language but, rather, it relates to a State's procedure for determining these reimbursement rates. In such cases, if the procedure is ruled by a court to be flawed due to lack of adequate public notice or other factors, a State may be liable for substantial retroactive reimbursement rates based on revised determination procedures and, again, the Federal Government may or may not share in the cost of the retroactive payments.

Now, we understand that the Department of Health and Human Services, in response to this problem, has tightened its process for reviewing the State rate determination procedures so that the potential acceptance by the courts will be, they hope, better than it has been in many instances in the past.

The State concerns, of course, are that they feel the Boren amendment handcuffs their ability to constrain the growth in Medicaid spending during times of fiscal crisis, requiring that Medicaid reimbursement rates be established within the limits of federally mandated criteria, restricts the scope of States' negotiations with providers of medical and nursing home services, and this potential litigation often causes a State to increase rates merely to avoid the legal action that might be forthcoming. States are concerned about the extensive and expensive work necessary to substantiate compliance with the law and protect against suits by nursing home or hospital providers.

This situation is especially true since the 1990 Supreme Court ruling in Wilder against Virginia Hospital Association. In that suit, the Supreme Court declared that medical care providers, instead of the Medicaid recipients, are the intended beneficiaries of the Boren amendment. This ruling allows medical facilities and nursing homes to obtain judicial review of State reimbursement rates under the Civil Rights Act, Section 1983. In effect, the Court ruling allows hospitals and nursing homes to claim that a State is violating the hospital's civil rights by failing to pay costs incurred to provide services.

The preliminary recommendation of the ACIR is that because States are traditionally responsible for the quality and safety of medical services and Medicaid is a State-administered program, States should be allowed to conduct reimbursement rate negotiations with Medicaid service providers without preconditions set by Federal law. Therefore, the ACIR preliminary recommendation is to repeal the language of the Boren amendment and insert language making States solely responsible for determining Medicaid reimbursement rates.

In concluding, I want to emphasize that my testimony, including the conclusions and recommendations regarding the Boren amendment, are based on the ACIR preliminary report and are subject to change based on final decisions of the Commission after receipt and review of public comments. The Commission will hold a conference for discussion of its preliminary report on March 6th and 7th and will receive public comments over the next 2 months before issuing its final report.

Thank you, Mr. Chairman.

Mr. SHAYS. I thank you.

[The prepared statement of Mr. Dearborn follows:]

ADVISORY COMMISSION
ON INTERGOVERNMENTAL RELATIONS

Testimony by
PHILIP M. DEARBORN
Director of Government Finance Research
U.S. Advisory Commission on Intergovernmental Relations

Hearing of the U.S. House of Representatives
Committee on Government Reform and Oversight
Subcommittee on Human Resources and Intergovernmental Relations

THE BOREN AMENDMENT TO THE MEDICAID PROGRAM

Thursday, January 18, 1996
Washington, DC

Mr. Chairman and members of the Committee, my name is Philip M. Dearborn. I am Director of Government Finance Research for the Advisory Commission on Intergovernmental Relations (ACIR). My testimony today is based on the Preliminary ACIR Report on Federal Mandates required under the *Unfunded Mandates Reform Act of 1995* (P.L. 104-4). In this report, ACIR reviewed 14 federal mandates to provide a basis for recommended changes in federal policies to improve intergovernmental relations. Final recommendations will be submitted to the President and Congress in March 1996. The Medicaid Boren Amendment is one of the 14 mandates reviewed in the preliminary report.

The Mandate

The Boren Amendment,[1] requires states to establish reimbursement rates to pay hospitals, nursing facilities, and intermediate care facilities for services provided to persons eligible for assistance through the Medicaid program. The mandated federal criteria provide that state-determined

[1] Section 962 of the Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) as amended by Section 2173(a)(1) of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35).

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reimbursement rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . . ."

Background

The intent of the Boren Amendment was to give states a means of controlling costs related to reimbursement claims from providers of Medicaid services. Rather than basing reimbursements on a cost-related payment requirement for hospitals and nursing home services, the amendment allows states to pay for services based on a predetermined reimbursement rate, giving states a basis for denying reimbursement for costs determined to be in excess of that necessary to provide "efficiently and economically" delivered services.

Despite good intentions, the law is seen by many states as more of a burden than a benefit. One problem is the use of vague, undefined terms to describe the federally mandated criteria for reimbursement rates (e.g. the terms: reasonable, adequate, efficiently, and economically). Consistent with the intent of the law, the federal government made a conscious decision not to issue regulations defining the vague terms in the statutory language.

An additional complication is that, while the law requires reimbursement rates to be "determined in accordance with methods and standards developed by the State," it also requires the federal government to be satisfied with the state-determined rates. To implement this requirement, the federal government decided to require state processes for determining rates and the rates themselves to be a part of Medicaid State Plans. These plans are subject to approval by the Secretary of Health and Human Services.

The vagueness of the statutory language, combined with the lack of regulatory definitions, has resulted in substantial litigation, with some courts viewing the Boren Amendment as a cost based

payment standard in which all cost incurred by the providers must be reimbursed. In these instances, states may be liable for significant sums to cover the retroactive rate increases ordered by the court for the group of providers involved in the suit. In some cases, the additional payments made as a result of a court-ordered retroactive rate increase are not eligible for cost-sharing from the federal government.

Much of the Boren Amendment litigation, however, does not relate directly to the vagueness of the statutory language. Rather, the issue is a state's procedure for determining reimbursement rates. In such cases, if the procedure is ruled by a court to be flawed due to lack of adequate public notice or other factors, a state may be liable for substantial retroactive reimbursements based on a revised rate determination procedure. Again, depending on the situation, the additional payments made as a result of the court order may not be eligible for cost-sharing from the federal government, even though the rate determination methodology was approved as a part of the state's plan for the Medicaid program.

I should add on behalf of the Department of Health and Human Services, that in response to litigation, the Department has tightened its process for reviewing state rate determination procedures to strengthen potential acceptance by the courts.

State Concerns

Responses received by ACIR to a survey of states indicate that many states feel the Boren Amendment handcuffs their ability to constrain the growth in Medicaid spending during times of fiscal crisis. Requiring that Medicaid reimbursement rates be established within the limits of federally mandated criteria restricts the scope of a state's negotiations with providers of medical and nursing home services. Further, the threat of potential litigation often causes a state to increase rates merely to avoid legal actions. States are concerned about the extensive and expensive work necessary to substantiate compliance with the law and to protect against suits by nursing home or hospital providers.

This situation is especially true since the 1990 Supreme Court ruling in *Wilder v. Virginia Hospital Association*, (496 US 498). The Supreme Court declared that medical care providers (instead of Medicaid recipients) are the intended beneficiaries of Boren Amendment. This ruling allows medical facilities and nursing homes to obtain judicial review of state reimbursement rates under the *Civil Rights Act*, Section 1983. In effect, the Court ruling allows hospitals and nursing homes to claim that a state is violating the hospital's civil rights by failing to pay "cost incurred to provide services."

Preliminary Recommendation

Because states are traditionally responsible for the quality and safety of medical services, and Medicaid is a state administered program, ACIR has concluded in its preliminary report that states should be allowed to conduct reimbursement rate negotiations with Medicaid service providers without preconditions set by federal law. *The ACIR preliminary recommendation is to repeal the language of the Boren Amendment and insert language making states solely responsible for determining Medicaid reimbursement rates.*

In concluding, I want to emphasize that my testimony, including the conclusions and recommendations regarding the Boren Amendment, are based on the ACIR preliminary report and are subject to change based on final decisions of the Commission after receipt and review of public comments. The Commission will hold a conference for discussion of its preliminary report on March 6 and 7 and will receive public comments over the next two months before issuing its final report.

Mr. SHAYS. Ms.—Professor Feder, would love to hear your testimony. It's nice to know that—the voice behind the nodding of the head.

Ms. FEDER. Thank you, Mr. Chairman.

Mr. SHAYS. I said one thing about what?

Ms. FEDER. I apologize, and I appreciated very much your correcting the record.

Ms. FEDER. I'm glad to be here today to talk about the Medicaid program. I have been impressed, in listening to the discussion this afternoon, at how much agreement there is about the need for enhanced flexibility in the program.

I think that there is very little disagreement on the key issues that have received so much attention: managed care, home care, and the Boren amendment, as the preceding speaker indicated. I think, unfortunately, where the disagreement lies is whether to retain what I believe is the purpose of the program and of the Federal funds and that is the guarantee of insurance coverage for the eligible population.

To briefly summarize my views, I think it is reasonable to argue that legislative change can enhance Medicaid's efficiency, as Dr. Scanlon described it earlier, and can generate savings in pursuing the program's fundamental purpose of insurance protection for vulnerable populations and that that is, in fact, the approach that has been taken in the administration's proposal for flexibility and a cap on per beneficiary, the growth in Federal payments per beneficiary, referred to as the per capita cap.

In contrast, the Conference Agreement and subsequent proposals from the Republicans that would eliminate the entitlement to coverage and would reduce Federal funds would not—dramatically provide flexibility in pursuit of that coverage goal. Rather, they would abandon the assurance guarantee that actually defines the Medicaid program.

Block grants, with limited funds, put States willing to sustain coverage at greatest risk. Under these proposals, coverage can be sustained only if States increase spending to offset Federal reductions. If, instead, States spend the minimum needed to draw down their allocation of Federal funds, insurance coverage of the eligible population would be dramatically undermined.

Let me elaborate briefly. First, as we heard from Dr. Vladeck, the HCFA administrator, Medicaid is a voluntary Federal/State partnership. Under the program, the Federal Government makes matching funds available to States to operate the medical assistance programs consistent with Federal guidelines. State participation is voluntary, and the guidelines aim to assure the intended use of Federal funds.

The most important of these guidelines define Medicaid as an insurance program. That is, they define the population that must or may be insured and specify the health and long-term care benefits that must or may be covered.

People who satisfy Medicaid eligibility criteria have a legally enforceable right to coverage for a defined set of benefits. That means that Medicaid beneficiaries, like people with private insurance, know what will be paid for when they get sick.

States can decide whether or not they wish to participate in the Medicaid program, but if they choose to participate, they are choosing to provide meaningful insurance coverage to a defined population. Under current law, as Dr. Vladeck indicated and you discussed extensively, States already have considerable flexibility in satisfying this requirement. As discussed previously, only 38 percent of total Medicaid spending is for populations and services that States are required, as distinct from having the option, to cover.

Now, when you consider legislation to reduce Medicaid spending, it is critical to preserve Medicaid as an insurance program. The administration's proposal preserves the insurance protections of Medicaid while promoting greater efficiency in their pursuit. The proposal would provide States the flexibility in service delivery they have been seeking, specifically with respect to managed care and the negotiation of provider payment, and I would add the home care and long-term care that we were discussing earlier today. As I said, I think those are the three fundamental flexibilities that were emphasized.

Both managed care and provider payment changes will facilitate State efforts to provide insurance protection at lower costs, satisfying the definition of efficiency that you discussed earlier. The administration further promotes these results with the additional action of establishing a limit on the rate of growth in Federal payments per beneficiary enrolled in the program.

The per capita cap has three fundamental characteristics: First, by focusing on expenditures per beneficiary, rather than total expenditures, it encourages States to focus on efficiency in coverage, not eliminating coverage, in slowing cost growth.

Second, by allowing funds to increase as the number of beneficiaries increases, it sustains the health insurance safety net and protects States against increased demands for coverage that come with economic recession or demographic changes, developments that are unpredictable and from which no State is immune.

Third, by establishing a growth rate for Federal funds that recognizes rising general costs and medical costs, it protects States and beneficiaries against the erosion of purchasing power as prices rise, thereby sustaining the value of insurance protection.

Far from constituting an unfunded mandate, these features establish appropriate constraints on Federal spending while continuing to assure States the availability of sufficient Federal funds to meet their population's need for insurance protection. At the same time, they demonstrate that fiscal responsibility does not require the abandonment of social commitments. The combination of flexibility and the per capita cap in the administration proposal would promote efficiency in pursuing the long-established and widely valued goal of the Medicaid program, insurance protection for vulnerable populations.

In contrast, block grants that eliminate entitlements are not focusing on efficient insurance protection. They are eliminating the guarantee of insurance coverage. The Conference Agreement repealed the Medicaid program and replaced it with a block grant that eliminates fundamental insurance guarantees, provides States insufficient funds to cover the population that is eligible under cur-

rent law, and leaves States at risk for recession, demographic change and price increases.

This is not a proposal to promote flexibility or efficiency. It is an abdication of Federal responsibility to protect the Nation's most vulnerable population.

The Conference Agreement would eliminate the fundamental elements of Medicaid as insurance—legally enforceable national criteria for who is covered for what benefits. At the same time, it would dramatically reduce, by 17 percent over 7 years, the Federal funds available to provide that protection. In other words, States would have neither the obligation nor the resources and ability to sustain current protection.

Under the Conference Agreement, Federal funds for the Medigrant program would increase at an average of 4.8 percent a year from 1996 to 2002 in the aggregate. This growth rate is well below the 6 percent per year needed to keep pace with estimated beneficiary growth, at roughly 3 percent per year, and general inflation, about 3 percent per year.

Looked at another way, if States were to retain coverage provided under current law, the Urban Institute estimates they would have to constrain expenditure growth per beneficiary to 1.3 percent, less than half the rate of general price inflation. Even the modifications that have been proposed to increase funding under the Conference Agreement have failed to assure a per capita growth rate that is sufficient to keep up with medical cost inflation.

To achieve this goal, the agreement provides no flexibilities in service delivery beyond those that are in the administration proposal. Nor is it clear that any such flexibilities exist that could sustain coverage with such limited resources. Rather, what is allowed under that proposal is a safety valve to States that undermines the program's fundamental purpose. That safety valve is the ability to eliminate coverage. That means that poor families, people with disabilities, and senior citizens would lose essential health and long-term care protection.

The Conference Agreement's threat to coverage goes beyond its reduction in Federal dollars. As we have heard earlier, by changing the matching formula and other current Medicaid provisions, it allows States to substitute the limited pool of Federal funds for the expenditure of State dollars. The Urban Institute estimates that if States reduce their spending to the minimum amount needed to draw down their allowed Federal payments, total spending on medical assistance would fall an additional 8 percent beyond the 17 percent reduction that I already noted, a total of 25.4 percent or $400 billion from 1996 to 2002.

No amount of flexibility can sustain coverage in light of such expenditure reductions. Coverage could be sustained only if States were actually to increase their spending in order to offset Federal reductions. Furthermore, fixed dollar Federal grants that do not vary with changing economic or demographic conditions that increase enrollment leave States fully at risk for such changes. Estimates prepared by the Center on Budget and Policy Priorities indicate that a recession could increase the costs associated with Medicaid coverage by $7 billion to $26 billion over 7 years. Under a block grant, all that risk would be born by the States.

Rather than enhancing States' ability to manage their programs, the major thrust of the Conference Agreement is to leave States holding the fiscal bag for protecting vulnerable Americans. Expecting States to bear such risks in order to preserve coverage is not only unrealistic, it would indeed represent the unfunded mandate that its proponents profess to avoid.

Thank you, Mr. Chairman.

Mr. SHAYS. I am going to enjoy our conversation.

[The prepared statement of Ms. Feder follows:]

GEORGETOWN UNIVERSITY MEDICAL CENTER

Institute for Health Care Research and Policy

Testimony

Before the

House Committee on Government Reform and Oversight,

Subcommittee on Human Resources

and Intergovernmental Relations

January 18, 1996

Judith Feder

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Mr. Chairman, members of the Committee, it is a pleasure to appear before you to discuss proposed changes to the Medicaid program--our nation's critical health and long-term care safety net for poor families, people with disabilities and the elderly. Based on better than twenty years of health policy research, my views, in summary, are as follows:

- Legislative change to reduce requirements on states regarding service delivery and provider payment can enhance Medicaid's efficiency and generate savings in pursuing the program's fundamental purpose: health insurance protection for vulnerable populations. This is the approach taken in the Administration's Medicaid proposal.

- In contrast, the Conference Agreement and subsequent Republican proposals that would eliminate the entitlement and dramatically reduce federal funds would not provide flexibility in pursuit of a goal; rather, they would abandon the insurance guarantee that defines the Medicaid program.

- Block grants with limited funds put states willing to sustain coverage at greatest risk. Under these proposals, coverage can be sustained only if states increase spending to offset federal reductions. If, instead, states spend the minimum needed to draw down their allocation of federal funds, insurance coverage is even more severely undermined.

Medicaid is a voluntary federal/state partnership. The Medicaid program is a federal state partnership. Under the program, the federal government makes matching funds available to states to operate medical assistance programs consistent with federal guidelines. State

participation is voluntary; guidelines aim to assure the intended use of federal funds.

Most important, these guidelines define Medicaid as an insurance program--that is, they define the population that must or may be insured and specify the health and long-term care benefits that must or may be covered. People who satisfy Medicaid eligibility criteria have a legally enforceable right to coverage for a defined set of benefits. That means that Medicaid beneficiaries, like people with private insurance, know what services will be paid for when they get sick.

States can decide whether or not they wish to participate in the Medicaid program. But if they choose to participate, they are choosing to provide meaningful insurance protection to a defined population. Under current law, states already have considerable flexibility in satisfying this requirement. The Health Care Financing Administration reports that in 1993 only 38 percent of total Medicaid spending is for populations and services that states are required (as distinct from the option) to cover.

Legislation to reduce Medicaid spending must preserve Medicaid as an insurance program. The Administration's Medicaid proposal preserves Medicaid's insurance protections, while promoting greater efficiency in their pursuit. The proposal would provide states flexibility in service delivery, specifically with respect to managed care and negotiation of provider payment. On managed care, the proposal would eliminate the requirement that states seek federal waivers in order to contract for managed care for their beneficiaries. This change would make it easier for states to expand the use of managed care, just as private employers are doing.

On provider payment, the proposal would eliminate the so-called Boren amendment requirements that have constrained states in setting payment rates to hospitals and nursing homes. This change will make it easier for states to limit payments to providers..

Both managed care and provider payment changes will facilitate state efforts to provide insurance protection at lower cost. The Administration further promotes these results with the additional action of establishing a limit on the rate of growth in federal payments per beneficiary enrolled in the program. The per capita cap, as it is called, has three fundamental characteristics:

- First, by focusing on expenditures per beneficiary, rather than total expenditures, it encourages states to focus on efficiency in coverage--not eliminating coverage--in slowing cost growth.

- Second, by allowing federal funds to increase as the number of beneficiaries increases, it sustains the health insurance safety net and protects states against increased demands for coverage that comes with economic recession or demographic changes, developments that are unpredictable and from which no state is immune.

- Third, by establishing a growth rate for federal funds that recognizes rising medical costs, it protects states and beneficiaries against the erosion of purchasing power as prices rise, thereby sustaining the value of insurance protection.

Far from constituting an unfunded mandate, these features establish appropriate constraints on federal spending while continuing to assure states the availability of sufficient federal funds to meet their population's need for insurance protection. At the same time, they demonstrate that fiscal responsibility does not require the abandonment of social commitments. The combination of flexibility and the per capita cap in the Administration proposal would promote efficiency in pursuing the long-established and widely valued goal of the Medicaid program--insurance protection for vulnerable populations.

In contrast, block grants that eliminate entitlements do not promote efficient insurance protection; they eliminate insurance coverage. The Conference Agreement repealed the Medicaid program and replaced it with a block grant that eliminates fundamental insurance guarantees, provides states insufficient funds to cover the population eligible under current law, and leaves states at risk for recession, demographic change, and price increases. This is not a proposal to promote flexibility or efficiency; it is an abdication of federal responsibility to protect the nation's most vulnerable populations.

The Conference Agreement would eliminate the fundamental elements of Medicaid as insurance--legally enforceable national criteria for who is covered for what benefits. At the same time, it would dramatically reduce (by 17 percent over seven years) the federal funds available to provide that protection. In other words, states would have neither the obligation nor the ability to sustain current insurance coverage.

Under the Conference Agreement, federal funds for the Medigrant program would increase an average 4.8 percent per year from 1996-2002. This growth rate is well below the 6 percent per year needed to keep pace with estimated beneficiary growth (about 3 percent per year) and general inflation (about 3 percent per year). Looked at another way, if states were to retain coverage provided under current law, the Urban Institute estimates they would have to constrain expenditure growth per beneficiary to 1.3 percent--less than half the rate of general price inflation. Even modifications Republican have proposed to increase funding in the Conference Agreement have failed to assure per capita growth rates sufficient to keep up with medical cost inflation.

To achieve this goal, the Agreement provides no flexibilities in service delivery beyond those in the Administration proposal; nor is it clear that any such flexibilities could sustain coverage with such limited resources. Rather, it allows states the safety valve that undermines the program's fundamental purpose--the ability to eliminate coverage . That means that poor families, people with disabilities and senior citizens would lose essential health and long-term care protection.

The Conference Agreement's threat to coverage goes beyond its reduction in federal dollars. By changing the matching formula and other current Medicaid provisions, it allows states to substitute the limited pool of federal funds for expenditure of state dollars. The Urban Institute estimates that if states reduce their spending to the minimum needed to draw down their allowed federal payments, total spending on medical assistance would fall an additional 8 percent

beyond the 17 percent reduction in federal funds--a total of 25.4 percent--$400 billion--from 1996-2002.

No amount of flexibility can sustain coverage in light of such expenditure reductions. Coverage could be sustained only if states were actually to increase their spending, in order to offset federal reductions. Furthermore, fixed dollar federal grants that do not vary with changing economic or demographic conditions that increase enrollment leave states fully at risk for such changes. Estimates prepared by the Center on Budget and Policy Priorities indicate that a recession could increase the costs associated with Medicaid coverage by $7 billion to $26 billion over seven years. Under a block grant, all of that risk would be borne by the states.

Rather than enhancing states' ability to manage their programs, the major thrust of the Conference Agreement is to leave states holding the fiscal bag for protecting vulnerable Americans. Expecting states to bear such risks in order to preserve coverage is not only unrealistic; it would indeed represent the unfunded mandate that its proponents profess to avoid.

Mr. SHAYS. Mr. Beach.

Mr. BEACH. Thank you very much, Mr. Chairman. I want to thank you, as all the witnesses have thanked this committee, for the opportunity to come before you and share the research we have done.

I must say that—two points. This has been an extraordinary seminar on this whole subject. I have learned a lot this afternoon, as I am sure everyone who has spent the whole afternoon with you has learned.

Mr. SHAYS. It's nice of you to say that. It's been an interesting hearing, and you have helped make it that way as well. Thank you, sir.

Mr. BEACH. And I appreciate also being on the last panel, though that's not normally the position one wants to be if one has other things it wants to do, because I think the testimony that I have heard from my fellow witnesses and the testimony I am about to give you puts an exclamation point on what went before our panel.

Let me summarize my main point, in a paper which has been distributed prior to this committee and which I am not going to read and I am just going to ask you to look at at your convenience.

The main point of the work that the Heritage Foundation has done on this particular subject is that if we assume that Medicaid remains a program of guaranteed health care for federally defined covered groups—that's our first assumption—and, second, that States are largely prohibited from making significant changes to the program that would reduce its costs beyond their current efforts—and I make that assumption, perhaps underlining that, beyond their current efforts—then it is highly likely that States will need to raise substantial new tax revenues or make major cuts in other programs, such as education, economic development and highway construction, in order to meet their Medicaid obligations.

Now, we came at this problem, Mr. Chairman, statistically. What we wanted to do was to develop 51 estimates, if you will, of what the States are facing over a 7-year period in terms of their obligation for meeting current law as well as the proposed blue dog or per capita cap program.

So we constructed 51 State statistical or economic models—that is, all the States plus the District of Columbia—and we found that failing to fundamentally change the Medicaid program as it's now defined may mean that States will need to raise, over this 7-year period, out of their own resources, an additional $146 billion in order to meet their current obligations under the current program.

Second, to restress my earlier point that these additional dollars from Medicaid may mean that States will need to raise new taxes or cut spending in other programs, if I could just say I think this afternoon we haven't heard enough on that latter point and that is that, at the State level, the debates aren't just in do we cover this group or do we cover that group or do we provide this level of service. The debate is rather, in the legislatures, do we support higher growth in higher education or do we meet these obligations as they are currently defined? They are between the program categories.

And, third, that moving to a per capita cap program that reduces Federal Medicaid program dollars may mean that States will need

to raise an additional $47 billion in order to pay for their portion or obligations.

Now, very briefly, how did we develop these estimates? Because I think I would like to put a pedigree on these numbers. The Heritage Foundation, as you may or may not know, is from time to time a critic of large government and has said from time to time that we tax too much. So in doing these estimates——

Mr. SHAYS. From time to time, give me a break. All the time. That's what you say.

Mr. BEACH. Well, most of the time.

So to make sure that these estimates had as little content in them as possible, we turned to one of the Nation's foremost econometric houses, consulting companies, the Wharton Econometric Forecasting Associates in Philadelphia, more particularly Balla Kenwood, working with them, we created three sets of models.

The first was a set of 51 models of the total Medicaid program at the State level; and these equations, if you will, include, among other things, variables for the relevant demographic groups that are covered by Medicaid and variables for gauging the health of the States' economies.

The second set of models was a set of projections of total State revenues and the third was a projection of total State expenditures.

We took the baseline solutions from those models and adjusted them in order to reflect the size of the program that the Congressional Budget Office in December—I believe December 12, 1995—indicated that the Medicaid program would be at the Federal level.

The Heritage Foundation has made a point of always adopting the CBO forecast. And, finally, the additional State revenues required to pay for Medicaid, which you see on table No. 1 of my testimony, over the next 7 years were calculated by subtracting State Medicaid spending in 1995 which is in the bank from what they may have to pay over the period 1996 through 2002. So our additional dollars are additional to 1995 total payment.

A couple of observations about what I put before you. First, I think it would be fair to characterize our projections as almost worst case. They are almost worst case for a couple of reasons, not quite worst case. First of all, we assumed that the States would not make any additional efforts beyond what they are doing now to address Medicaid costs. Clearly, they will be making additional efforts, but there is a set of parameters in which they, or channel in which they can make additional efforts. That has been defined by previous testimony.

Second, because CBO Medicaid forecasts of December 1995 are based on economic projections that do not contain a recession, our estimate of $146 billion in additional State payments would certainly go up or grow if the economy experienced significant declines over the next 7 years.

Finally, the probability of slower growth and recession is certainly higher today than it was a month ago in light of the continued failure of the Congress and the administration to reach a 7-year balanced budget plan.

I thank you very much, and any questions you have I would be happy to answer.

[The prepared statement of Mr. Beach follows:]

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Congressional Testimony

The Costs to the States of Not Fundamentally Reforming Medicaid

Testimony
of
William W. Beach
Visiting Fellow in Tax Analysis
The Heritage Foundation
Washington, D. C.

Before
The Subcommittee on Human Resources
and Intergovernmental Relations
United States House of Representatives
on January 18, 1996

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> "We must, however, continue to express our concerns about mandated Medicaid expansions. States do not have the luxury of operating a budget deficit. Every mandated dollar that we spend is a real dollar that has to be taken from another program."
>
> Governor Bill Clinton of Arkansas, June 7, 1990

Much of the debate between Congress and the President on reforming Medicaid, the health care program serving the nation's poor, has transpired without adequate attention paid to the effect of the program on state finances. If significant reforms to Medicaid are not enacted, states will face a heavy increase in spending and a rise in the proportion of their projected revenues that must be dedicated to the program. And, because the rate of growth in state Medicaid spending will exceed the rate for total state spending, the states will be forced either to increase taxes or to divert money from other programs, such as education and crime control.

Medicaid is a state-administered program that operates under federal guidelines. Federal and state governments jointly fund the program. Federal reimbursement to the states is based on a statutory formula designed to give a higher matching rate to states with lower per capita incomes. Matching rates for these services range from 50 percent to 83 percent and are adjusted annually.

The cost of Medicaid to the federal government has been growing at double-digit rates in recent years. The Congressional Budget Office ("CBO") projects that annual federal Medicaid costs will almost double by 2002.

Annual Federal Medicaid Costs
(Millions of Dollars)

Fiscal Year	Annual Federal Medicaid Costs
1995	$89,216
1996	97,292
1997	107,021
1998	118,060
1999	129,631
2000	140,116
2001	156,600
2002	172,800
7-Year Total	1,010,736

Source: Congressional Budget Office (December, 1995)

Although the financial impact on the federal government of generally unrestrained Medicaid growth is alarming enough, the future impact on states could be even more severe: a remorseless growth in the share of their own projected revenues going to Medicaid that either forces them to raise taxes in order to maintain spending for other programs or to reduce state expenditures for non-Medicaid programs. States can make some cost-saving reforms in the program, but only subject to federal rules requiring that certain levels of coverage (entitlements) be provided to certain populations.

To examine the probable future budget impact on states, The Heritage Foundation analyzed the likely trend of total Medicaid spending using certain assumptions to forecast the state share of Medicaid payments for the period 1995 through 2002.[1] This analysis resulted in two sets of findings: first, the additional costs to the states if no changes are made in the Medicaid program and, second, the additional costs stemming from President Clinton's proposed "per capita cap" reforms to Medicaid. Hence, the following charts and tables project the future state-level Medicaid burden if Congress either does nothing or adopts the President's proposal. These projections of state spending incorporate expected changes in state economic activity, in the size of the eligible population, and in the trend of federal Medicaid transfers to the states.

These forecasts of future state Medicaid spending were prepared jointly by Heritage and Wharton Econometric Forecasting Associates ("WEFA"), a nationally recognized economic consulting firm that maintains detailed models for each state. For 47 states, WEFA found a significant relationship between changes in historical Medicaid spending and fluctuations in the state's economic activity and Medicaid-eligible

[1] The original estimates of additional state Medicaid costs under current law and the technical assumptions behind these estimates are contained in William W. Beach, "The Cost to States of Not Reforming Medicaid," Heritage Foundation *F. Y. I.* No. 63, September 26, 1995. The cost estimates in this earlier paper were revised downward on December 18, 1995 after the Congressional Budget Office recalculated its seven-year projections of federal Medicaid outlays. The CBO made its revisions in order to reflect the influence of lower forecasted inflation on federal Medicaid outlays. See Beach, "Updated Estimates of the Costs to the States of Not Reforming Medicaid and the Additional Costs of Adopting Per Capita Caps," Heritage Foundation *F. Y. I.* No. 81, December 18, 1995.

populations. In four cases, however, the relationship was sufficiently weak that WEFA simply projected the historical trend in spending; these states are North Dakota, South Carolina, Utah and Wyoming. This table shows the additional state revenues or program cuts needed if the states are to meet their projected Medicaid expenditures.

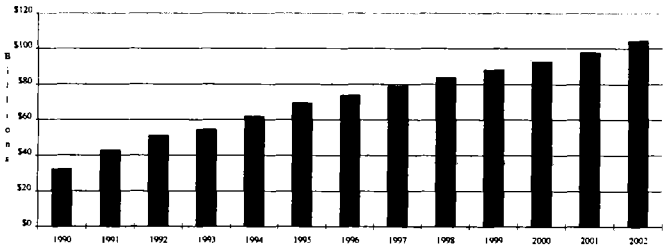
Estimated Additional Costs Without Reform

Between 1995 and 2002, if no reforms are enacted that address the costs of entitlements and the composition of covered groups, states will have to spend $688 billion of their own money on Medicaid. Total state spending over this period is projected to be $1,700 billion, of which $1,011 billion will be supplied by the federal government (if CBO's forecasts of federal spending prove correct). The difference between federal and state spending on Medicaid means that states will have to devote an average of 8 percent of their non-federal revenues to the program. Among the hardest hit states, Pennsylvania will have to devote 17 percent of its revenues to the health care program.

As Chart 1 shows, the amount of state Medicaid payments alone steadily increases between 1995 and 2002. In 1990, the states spent just $32 billion of their non-federal funds on Medicaid. These unfunded payments are projected by our analysis to grow to $69 billion by 1995 and $104 billion by 2002. In other words, the Medicaid amount paid by the states will have increased by 225 percent over the twelve-year period between 1990 and 2002.

Chart 1

Medicaid Expenses Paid With State Revenues, 1990-2002

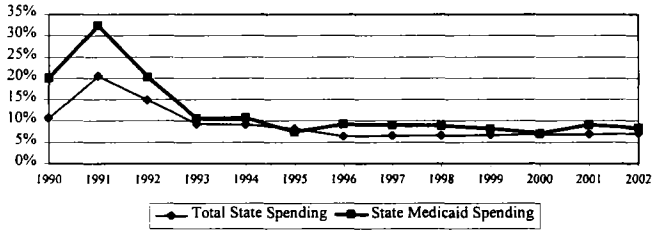


Some individual states will be particularly hard hit. For example, California will need to raise $18 billion in new revenues or in budget cuts to pay its part of Medicaid growth between 1996 and 2002. Similarly, New York will need to raise $17.3 billion; Florida, $12.9 billion; Pennsylvania, $11.6 billion; and Texas, $7.2 billion. If these states choose to raise taxes to meet their Medicaid obligations, then California will have to increase the average taxpayers bill by $246 per year; New York by $370; Florida by $374; Pennsylvania by $362; and Texas by $177.

This rapid growth in the states' Medicaid share is reflected in the annual percentage change in state-level Medicaid spending as compared with total state spending, which includes support of such things as education, crime control, and transportation infrastructure (see Chart 2). The Heritage analysis anticipates 1995 state Medicaid spending to grow at a rate of 7.5 percent, while total state spending should grow at an 6.4 percent rate. This higher rate of change for Medicaid means that states either must raise taxes or must take funds away from other state programs. The forecast suggests that state spending on Medicaid will continue to keep pace with total spending. Over the forecast period (1995-2002), Medicaid spending is projected to grow at an 8.4 percent rate, while total state expenditures are expected to grow by an average of 5.8 percent.

Chart 2

Relationship Between Total Expenditures and Medicaid Spending
Percentage Change, 1990 - 2002
(Source: WEFA Trend Forecast, July 1995)



Fiscal Effects of the "Blue Dog" Democrat Plan

The Democratic "Blue Dog" plan to reform the federal Medicaid program, the principal elements of which have been advanced by the Clinton Administration in their seven-year budget proposal, would increase the federal fiscal burden on the states by an estimated $47.4 billion over the next seven years. This new fiscal burden has been described as "one of the biggest and most expensive unfunded [federal] mandates ever"[2] and, over the seven-year period 1996-2002, would amount to $4.4 billion in California, $3.7 billion in Florida, $3.4 billion in New York, $3.2 billion in Pennsylvania, and over $2.9 billion in Texas. Overall, this unfunded federal mandate would exceed $1 billion in 16 states.

[2] News release, "Clinton Medicaid Plan Places New Unfunded Mandate on States," House Committee on Government Reform and Oversight, December 15, 1995.

First proposed by a group of Democratic House members earlier this year,[3] this plan would further challenge the fiscal resources of the states by maintaining all the existing program mandates which the federal government imposes on the states[4] while simultaneously reducing the federal government's contribution through the mechanism of a "per capita cap" on the federal share of the program. Under the "Blue Dog" plan, the per capita cap limits the amount of federal medical assistance that states would receive for each Medicaid recipient. Any expenses that exceed this limit would be the sole responsibility of state and local taxpayers. Because the full array of federal Medicaid mandates would remain in effect, states would not be able to offer innovative, and less expensive, health care options to Medicaid recipients. Overall, the per capita cap would shift an estimated $47.4 billion of mandated Medicaid spending from the federal to state governments over the next seven years.

States would probably respond to this shift in one of three ways: 1) enact dramatic tax increases; 2) reduce state spending on education, infrastructure, law enforcement, and other important state functions; or, 3) some combination of the above. Indeed, the proliferation of Medicaid mandates during the late 1980s and early 1990s has already forced the states to reallocate their resources to Medicaid. According to the National Association of State Budget Officers, Medicaid spending has doubled from approximately 10 percent to 20 percent as a share of overall state spending since 1987.[5]

Technical Assumptions

The Heritage Foundation and Wharton Econometric Forecasting Associates used state models of economic activity to develop state-by-state estimates of Medicaid spending and the additional funds states would need to meet their future Medicaid obligations.

Our baseline estimates assume no change in current Medicaid eligibility rules and allowed federal Medicaid transfers to the states to grow at the rates implied by the history of this program. Total Medicaid program spending in each state is a function of the state's historical Medicaid expenditures and expected demographic and economic change. We used this as the basic structure for future Medicaid spending.

These baseline forecasts of state Medicaid spending were adjusted upwards by Heritage to reflect the higher federal expenditures on Medicaid projected by the Congressional Budget Office. The difference between our initial baseline for total (federal and state) spending and the CBO adjusted estimates is $58 billion over the period 1996 to 2002. We distributed the state portion of this additional amount by each state's

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[3] On October 26, 1995, Representative Bill Orton (D-UT) and a group of House Democrats offered a substitute to the Balanced budget Act of 1995 (HR 2491). This proposal, which would reduce baseline federal Medicaid expenditures by $85.1 billion over seven years, was defeated by a vote of 72-356. Sixty-eight Democrats and four Republicans supported the plan.

[4] Federal Medicaid law defines precisely who is eligible to receive benefits under the program, which medical services beneficiaries can receive, and the amount, scope, and duration of these benefits.

[5] Information obtained from House Commerce handout, September 20, 1995.

annual percentage of total national Medicaid spending for each of the seven forecast years following 1995. Estimates of additional taxes that would be raised to meet each state's additional funding requirement were calculated by dividing the additional funding requirement by the estimated number of taxable individual federal income tax returns in 1995.

Table 1

Additional State Medicaid Obligations Under Current Law and Per Capita Cap, 1996-2002

(Amounts in Thousands of Dollars)

State	Additional Spending Under Current Law	Addition to Current Law from Per Capita Cap	Total Additional State Medicaid Obligations
Alaska	$108,258	$24,883	$133,141
Alabama	1,699,383	1,024,889	2,724,272
Arkansas	832,824	567,691	1,400,515
Arizona	2,779,037	1,020,447	3,799,484
California	18,027,116	4,461,013	22,488,130
Colorado	1,629,869	419,704	2,049,574
Connecticut	2,155,812	547,555	2,703,367
DC	1,531,731	331,399	1,863,130
Delaware	663,156	115,971	779,128
Florida	12,870,910	3,710,823	16,581,734
Georgia	5,270,028	1,500,974	6,771,002
Hawaii	1,193,243	186,034	1,379,277
Iowa	448,548	449,939	898,487
Idaho	359,798	93,388	453,186
Illinois	2,321,244	1,718,303	4,039,547
Indiana	2,054,049	942,267	2,996,316
Kansas	1,023,210	426,814	1,450,024
Kentucky	1,647,154	855,243	2,502,397
Louisiana	2,352,886	1,319,094	3,671,981
Massachusetts	4,347,438	1,137,495	5,484,933
Maryland	3,143,417	704,388	3,847,804
Maine	377,690	180,319	558,010
Michigan	4,371,374	1,616,829	5,988,203
Minnesota	2,365,431	602,981	2,968,412
Missouri	2,079,914	943,278	3,023,192
Mississippi	719,280	632,456	1,351,737
Montana	229,234	144,534	373,768
North Carolina	4,224,599	1,454,869	5,679,468
North Dakota	73,614	103,467	177,081
Nebraska	586,179	227,303	813,483
New Hampshire	490,432	125,549	615,981
New Jersey	4,510,780	1,192,846	5,703,626
New Mexico	331,042	228,683	559,724
Nevada	1,026,297	196,689	1,222,986
New York	17,325,783	3,425,603	20,751,386
Ohio	5,141,895	2,068,439	7,210,334
Oklahoma	708,006	569,564	1,277,570
Oregon	864,518	439,316	1,303,834
Pennsylvania	11,556,950	3,188,606	14,745,556
Rhode Island	-31,354	105,709	74,355
South Carolina	1,037,409	601,712	1,639,121
South Dakota	102,365	94,091	196,456
Tennessee	5,438,037	1,874,606	7,312,643
Texas	7,228,538	2,941,115	10,169,653
Utah	-21,110	136,352	115,242
Virnigia	4,604,946	916,841	5,521,787
Vermont	175,053	71,058	246,111
Washington	2,243,972	607,348	2,851,320
Wisconsin	2,054,465	790,899	2,845,364
West Virginia	225,364	349,159	574,524
Wyoming	-88,126	11,673	-76,453
Total	$146,411,691	$47,400,214	$193,811,905

Source: The Heritage Foundation and Wharton Econometric Forecasting Associates. Estimates include new Congressional Budget Office economic assumptions released on December 12, 1995.

Mr. SHAYS. I am trying to think of where we will begin here. Professor Feder, let me ask you this question: When the President wants to make savings, do you call that a cut or a savings; and when Republicans want to make it a savings, do you call it a cut or a savings?

Ms. FEDER. I think that what we are talking about, as you indicated with respect to both kinds of proposals, is cuts in rates of growth. The point that I think needs to be made when we call it a cut, it is always Federal savings.

Mr. SHAYS. It is always what?

Ms. FEDER. It is always going to be Federal savings. The question is whether it is cutting the purchasing power that is associated with the program.

Mr. SHAYS. There are two issues, if we could kind of establish our ground rules. There is one question of whether we are actually spending more absolute dollars; and there is the other question, are we spending enough to keep up with the current program.

Ms. FEDER. I would say there is a third, which is whether we are spending an amount that is adequate to finance the coverage that the program aims to provide.

Mr. SHAYS. The current level of service. In other words, are we maintaining that current level of service? And it gets into this whole issue that the Federal Government started to do in the early 1970's. That is why I am sensitive to it. Our national debt has grown since after World War II from about $430 billion—excuse me, after the Vietnam war, in 1974 it was about $430 billion, a lot of money, and it is now $4.9 trillion. So since 1974 to now 1996, we have seen a tenfold increase in our national debt. And my constituents, when I was first elected in 1987, would say: What do you mean; you keep telling me you are cutting spending when your budget keeps going up.

I thought that a fair question, because I kept talking about we are cutting this program, cutting spending, yet the program kept going up. I realized, as I obviously had to, that we were using quote unquote a baseline budget where we say each year we add inflation and new population, and whatever is taken from that we in the Federal Government will call a cut. So constituents out there and the press dutifully report we cut spending. No, we did not cut spending. We spent more dollars. We may have in fact cut the program. A fair question.

So one of the debates that we are going to have a dialog here is—I would concede, if you concede this point, one, we are spending more dollars—I would concede that under a baseline budget, if you spend less dollars than inflation plus the new population, that you are under existing program, you know, rules, you would be cutting that program. Is that fair?

Ms. FEDER. I think that is fair.

Mr. SHAYS. So one of the debates that I think we are going to have in this panel is going to be we obviously want to change the program. So the debate that we have with the White House on Medicaid, our number was a savings to the growth of about 133. My leadership dropped that number down to $85 savings, the White House is at $51; so, yes, we are, my gosh, we are only $34 billion apart in one sense.

But we would contend that it is not just the number; it is are we going to change the program. So that is where the debate will be. Case closed. If we do not make changes in the program, we have got to spend exactly what that baseline budget tells us. Even the President's number of $51 billion will cut that program if we do not change the system.

Ms. FEDER. That is why I began my testimony with the comment that I think that there is agreement on the need to change the system. The questions that have to be asked: what can be expected in terms of reduced rates of growth from those changes and whether the level of continued funding is sufficient to provide the health care coverage, albeit in a more efficient system? But whether it is sufficient to provide the coverage, I think that it is there that the conference agreement and even the subsequent proposals fall down.

Mr. SHAYS. Now, what I have asked Ms. Feder, either of you gentlemen are more than—she has provided a focal point of some disagreement. I may ask questions but I am more than happy to have either of you gentlemen jump in. Would you, either, care to make a comment so far? Are you basically content with this parameter of we are spending more dollars?

The question is: Are we spending enough? If we do not change the program, we are not spending enough to keep up with the same level of service. If we change the program, then the question is are we able to meet all of those program needs, in other words. And it gets me back to this issue of the previous witness who basically talked about cost savings versus efficiencies.

Mr. BEACH. I do not know too many people who would disagree that there needs to be, in some fashion or form, a program like this. How we construct it and how we put it together is the big issue.

I would think we would also want to bring into this another parameter no one has discussed today—perhaps it is not relevant—and that is that we need to promote, in some way through public policy, savings so that people can provide for these kinds of emergency care that bring them to this point.

How do you promote savings among very, very poor people? You promote economic growth. And the level of economic growth we have now is so very low that it endangers the future of this program as much as it endangers the future of generations yet to come into the work force. These are all related questions.

Mr. SHAYS. Which triggers a point again that I would throw out to the panel and address to you, Ms. Feder. You make a point that the population growth requires 3 percent more to meet the need of that population, plus an additional 3 percent for inflated health care costs.

Ms. FEDER. That was general inflation.

Mr. SHAYS. OK. Medicaid is in some cases, in some years has grown at 20 percent a year as we added more voluntary programs, some mandatory programs. Some years it has grown at less than that. We have been looking at a range of about 10-plus a year. Do you think it is conceivable that we could maintain Medicare and Medicaid at a growth of 10 to 15 percent a year ad infinitum?

Ms. FEDER. I think that as we both indicated earlier, that there is some room to constrain the Federal payments, but it is critical

to me that they be done in a way that sustains the capacity for coverage and the commitment to coverage, and I think that that is the proposal; we are not talking about the status quo.

Mr. SHAYS. I am kind of like——

Ms. FEDER. We do have an agreement that some change, some restrictions are possible and appropriate. I think that is fine.

Mr. SHAYS. If the White House and our leaders cannot work out their disagreements, I want to know if we can.

Ms. FEDER. I do not know. We will see.

The point I wanted to make about the growth rates over the years, the very high—and they were in the—actually I think in some years even in the high 20 percents, in the early part of the 90's in Medicaid were only partly a function of expanded population. That was, I think, about a third of the growth. It was a commitment to cover low-income pregnant women and children. A sizable portion of that quite dramatic growth had to do with the—what was discussed earlier—the provider taxes and donations and disproportionate share payments. And there were then, and actually I would call it perhaps some buck passing between the Federal Government and the State governments.

Mr. SHAYS. If we could be candid here, and we are being candid, the other factor was that Congress devised this Gramm-Rudman that was going to control the growth of costs, and Gramm-Rudman only focused on savings in one-third of the budget. It focused on discretionary spending. It did not look at entitlements.

President Bush, right or wrong, with his budget agreement and some tax increases, was out to do one thing: He was out to say if you expand an entitlement, you have to come up with the money to pay for it, either with spending cuts somewhere else or a tax increase. That was part of the 1990 agreement. I voted for it. I know that was part of the agreement.

That was the concept of basically pay as you go. It was to get around Congress, which when it could not live within the discretionary spending because we were capping spending under Gramm-Rudman, went and just kept loading entitlements. So we candidly had to get at that. So I mean, there are fascinating questions here.

Mr. Dearborn, you basically spent most of your time on the Boren amendment. It appears from Mr. Vladeck's emphasis that the White House wants to get at the Boren amendment. But they still want to leave a right of action in Federal court. My question mark is—I guess maybe we do not have enough details to know—by getting rid of the Boren amendment in name, do we still have its ghost linger in the courts? Because, candidly, when Mr. Vladeck was talking about nursing care and no quote unquote requirement of the Federal Government, you both in a sense directed your attention to the fact of regulation; you in particular, the regulation, the law not being defined by regulation. Therefore, where is it being defined by it? By the Federal court.

And the Federal court, it is almost a little disingenuous to say that we do not have a Federal requirement of so many nurses per patient when you have the Federal Government saying since it is ambiguous, we are going to step in and we are going to start to describe on the Federal level what we need.

So does anyone here have any information as to what—I wish I had thought to ask Mr. Vladeck this when he was here—if you do not have the answer, I understand. It will be something we will pursue. Is there any understanding about once we get rid of the Boren amendment, does its ghost still linger?

Mr. DEARBORN. Mr. Chairman, I do not have that information. Until we saw Dr. Vladeck's testimony, I was not aware that the administration was going to recommend repeal of the Boren amendment. Our recommendation of course suggests that it not only be a repeal but a clear statement that the rate-setting process is solely that of the States, and presumably any lawsuits would be under the State law and not under the Federal law if that were done. There is no way you could preclude——

Mr. SHAYS. What troubles you about that?

Ms. FEDER. I would want to think more about that, but I think my understanding is that the primary problem is—which is consistent with the testimony that was given—is that the statutory language of the Boren amendment is quite vague and that the courts have no standards by which to apply it. Consequently, I think quite consistent with what you testified, that has been the major source of the problem.

So I think throwing something to the courts without any specifications is the biggest problem there, not necessarily the Federal courts.

Mr. SHAYS. We have our Medicaid. Medicare growth is growing at 7.2 percent. Our Medicaid growth was not 4.8, it was 5.2 percent. But the confusing thing for you and all of us is what is the baseline. But it is a 5.2 percent growth.

Having said that, I conceded earlier on as someone who helped set these numbers on the Committee on the Budget—I have raised it with my leadership and Mr. Panetta as well and his legislative liaison people—that we allowed for a greater growth in Medicare but not basically that same level in Medicaid. My contention is that the 7.2 percent growth in Medicare is a very significant growth.

Your argument would be that Medicaid should be closer to that gross level of getting over the 6 percent. Whereas I now would respond to you that we are looking to change the program. We made significant savings in Medicare, made significant savings in Medicare without negatively impacting beneficiaries. We do not increase the copayment, we do not increase the deduction. We keep the beneficiary rate at 31.5 percent, with the tax break continuing to pay 68.5 percent. We have a test for the wealthy. The wealthy are going to have to pay more for Medicare Part B. They are paying 31.5 percent. They are going to have to pay potentially up to 100 percent on incomes over $100,000.

What we also do, which is something that we did in the private sector. I am just trying to illustrate changing the system means a savings. What we also do with Medicare is we then provide for a whole host of choices for the beneficiaries, allowing them, though, if they choose to get into managed care or some other private care—and their only inducement to do that is if they get something they do not get now under the traditional Medicare system—eye care, dental care, a rebate on the premium, no copayment, maybe the Medigap is paid for by the managed care people. If they don't

like it, they have, every month they can get on and get back onto their old fee-for-service system. There we make significant changes. And that is why we are able to keep the growth at 7.2 percent as opposed to a 10 percent or 11 percent growth.

Have you had a chance, Ms. Feder, to look at Medicare, or are you more focused on Medicaid?

Ms. FEDER. I am familiar with Medicare as well.

Mr. SHAYS. Are you as troubled with Medicare, or is there more trouble with Medicaid?

Ms. FEDER. I would rather—rather than make a comparison, I would tell you, if you wish, what my concerns are about the Medicare proposal.

Mr. SHAYS. I would welcome that.

Ms. FEDER. I will do it briefly and relate them to what we are talking about, specifically what can be expected from structural change.

On the Medicare proposal, the savings according to not only experts but also the Congressional Budget Office, the savings with the slowdown in the rate of growth come not overwhelmingly from changes in the structure in terms of beneficiary choice, but rather they come from caps that are established in terms of Federal payments.

So it is, I think, not quite right to see it as coming from market efficiencies. It comes from restrictions and really turning the program from a defined benefit program to a defined contribution program, where the risk is shifted from the Federal Government to the beneficiaries or to health plans. So——

Mr. SHAYS. With all due respect, you are really stretching it. The Federal Government is going to keep the fee-for-service system. For anyone who wants the fee-for-service system, they get it. We do not scrap that.

Ms. FEDER. You are quite right, but the growth in it is capped, and there are a number of concerns about what happens to that arbitrary cap relative to the cost and the fee-for-service system over time. Then you are quite right. That system remains available. The question is whether the rates paid to providers in that system are sufficient to assure access to care to beneficiaries, which is not dissimilar to the concerns that have been raised in the Medicaid program.

Mr. SHAYS. And your comparison to Medicaid is what?

Ms. FEDER. What I wanted to say, again going back to what we can expect from changes in structure, and again, I am impressed by the level of agreement, there is agreement on the Boren amendment. There is agreement on managed care. There is agreement on home community-based care. There is agreement on delivery flexibilities. The evidence from managed care, is that it provides one-time savings of about 10 to 15 percent—or I think it is 5 to 15 percent actually—of expenditures. And, in terms of our States' experience with managed care and experience in the private sector, that saving is applicable to the portion of the program that is mothers and children. We do not have experience with long-term care and managed care. So——

Mr. SHAYS. We are starting to get experience in Arizona with long-term care.

Ms. FEDER. Arizona is an exception in which there is some experience, but we could talk more about that. In general, I think that what the States have wanted to do is apply managed care to the women and children portion of their programs, which as we saw is only 30 percent of the spending. So if we save 15 percent on 30 percent, we are talking about——

Mr. SHAYS. When you talk percent on percent, my mind tends to wander.

Ms. FEDER. We are talking about managed care generating savings of, at maximum, 15 percent of expenditures. We are going to apply where now we have experience and can generate savings and can actually make a managed care system, design a system to do it, we are talking about taking 15 percent of only 30 percent of the program's spending.

Mr. SHAYS. You make an assumption that I do not agree with. That is it is a one-shot savings.

Ms. FEDER. I am reporting to you what the literature and the evidence tell us.

Mr. SHAYS. Well, would you agree that some literature says one thing and some says another? If we cannot agree on that, we have a problem.

Ms. FEDER. The literature has said that historically and in the last couple of years, that we have seen a more aggressive negotiating with providers and discounting that might be sustainable to some greater extent over time.

Mr. SHAYS. Thank you.

Ms. FEDER. What I am pointing out is that we do not have experience with managed care for the population with disabilities, nor with the elderly population, or on long-term care, virtually none—not none, you are quite right, but very little.

Mr. SHAYS. This committee that I have been on for a good number of years oversees HCFA for waste, fraud and abuse. I was elected thinking that the Federal Government would do it better than the States, and I have evolved to realizing that it does not do it better than States. It does it worse. I have a gigantic question mark when I look at Medicaid and Medicare; I see extraordinary waste in the program, extraordinary waste.

So I have a level of confidence that a system that the private sector gets more involved in, has a financial incentive to be involved in and realize a benefit by trying to get at the waste, fraud and abuse, that there is a lot in the system to squeeze out that is simply not cost savings but is efficiencies.

If that is not true, God help our country, because we cannot continue to have growth rates of 10 or 12 percent a year. We just simply cannot. It is not sustainable. And my conversations with Leon Panetta and others, when he was in Congress was saying we have to find a way to slow the growth of entitlements.

Do either of you gentlemen have a comment?

Mr. BEACH. If I could say something about the drift of the conversation, it seems to assume on both parts that there is a population that will just continue to grow that is eligible. Let us assume you do not add new wrinkles or new beneficiaries to that population; what makes that sort of a difficult assumption for me to swallow is that if there are certain policy changes at the Federal

level and certain international changes that will alter the economy, that population could very well shrink. And so I think that the conversation has to be tied to this other dimension, if today is where the conversation is going forward.

Mr. SHAYS. I would like to deal with that issue because—but it was the point that you had triggered when I began to talk about population growth versus the increased cost of a program, I mean the inflated cost, the inflation cost.

Mr. BEACH. Perhaps one of the reasons we had a number of groups added—Professor Feder could answer this—in the 1980's is we had fairly substantial growth in some parts of our country economically.

Mr. SHAYS. One thing we probably agree on is that the elderly are going to get older and therefore be in nursing homes.

Mr. BEACH. Not necessarily.

Mr. SHAYS. Let us agree on this point though; I realize there are exceptions. It seems to me your point is more focused on the poor population, the nonworking poor, more than the nursing home population which is the elderly. Unless you are saying that the elderly are going to have more money, so they are not going to go on Medicaid as soon.

Mr. BEACH. Perhaps that is one part of it. The other part of it is—let me just add one other wrinkle.

Mr. SHAYS. I want to get to this. I want all three of you panelists to respond. You can make your point.

Mr. BEACH. I will listen to you.

Mr. SHAYS. Let us just deal with this issue. Your point is that if we can get the economy to generate more economic activity, that we would affect the population. But all I am asking is, would you basically acknowledge that the population you are most affecting would be really the 72 percent of the population that grabs about a third of the cost?

Mr. BEACH. That is very reasonable.

Mr. DEARBORN. One thing I think is somewhat comparable. If you look at SSI versus AFDC, SSI with the blind, disabled and the aged, the Federal program, people that become eligible for that program, as far as I know, virtually never fall off the program. Only more come in, none ever leave. The AFDC tends to be up and down, and we hope go down perhaps.

I think there is a comparable situation with Medicaid. Those elderly who are now in nursing homes, elderly poor who are now receiving Medicaid, are probably always going to be in that situation, and to a great extent the disabled will fall into that, too. So that there is one group that will only get larger, that will not decrease.

It is the women and children part of Medicaid that can fluctuate, and it seems to me that that makes a considerable difference as the Federal Government and State governments look at this program.

Mr. SHAYS. We have Governors and some legislatures, but a good number of Governors, who are eager to take on this challenge as a block grant. What is your best take or worse take on their, for example, eagerness to do it, Ms. Feder? Then I will ask the others.

Why do I have so many Governors saying we cannot stand this program? You had Governor Weld basically—you had more than Governor Weld, you had President Clinton—say we need to get a

handle on the Medicaid mandates; otherwise some of us are going to go broke. Accelerated costs of Medicaid, Medicare and other health programs argue for a new look at health care financing options.

Then you have Governor Weld, just basically: Release us from Federal nonsense. So he says: In Washington Democrats characterize our enthusiasm for block grants as naivete or worse, a perverse desire to begin some race to the basement. They miss the point entirely. If the Federal Government would just release us from its bureaucracy and nonsense, we would make these programs better for those they serve and would do it for less money.

Then he basically says: It is time for President Clinton to allow the States to give it our best shot. We could not do worse than Washington. I know we would do much better, much better.

What is your worst or best take on why the States want to do it?

Ms. FEDER. Well, as you said we should be candid, and I think that in all candor——

Mr. SHAYS. Haven't you been candid?

Ms. FEDER. Totally, and I will continue to be.

Mr. SHAYS. You may not be right, but you are never in doubt? That was said to me one time, so I just had to say it to someone else.

Ms. FEDER. I took it in good spirit, I think.

Mr. SHAYS. I figured, since you had such a good sense of humor, I could get away with it.

Ms. FEDER. I think that we have a lot of statements by a lot of political actors in the current debate that reflect a number of varied objectives.

Mr. SHAYS. Fair enough.

Ms. FEDER. I think that if we are looking at the problems that States are likely to face, and now face, States are looking for flexibility. I really think it is important to keep reiterating that on the flexibility in delivery and payment side there is agreement, and in terms of the desire to slow the growth, the rate of growth in the Medicaid as well as the Medicare program, there is agreement. The question is whether that is going to be done in a way that protects the coverage of the population.

Mr. SHAYS. Gentlemen?

By the way, I will ask a few more questions and then we will end this hearing.

Mr. DEARBORN. Mr. Chairman, I think there is no doubt States are concerned about the growth that has occurred in Medicaid and, as you said, the only question is how best to go about curbing that growth.

Mr. BEACH. If I could share one personal experience, I used to work for John Ashcroft when he was Governor of the State of Missouri, was on his budget and planning staff. Well before it became a Federal issue of note, Governor Ashcroft was closing nursing homes right and left across the State, largely because they were abusing elderly people. He took this as a personal thing and, as you know, he is a very devout fellow. It was politically very important to him as well within the State.

So I think, in part, some of our Governors are interested in doing this because they want to show that they can do it. It is an issue that the public has before them and they want to demonstrate their ability to do this. But also we just found a lot of ways within the State government in which we could cut costs if we were not required to do things a certain way or report a certain way. And it was continual frustration, a maddening frustration as we ran up against budget constraints, that we were not enabled, we were not capable of doing those things. So there is a whole inventory of items that Governors, particularly their long-serving and -suffering staffs, know that they can do if they could only do it.

Mr. SHAYS. Mr. Cuomo is reported saying in the New York Times a few months ago, he said: When we had the chance to fix the system, we did not take advantage of it.

Now it is, I think he might have used the word "destroy."

I would not agree with all of that, but it is interesting to me that we are finally wrestling with this issue which I think has just been kind of there for a long time, calling out for addressing.

It is kind of sad in one sense that it has taken us so long to get to this point where we are at. I am struck by one point. In my own mind, I hope we go all the way. If we go 70 percent of the way or even 50 percent of the way, it will be a significant progress. To me as I look at it, why not go the full distance?

This has been a very interesting discussion. You have added a lot to my knowledge. You have made my day by at least acknowledging that a cut in the growth is still an increase. The record will be open for 3, for a period of time, 3 days, for any submission of anything you would like to add, anything that our colleagues on the other side of the aisle would like to add. I am going to submit for the record a number of letters from Governors who are eager to get into this program and hope that we get rid of the red tape.

[The information referred to follows:]

Letters from Governors

Tommy G. Thompson, Wisconsin	John Engler, Michigan
Michael O. Leavitt, Utah	George V. Voinovich, Ohio
Terry E. Branstad, Iowa	George E. Pataki, New York
William F. Weld, Massachusetts	David M. Beasely, South Carolina
Kirk Fordice, Mississippi	Bill Graves, Kansas
Fife Symington, Arizona	Edward T. Schafer, North Dakota
Marc Racicot, Montana	Gary E. Johnson, New Mexico

are available in subcommittee files.

Mr. SHAYS. I would allow each of you to make a closing comment if you would like.

Mr. BEACH. I just would, in 10 seconds, like to say that the growth of this program and its related Medicare program is a constraint on economic growth, and anything we can do to make this a better program that is less costly will aid the economy, which of course aids the targeted groups.

Mr. DEARBORN. Mr. Chairman, at the very least, I hope that the repeal of the Boren amendment would come out of this.

Mr. SHAYS. I think you have got a commitment on that. We just have to make sure its ghost does not still stay there.

Ms. FEDER. And, Mr. Shays, I would just like to be sure that the entitlement to insurance coverage for vulnerable populations comes out of this process.

Mr. SHAYS. I get the last word. I will tell you that with all my heart and soul, I believe the States are going to be as responsible, if not more responsible and responsive to the population that you and I both care deeply about, all of us do.

I thank you for coming.

I would like to thank Kate Hickey on my staff and others on my staff; also the recorders that have been here diligently and have done their job, as they always do, extraordinarily well. I thank you all very much.

The hearing is now adjourned.

[Whereupon, at 3:44 p.m., the hearing was adjourned.]

[Note.—The following attachments can be found in subcommittee files: Attachment 1, Medicaid budget charts; Attachment 2, Advisory Commission on Intergovernmental Relations (ACIR) draft report on Federal mandates; Attachment 3, National Governors Association (NGA) July 17, 1995 briefing paper; Attachment 4, Governor William Weld's December 11, 1995 Wall Street Journal article; Attachment 5, Congressional Quarterly (CQ) April 15, 1995 article on the Unfunded Mandates Act of 1995 (P.L. 104–4); and Attachment 6, Time Magazine December 18, 1995 article on Medicaid reform, "A Tale of Two States."]