S. HRG. 109–234

THE FUTURE OF MEDICAID: STRATEGIES FOR STRENGTHENING AMERICAN'S VITAL SAFETY NET

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

JUNE 15, 2005

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

25–121—PDF WASHINGTON : 2005

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON FINANCE

CHARLES E. GRASSLEY, Iowa, *Chairman*

ORRIN G. HATCH, Utah
TRENT LOTT, Mississippi
OLYMPIA J. SNOWE, Maine
JON KYL, Arizona
CRAIG THOMAS, Wyoming
RICK SANTORUM, Pennsylvania
BILL FRIST, Tennessee
GORDON SMITH, Oregon
JIM BUNNING, Kentucky
MIKE CRAPO, Idaho

MAX BAUCUS, Montana
JOHN D. ROCKEFELLER IV, West Virginia
KENT CONRAD, North Dakota
JAMES M. JEFFORDS (I), Vermont
JEFF BINGAMAN, New Mexico
JOHN F. KERRY, Massachusetts
BLANCHE L. LINCOLN, Arkansas
RON WYDEN, Oregon
CHARLES E. SCHUMER, New York

KOLAN DAVIS, *Staff Director and Chief Counsel*
RUSSELL SULLIVAN, *Democratic Staff Director*

CONTENTS

OPENING STATEMENTS

WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

THE FUTURE OF MEDICAID: STRATEGIES FOR STRENGTHENING AMERICAN'S VITAL SAFETY NET

WEDNESDAY, JUNE 15, 2005

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:59 a.m., in room SD–628, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Present: Senators Hatch, Snowe, Thomas, Smith, Crapo, Baucus, Rockefeller, Kerry, Lincoln, Wyden, and Schumer.

Also present: Mark Hayes, Rodney Whitlock, Susan Jenkins, Pat Bousliman, and Alice Weiss.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. I know you are all shocked that we are starting on time, or even a little bit early. But our governors have to be to the other body at a certain time, and we have a vote coming up at 10 o'clock.

I am hoping that Senator Baucus is voting, and then he will come back and run the committee, and then I will go over and vote and will be back then so we can keep the meeting going to accommodate the governors.

Welcome to our hearing on the future of Medicaid, Governors, and also anybody in the audience, in which we hope to examine, and will examine, ways to strengthen the Nation's health care safety net.

First, I would welcome our witnesses and thank them for joining us today, and particularly already at the table, Governor Huckabee and Governor Warner, for being with us today.

While Medicaid is a program financed jointly by State and Federal dollars, the States have the principal responsibility for running this very important program. It is for this reason that the bipartisan proposals of the Nation's governors are of such importance, and it is these proposals that are going to be the focus for today's hearing.

We are here today to begin a process of strengthening Medicaid. We are at a very important juncture with Medicaid, and we need to take decisive action to protect this vital safety net for the people who need it.

Medicaid has overtaken Medicare as the largest health care program, and it is rapidly growing as a share of State budgets, doubling since 1990, while education spending has remained about flat.

States like Missouri, Tennessee, California, Mississippi, and even my own State of Iowa are struggling with these growing costs. Between 1998 and 2003, combined Federal and State spending on Medicaid grew by more than 55 percent.

When you take into account CBO's forecast for the next 10 years, combining Medicaid spending from 1998 through 2015, it will grow by more than 275 percent. Spending in the year 2015 will be almost triple what it was in 1998. Many States have already had to take drastic measures to address these growing fiscal pressures.

With bipartisan voice, our Nation's governors have placed Medicaid on the forefront of their agenda. We have been hearing from the Nation's governors, both Republican and Democrat, since the beginning of this year.

Their message has been clear. If we do not work together to control the growth of Medicaid spending right now, these growing fiscal pressures will force States to take even more far-reaching steps to control expenditures.

My hope is that, today, we begin the process of finding common ground to make good decisions for Medicaid's beneficiaries and the program's financial future. It can be done if we work together. The causes are complex. More people are accessing Medicaid services.

Health care is becoming more expensive. We need to do more to more carefully scrutinize how we pay, and how much we pay, for these services. We need to examine whether or not we are paying too much for prescription drugs.

Any ideas we consider should not jeopardize the coverage of optional beneficiaries just because they are optional rather than mandatory. I think we can come up with policies that improve Medicaid's fiscal health without jeopardizing that coverage, and, in fact, we will.

To my friends who do not want us to find any savings in Medicaid, I hope they reconsider their position. If we do not find ways to relieve some financial pressures the States are facing, we end up jeopardizing the coverage of very needy people that we seek to protect.

If the States do not get relief, they are going to have to make some difficult decisions to keep their schools funded and their budgets balanced, decisions that will jeopardize the coverage of current Medicaid beneficiaries. I believe that is why the governors have united to tackle this difficult issue, as I think we will hear today in their testimony.

Ladies and gentlemen, we have a responsibility to be good stewards of the Medicaid program. We need to spend the next few days making good decisions about how to preserve and strengthen the Medicaid program for the people who truly need it.

Senator Lincoln would like to introduce her governor.

Senator LINCOLN. Mr. Chairman, thank you. I would like to let you know that the staff has noted that this is the first time I think I have been on time, so I am on a roll, between yesterday and today.

The CHAIRMAN. It is a good thing I started running; I have a strong heart. [Laughter.]

Senator LINCOLN. Well, thank you, Mr. Chairman. This is such a vitally important hearing we have today. We are very proud to have you gentlemen with us, Governors, to really talk about the partnership that we need to build in making sure that we do make Medicaid both efficient and effective, and making sure that we are getting the best bang for our dollar there. I think you all have certainly gotten off to a great start in some of the suggestions you have that you will be presenting to us today.

But it is certainly my privilege to be here today to introduce our governor, Governor Mike Huckabee, from my own State of Arkansas, who is testifying on behalf of the National Governors Association, along with Governor Warner, who also represents me a little bit, actually. For the time I spend here in Washington, we stay out in North Arlington and am certainly proud of that as well, Governor Warner.

But, Governor Huckabee, I am so appreciative to you for being with us today to discuss Medicaid. It is a program that provides health care and long-term care to people who would otherwise go without those services, and it truly is our Nation's safety net for health care and long-term care.

I think you know, as we have discussed many times, as well as I do, how important Medicaid is to our Nation, and especially to our home in Arkansas, where 1 in 5 people receive Medicaid, more than half of the births are financed by Medicaid, and close to 80 percent of nursing home residents are paid for by Medicaid in the State of Arkansas.

I applaud your efforts as an advocate for Medicaid, most recently in your strong stance against budget cuts to the program. You and I both believe that budget cuts should not be made on the backs of our Nation's most vulnerable: poor, children, pregnant women, parents, the elderly, and individuals with disabilities. The place to look at that is to go through these types of thoughtful processes and figure out ways that we can make Medicaid more efficient.

I hope that we can build on the common ground today and in the future. I am looking forward to getting more information about how NGA's proposal will impact rural Americans who are truly difficult to serve, and women who make up the majority of the Medicaid population. Those are two focuses here in Congress that I often focus on, and I am appreciative to have such thoughtful folks working on this proposal as you two governors.

I am also incredibly concerned about the impacts some policy recommendations would have on those seniors and individuals with disabilities who depend on Medicaid for long-term care, people who would otherwise not be served by private insurance because they are too poor or too sick.

Medicaid deserves a lot of attention and thoughtful consideration, and I think the proposal that the governors have come together with has indicated just that. I believe it is critical that we look at this program through the eyes of the 58 million Americans who really, really depend on it.

Governor Huckabee, we are proud of you, proud of not only the hard work you have put in with the Governors Association, but the

great example that you set nationwide for overall health, and your attention to it. You have certainly taken a personal attack on that, and we are very proud of that, but you cannot lose any more weight.

Governor HUCKABEE. All right.

Senator LINCOLN. We look forward to working together, because we do know that one thing is for sure, and that is, this is an important enough issue, it is also a challenging enough issue, that none of us can do it by ourselves. We are grateful to both of you for working together, and being willing to work with us to preserve and to improve this very, very vital program.

Governor Huckabee, we in Arkansas are very proud that you are here. We are glad that you have joined us today. We are proud of the accomplishments that you have made on behalf of our State and the millions of people there that you represent. Most importantly, we look forward to a good working relationship with the Governors Association where we can really come up with the kind of solutions we need for our Nation.

So, welcome, Governors, to both of you, and a special thanks to Governor Huckabee. We are proud of you. Thanks for being here.

The CHAIRMAN. Besides being the Chief Executive Officers of their two States, Virginia and Arkansas, we have the privilege of having the Chairman of the National Governors Association and the Vice Chairman of the National Governors Association, respectfully, Governor Warner and Governor Huckabee.

Today, their association is releasing a preliminary policy paper outlining bipartisan recommendations for the Medicaid program, so we are very pleased to have you with us here today to share the Governors Association proposal on Medicaid changes. Thank you both for being here.

I assume that you start out, Governor Warner.

STATEMENT OF HON. MARK WARNER, GOVERNOR, COMMONWEALTH OF VIRGINIA, RICHMOND, VA

Governor WARNER. I do. Thank you, Mr. Chairman. I want to thank you on behalf of all the Nation's governors for allowing us to appear before this distinguished panel today.

As the Nation's governors, we are very proud of the product that we are laying before you today and appreciate the chance to be brought into this debate.

I would add at the outset that what we released this morning is a document that has had the active involvement of more than 35 governors or their Medicaid directors. We have not had a single governor opt out of the proposals that we are outlining.

So, as the Nation's governors, we have come together. We are the folks who are responsible, day in and day out, for, as Senator Lincoln indicated, providing health care to some of our Nation's most needy and providing, in total, the largest health insurance plan in the Nation.

I want to also commend my Vice Chair, Mike Huckabee, who has been a great partner in this whole effort. We are proud of the fact that we have maintained this bipartisan spirit in the document that we are laying out for you.

Today's work, though, is simply the beginning of this process and should not be viewed as a final product. We look forward to working with you and the administration as we work towards a meaningful reform of the Medicaid issue.

Now, as governor, Medicaid and health care-related issues take about as much time as any subject that I am faced with. I simply, as a starting point, want to say that I was involved in this issue long before I became governor.

I remember back in the early 1990s when I was a private citizen. I helped form something called the Virginia Health Care Foundation, which was going to take on the problems of the uninsured in Virginia. Back in 1992, we had a million uninsured.

Well, we have had one of the most successful public/private health care foundations in the Nation. We helped 600,000 Virginians get health care. That is the good news. The bad news is, in 2005, we have still got a million uninsured Virginians.

So, how we deal with Medicaid in relationship to the uninsured, and recognizing that Medicaid is not some island in our health care system, is terribly important.

In addition, one of the things I am proudest of in Virginia is, as governor, we have taken Virginia from really the bottom in the States in terms of signing up children for both our Medicaid and SCHIP program. In rural Virginia, we are literally close to the top. We now have signed up over 128,000 kids.

We have 96 percent of our eligible children signed up for either the Medicaid or SCHIP program, again, one of the most meaningfully effective components of this terribly important health care issue.

Before we start with the specifics, though, I want to again reinforce a couple of the things that the Chairman and Senator Lincoln have already indicated.

Governors start each budget cycle with a debate on Medicaid. The Medicaid reforecast now, in terms of setting your budget terms, becomes even more of a driving force than your education reforecast.

In Virginia, for example, in 1990, Medicaid was a $1 billion program. By the end of this current budget cycle in Virginia, it will be a $5 billion program.

Now, I would feel much better about the growth in this program if we had achieved better coverage, improved payments to providers, or a series of expanded services. But, unfortunately, even though we have seen a dramatic increase in costs, we have not seen a dramatic increase in the quality of service.

Like a series of bipartisan governors, I am interested in Medicaid reform because Medicaid, as it is currently situated, is simply not sustainable for the States over the long term.

Strictly speaking for myself, not as an NGA representative, I believe solving the Medicaid crisis ought to be first and foremost in terms of addressing entitlement reform at the Federal level.

But let me be clear: Medicaid reform should be policy-driven and not budget-driven. It should be considered, and must be considered, in the overall context of health care reform.

Let me also make clear at the outset that governors have not changed their time-honored position that we oppose block grants or

caps that are simply tools to shift further responsibility down to the States.

But we welcome Federal policies that have achieved greater efficiency that provide us, in effect, as I think my colleague will say in a few minutes—we as CEOs of the largest insurance programs in our State—some additional flexibility, and can help us provide both greater savings and what we hope will be greater expansion of coverage.

Mr. Chairman, I indicated, overall in our Nation, Medicaid budgets now make up 22 percent of State spending. In aggregate, they total more State spending than K–12. We have literally created a situation where we are pitting the needs of grandma against the needs of the grandkids.

Now, three factors are driving Medicaid growth. First, as we all know, the Medicaid program is increasingly serving low-income, frail seniors and people with serious mental and physical disabilities who, while they represent only about 25 percent of the Medicaid population, account for more than 70 percent of the Medicaid budget. Those who are dually eligible for both Medicare and Medicaid account for 42 percent of Medicaid spending.

This has been one of those cost shifts that has taken place over the years; as what was originally laid out to be a Federal responsibility, some of these costs have shifted down to the State.

Second, the caseload has increased about 40 percent over the last 4 years. Now, some of this has been because States have successfully, I think, done the right thing in stepping up signing up kids for their SCHIP programs.

But we are also seeing other cost shifts taking place as more and more employers, through either economic reasons or otherwise, are no longer providing health care to their employees, and oftentimes even encouraging these employees to go upon the Medicaid rolls.

Third, again, as has been already noted, the Consumer Price Index for health care has been increasing 2 to 3 times the average price index. Medicaid, like all insurers, has been faced with rising costs.

One of the things that we have tried to do in this paper, and while this paper is the first step as you go through these budget deliberations between now and Labor Day and early fall, we recognize that Medicaid reform cannot be that island. It has to be combined with other health care reform.

I want to touch on a couple of the subjects that we hope will be included in your deliberations. Our non-Medicaid recommendations have three goals. First, to increase quality in health outcomes by better utilizing modern technology in our health care system.

I think, as somebody who has spent a career in the technology field, the fact that we really have not brought the power of IT to health care should be an embarrassment. The fact that we still do not have electronic medical records beyond pilot programs is something we need to move beyond.

Second, we need to develop alternative and more effective policy tools that would assist individuals and employers to obtain and maintain private health insurance as opposed to these individuals falling onto the Medicaid rolls.

Third, to improve financing and delivery of long-term care by developing incentives for quality, private, long-term care insurance products: community-based care, innovative chronic care management, and alternative financing approaches.

Now, governors recommend a Federal refundable health care tax credit for individuals, as well as employer tax credits for small employers. Now, again, these are issues where the devil is in the details, but we hope to be able to get into some of that. These are also recommendations to help create more competition in the health care marketplace.

Our paper also includes a number of recommendations promoting the purchase of long-term health care insurance, again, through the use of Federal tax deductions and credits, as well as expanding long-term care partnership legislation, a partnership that is now only existing in four States. Long-term Medicaid cannot remain the majority payor for long-term care in this country.

Finally, there are recommendations to improve the quality of home- and community-based care options, something where, over the long haul, we must put much, much more attention.

Now, Mr. Chairman, let me again thank you for the opportunity to appear before you today.

I am going to now turn it over to my colleague, Mike Huckabee, who will take you through some of the specific Medicaid reform options we have laid out.

The CHAIRMAN. Could I announce to the committee members, Senator Baucus, I believe, if the vote has started, is going to vote and he is going to come over and chair this so we can keep the meeting going. They have to be over to the House side by 11 o'clock.

Senator Huckabee? Or, Governor Huckabee?

STATEMENT OF HON. MIKE HUCKABEE, GOVERNOR, STATE OF ARKANSAS, LITTLE ROCK, AR

Governor HUCKABEE. I was getting a promotion and did not even realize it. Thank you, sir.

The CHAIRMAN. It is quite an honor to have a governor tell us that they might get a promotion in the Senate.

Governor HUCKABEE. That is because I am appearing before you, sir. [Laughter.] That is called "kissing up" in any State, I can assure you. [Laughter.]

Mr. Chairman, I am deeply grateful for the opportunity to join my colleague, Governor Warner. I also realize Senator Lincoln had to step aside to take a vote, but I do want to say how much I appreciate her very kind, gracious introduction.

But, more importantly, I appreciate her as a Senator from our State. She has been an exemplary Senator and has served us very honorably, and has also been a real champion for some of the issues that we are going to be talking about here today. That is, how can we best protect the children and the families of our States.

I want to assure you that the governors approach Medicaid reform not with the idea that we are trying to get out from under the responsibility of making sure that we provide the best, most efficient, and effective coverage to the families that we are there to

serve. We are looking for ways to improve that service, and to do it in a way that does not break either the Federal budget or ours.

Quite frankly, the Medicaid program needs a new look. Next month, on July 30th, the Medicaid program will celebrate its 40th birthday. When you look back to 1965, the number-one song on the billboard charts was "Help" by the Beatles. Perhaps we could say that that song would be appropriate today. We need some help.

The cost of a new Chevrolet was $2,350, gasoline was 24 cents a gallon, a loaf of bread was 21 cents. The best movie in 1965 was "The Sound of Music." The top three television shows were "I Love Lucy," "Hazel," and "My Three Sons."

Clearly, the world has changed from those days. There are some people in this room who do not have a clue of what I have just spoken about because they have never heard of those television shows, except for the remakes of the movies.

What I would say today is, we are coming today, realizing that Medicaid is, in essence, a 45-rpm program in an MP–3 world, and it is time for us to take a fresh look at it, not so that we can undo it, but so that we can better do it.

Today, Governor Warner and I represent not simply a consensus of a few governors who begrudgingly bring some proposals, nor do we represent a deeply divided group of governors who have split ideologically, politically, or even geographically. What we do represent today is somewhat unique in politics. We represent governors who have completely united behind the proposals that we present to you.

In fact, over the past few months, the tedious and often very delicate discussions in which we have engaged to bring these proposals have happened in such a manner that it was difficult to tell who were the Republicans and who were the Democrats in the discussion.

We have not presented to you today the things that we have not yet agreed on. There may be questions that will be raised about issues that we are not proposing, for the simple reason that they are issues that we have not quite come to terms on.

But today we are presenting issues that we have come to agreement on in complete, unanimous spirit. We hope that, with the kind of effort that we have put forth, that those of you here in the U.S. Senate will give us an opportunity to test these ideas, to put them into motion, not for the sake of saving money, but for the sake of better serving and saving families that we care about, just as you do.

Governor Warner has spoken specifically about the broad overview of what we seek to do. What I would like to do is to mention seven of the specific proposals that we have before you. I think your staff is aware of some of the greater details that we have in a more thorough document, but let me touch upon those, if I may.

The first one is in the area of prescription drug improvements. Currently, we have a system that leaves very little transparency and a whole lot of capacity for us to make it extremely difficult to get the best price so that people can get the best prescription drug. There is a very convoluted formula that deals with what is commonly revered to as "average wholesale price."

We would agree with the General Accounting Office that says that the pricing structure is neither average, nor wholesale. It is a convoluted structure that includes the figures of the acquired cost, plus the dispensing fee, minus a rebate, and somehow through this very cloudy process, our Medicaid budgets are strained.

Even in our own State, even though Medicaid itself is going to grow at 11.5 percent this year, the prescription drug component will grow at almost 20 percent this year. We realize prescription drugs are often a way to keep people from the hospital and to live a better quality of life, but we would ask for the tools to manage our prescription drug program in the same way that any CEO running a program would wish to manage his prescription drug program.

The fact is, every governor operates the largest insurance program in his or her State, larger than any private sector insurance program. Six hundred thousand Arkansans out of 2.6 million currently receive Medicaid benefits, and the cost since I have become governor in July of 1996 has risen from some $600 million to over $3 billion. We look for ways to make the system more transparent.

A second proposal is in changes in the asset policy. There is a growing problem, in that many people are creative enough to be able to divest themselves of assets and wealth in order to more rapidly access Medicaid benefits in the long-term care area. We would like to close those loopholes to make it so that the people who are really needy are really getting the services they need.

A third area is modifying the cost-sharing rules. While this may be touchy to many people, this is another area where, remarkably, Democrats and Republicans have come to an agreement, realizing that every person receiving a benefit will receive a better benefit and a more responsible benefit when he or she has some skin in the game.

Our own experiments in various State plans, particularly with children's health policies, find that not only are the recipients more grateful and willing to have a small co-pay for the pride and the opportunity to participate, but it gives us the management tools necessary so that we can help make sure that utilization is responsible, but at the same time, that coverage is guaranteed.

A fourth area is creating benefit package flexibility. If there is one message that we could bring to the Senate today, it would be this: Medicaid is not a program. Medicaid is 50 programs. It is unique to each State.

Every State has its own State plan, and, therefore, making Medicaid proposals is a most difficult type of enterprise, for the simple reason that, any time you put something on the table, we found that 15 governors loved it, 15 governors hated it, 15 governors did not care, 5 probably did not open up for discussion.

The reason is because every Medicaid State plan is uniquely different to that State population and to what has evolved over the past 40 years. That is one of the reasons that reform is so difficult, and yet it is also one of the reasons that we bring to you today proposals in which we have so much confidence.

A fifth area is developing comprehensive waiver reform. Waivers are very difficult at times. They can become tedious, and the process itself can become laborious.

What we would like to do is to see that there would be portions of the Federal Medicaid statute that could be changed so that waivers would be able to be granted more efficiently and more expeditiously so that the kind of changes and reforms in the program could actually be carried out in the States.

A sixth, and perhaps if I would mention, a singular, most important reform, foundation to all of the others, is judicial reform. Congress and the Department of Health and Human Services need to authorize States to rightfully make some basic operating decisions about optional categories of the Medicaid program.

One of the problems we face is that, when we try to make improvements and extend coverage and bring real reforms to the process, we often are sued in Federal court and two things happen: HHS disappears and they simply leave us to stand on our own, even though the very permission and authority to do the things we have done have been granted by them, and the second thing that happens, we inevitably lose and incur more cost rather than less cost.

The seventh thing is to make some changes in Medicaid for the commonwealths and the territories. There is clearly an unfair disadvantage that is taking place with the commonwealths and territories, and many of those territories and commonwealths are now providing up to 80 percent of the coverage. They have far greater limitations. We would urgently request that their needs be looked at, because many of those areas are in a desperate situation.

Mr. Chairman, it looks like I have pretty well cleared the room except for you. [Laughter.] I am grateful for the opportunity, and we will be happy to respond to any questions.

Governor WARNER. That happens normally when Mike Huckabee speaks. [Laughter.]

Governor HUCKABEE. Thank you, Governor.

Senator WYDEN. Thank you, both. This is going to be something of a moveable feast, because we are going to have votes and Senators will be coming in.

But I, too, want to commend you both and get into the issue of pharmaceuticals with you, in particular. I think it is clear that that is one of the driving forces behind what Medicaid is facing, and I am convinced that Medicaid needs to be a more prudent purchaser here. I want to outline to you in particular my concern.

Of the 14 drugs that cost Medicaid the most in 2003, 9 of them were directly advertised to the consumer on television and in the popular media.

I do not think it is a coincidence that Nexium, the number-one advertised drug, and Prevacid, the number-two advertised drug, show up on that list of pharmaceuticals that Medicaid is buying.

So what this means is that Medicaid programs across the country are shoveling out huge sums for those television advertisements where colorful pills are dancing across our TV screen. For the life of me, I cannot figure out what the interest is in the Medicaid program in paying for those advertisements.

Now, Senator Sununu and I have introduced a bipartisan bill to change pharmaceutical reimbursement so that Medicaid does not pay these huge sums for direct-to-consumer advertising.

I would be interested in your thoughts, Governor Warner and Governor Huckabee. This is an area, it seems to me, where you can save substantial sums without hurting people and simply by making the Medicaid program a more prudent purchaser.

Now, when it comes to advertising, I think it is fine to say it is going to go forward in the private sector. It is a first amendment right. I am not interested in censorship. But why should Medicaid be paying for those television advertisements?

I would like both of your views. I know you do not know the specifics of the legislation I have with Senator Sununu, but conceptually, would that be the kind of thing, on a bipartisan basis, that governors would be supportive of?

Governor WARNER. Well, Senator Wyden, at first blush, that makes some sense. I mean, obviously, how you would sort out, if you could get to the level of scrutiny from the pharmaceutical companies on how much they spend on advertising versus R&D versus production, it would help us get to the transparency, I think, that Governor Huckabee talked about.

So at first blush, I think I would be very interested in seeing legislation and finding ways. Again, I think you made the point, if there are ways we can make savings that do not restrict Medicaid's ability to receive the drugs they need, that could be a win on both sides.

Senator WYDEN. I think, Governor, just for a little bit more detail—and again, all you know is the concept. As you know, the Medicaid program gets a rebate under the process for negotiating pharmaceutical prices. What Senator Sununu and I would see is, in effect, giving you the opportunity to negotiate a deeper rebate, a more extensive rebate, so as to reduce the premium you pay in Medicaid for pharmaceutical ads.

Governor HUCKABEE. Senator, this points up two concerns of ours that we just mentioned in laying out some reforms, one of which is the prescription drug price, the other is the judicial issue. In our State, we attempted to put some controls on what we were paying for prescription drugs.

We pay more than twice the next payor, which is Blue Cross/Blue Shield, in our State, as it turns out. So we are, 2 to 1, the largest purchaser of prescription drugs, and naturally the cost of those drugs is of great concern to us.

We would like the ability not only to have a better handle on the cost, but also on the selection. We put into motion, thinking we had the authority as a State, plans that would have demanded the best price equal to the price given to the next customer. We were sued in Federal court and we lost. The court said that we could not ask for the best price.

It is those kind of issues that have really brought Democrats and Republicans together in the governor ranks, and I think that we would be very interested in any proposal that you could present that would help us to get to those areas of great concern, of greater transparency in how much the drugs really cost, and how much we really should be paying.

Since we are serving the neediest populations in our State, we want to pay a fair market value, but we do not want to pay an unfair market value. We are willing to pay what will help to provide

additional research and development, and even for some responsible advertising.

But because the drugs that we are purchasing through the Medicaid program are going to the most vulnerable citizens in our State, because it is the taxpayer money that is covering it, we do feel like we need greater levels of ability to manage those funds and to have the ability to negotiate for best price, something we currently do not have the authority to do.

Senator WYDEN. Governor Warner?

Governor WARNER. Senator, I would just like to add as well, you mentioned the Medicaid rebate. I mean, having that flexibility to negotiate a deeper Medicaid rebate or receive a deeper Medicaid rebate, even the President's earlier proposals, when he, I think, early in his administration proposed moving the Medicaid rebate from 15.1 percent to 20 percent, we are in excess of a couple of billion dollars worth of savings. So if there was a way to tie that partially to advertising, I think there could be significant dollars.

I mean, also, as long as we are talking drug pricing here, one of the things we have shared is that if you look at drug pricing, some of the initial proposals seem like they put a disproportionate burden on the pharmacists themselves.

Some of this burden ought to be shared between pharmacists, big pharmaceuticals, even finding some ways to continue to encourage generics, but also have some savings there.

One thing the governors also raise in their report, while we are looking forward with some anticipation and trepidation to the Medicaid drug benefit, we are concerned that, as this Federal drug benefit is put into place, that States that have negotiated better prices may, through the clawback provision, actually end up on the losing side.

I can tell you, in our State, having the 2003, in effect, cut number as your starting point, we put in place, with some of the drugs you have actually mentioned, a much more aggressive PDL. After that fact, we get none of the benefit for that with the new Medicaid drug benefit, as it is currently constituted.

Senator WYDEN. Let me ask about one other area, then recognize my friend from Oregon, who, as you know, has done so much good work in terms of trying to preserve the funds that are essential to assisting low-income people.

With respect to long-term care, going back to the days when I was director of the Gray Panthers, we were constantly fighting a battle to make it easier to shift Medicaid dollars that were essentially designated for care in institutions into the home and community-based care kind of area, where, in effect, you get a two-for.

You get more of what older people want, which is to be home and in the community at a cheaper price to the taxpayer. We have been trying to bring CMS and the administration, in effect, kicking and screaming, to streamline that process to make it easier.

Mark McClellan, whom I like and admire, is always telling us, it is coming soon. It is kind of like the marquee at the old movie house where it says "Coming Soon," and it just kind of never sort of gets to you.

What suggestions do the governors have with respect to this huge area of cost where, if we could just get a little bit more flexi-

bility, we could start steering the dollars out of the institutional area, get them into the home care area, and give older people more of what they want at a cheaper price to the taxpayer? I would like to hear from either of you, then recognize colleagues who have been waiting.

Governor Warner?

Governor WARNER. Senator Wyden, a couple of specific suggestions. First, we think we need to change the mind-set in this country to encourage all-age folks to purchase long-term care insurance and have those long-term care insurance products that will also provide support for in-home care. We suggested, for example, the use of a Federal tax credit as one way to move forward in that direction.

Second, we do think that our current situation actually encourages some folks to perhaps use legal tools to disproportionately shift assets prior to going into a nursing home, which we are not sure how often it is done, but it is done. Sometimes that shift takes place because there are not viable in-home care options.

One of the things we have suggested in our paper is greater use, for example, of reverse mortgages, but a reverse mortgage that would still allow the individual to maintain some equity in their home so that they could pass that equity on to their children. We do understand the very real concern.

Somebody late in their life should not have to perhaps spend down their single last asset, which oftentimes is their home, and have nothing to pass on to their kids.

If we could retain some equity and use that reverse mortgage, again, as a tool to provide some investment in home care, I think you would get, not a silver bullet, but you actually do move forward on this issue of how we give a more viable option as opposed to the kind of nursing home or nothing option, or other long-term care or nothing option that we have right now.

Senator WYDEN. Governor Huckabee, did you want to add anything to that?

Governor HUCKABEE. Very briefly. The NGA's position is essentially what Governor Warner has mentioned, and that is kind of what we are limited to speak for on behalf of NGA.

There are certainly a lot of models in our States, including one that we pioneered along with Florida and Pennsylvania, with a grant from the Robert Wood Johnson Foundation, called Independent Choices, which did allow people to make a lot more of their own purchasing decisions for home health care.

We have data on that, some science behind it that shows that it is a dramatic improvement, giving people an option to have home care that delays the necessity of going into long-term care. So, there are some excellent tested models in the State, the very kind of experiments that we believe can be brought to the broader Medicaid program.

Senator WYDEN. As a novice chairman, I am told that Senator Lincoln comes next, and my apologies to Senator Smith.

Senator Lincoln?

Senator LINCOLN. Thank you. Did you need to get somewhere, Senator Smith? All right.

Thanks, again, gentlemen, for being here. We are very grateful for your knowledge, and certainly the hard work that you have already invested in how we can make Medicaid more effective and efficient.

I am very proud to hear us talking about long-term care. Senator Grassley and I just introduced a bill yesterday, as a matter of fact, on the issue of incentives for long-term care insurance, and making sure that we are doing our part to really encourage that.

The NGA's plan suggests requiring beneficiaries to pay higher co-payments as a way of saving money in Medicaid, and we certainly know that personal responsibility is an important part of everything that we want to encourage. Yet, several studies show that charging high co-payments to low-income people, particularly, results in people simply not getting the care they need, and that is a concern we have.

So, I guess my question really is, how do you propose raising co-payments for some Medicaid beneficiaries who may be able to pay just a bit more, while protecting those who truly cannot afford to pay more in out-of-pocket expenses, particularly those who take multiple drugs every month or who have chronic conditions?

Governor HUCKABEE. Senator Lincoln, this is a question I am glad was raised, because I think it is one of the more fundamental issues that will create some controversy here. But it is also one of the ones that the governors were able to come to a real, solid agreement on, I think, much to the surprise of many.

You were perhaps more familiar with this than any other Senator here because of the Our Kids First program and the tremendous success it has had. It has helped Arkansas become the national leader in reducing the number of uninsured kids, over 49 percent in the last 8 years. We have a proven track record of a program that was really a precedent to SCHIP, and put in place before there was an SCHIP.

What we learned from that program, was that a very reasonable, responsible, and modest co-pay did not cause people to shun the system. In fact, they accessed the system when they needed it.

What it did, however, was to give us some control of utilization where people did not go to the emergency room when a clinical visit would have done just as well. People did not go for extraordinary tests when a simple test would have done the job.

But, more importantly, it was not a cost containment issue, it was an issue in which people felt that they had some ownership. They had, actually, some pride in the fact that they were not being given something. They were able to walk in and out of that clinic with their heads held high, with their pride intact, for having participated.

What our proposal calls for is that there would never be more than a maximum 5 percent of a family's income ever expended, and we feel that making sure that there is a containment so you do not put an undue burden on an already struggling family is important.

But equally important is to make sure that we can extend the coverage as wide and far as possible. Currently, the biggest flaw in the Medicaid system is that it is like a cliff in which those who are currently covered have, amazingly, complete and comprehen-

sive coverages the likes of which the State employees in our State do not have.

What we would rather see is the flexibility so that we can have the management tools that every other insurer has in order to contain some cost, realizing that those who are mostly impoverished need very, very careful protections, but by doing that, actually being able to cover more people, to give at least some type of benefit, because there are so many people who have absolutely nothing under them.

The Our Kids First program with which you are familiar, which is operating as a waiver program with Medicaid, is proof positive that, rather than it having a chilling effect upon access, it has just the opposite, a responsible effect on people accessing care that they desperately need. So, we believe that is why you see the governors come to an agreement on this with some level of real enthusiasm.

Senator LINCOLN. There is somewhat of a ceiling on the amount as a percentage of the family income that can be spent there. The other thing I would hope is, because there are studies that do show us that charging some of those higher co-pays or payments can deter, that we would at least do the follow-up to make sure that that is not occurring and we are monitoring that.

Governor HUCKABEE. And Senator, we would want to make sure that we did the follow-up, and that is why we have done it extensively with our program. I think, also, the co-pays that we discussed are minimal, and even the expanded children's program, the maximum co-pay is a $10 co-pay.

That would be decided at each State level. It would simply give the States the opportunity to implement them. They would not be forced to, they would simply have the option. Some States may opt not to do them.

Governor WARNER. Senator, let me add as well, in Virginia, one of the things we did is we actually even lowered—in some cases eliminated—some of our co-pays in our SCHIP program, called Famous, when we moved from an under 50-percent sign-up rate to a 96-percent sign-up rate. We think it was morally the right thing to do, economically the right thing to do, to get these kids signed up.

But if we look at the overall system, the overall Medicaid co-pays have been set at a $1 to $3 level since the early 1980s.

Senator LINCOLN. Right.

Governor WARNER. We are thinking, some incremental increase, with the appropriate caps, particularly for the most needy, is appropriate. At the same time, there is great debate out there and speculation. We often hear the stories of, how often is that Medicaid recipient coming for the fourth or fifth time to the emergency room for the head cold? A lot of it, I do not think we know. I have seen some of the studies. There is great debate back and forth.

I mean, for example, in Virginia, we have a tool that we have used where we will not reimburse the hospital at an ER rate, we will reimburse the hospital at a doctor visit rate, if it is determined that it was inappropriate use of the ER.

We need more tools like that so we can only add, as my colleague said, that personal responsibility component, but also partially, I think, debunk part of the myth that there is great over-utilization by some of our poorest people.

Senator LINCOLN. Thanks, Mr. Chairman. I have some other questions and I will wait for the next round.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thanks very much, Senator.

First of all, I apologize to the governors for being late here. I, frankly, applaud what you are doing in many ways. First, the substance, trying to help us get a handle on this.

Second, coming before Congress, which frankly, I think, provides the Congress with an opportunity to reclaim responsibility that we have not exercised, namely, oversight over the Medicaid program, and in particular oversight over the 1115 waiver program. I do believe, frankly, that it has been abused.

The 1115s have been used in a way that Congress did not intend. I think there are a lot of good 1115 waivers, but I also think that Congress abdicated responsibility, and it is an opportunity now for Congress to step in, working with the administration, working with the governors, to make sure those waivers are appropriate.

Third, I think it is important for us in this body to reaffirm—and I know the governors agree with this—the safety net feature of Medicaid, because Medicaid is a safety net. That is why it was set up, that is what it is.

With all the innovative talk about flexibility, co-pays, and so on and so forth, it is important for us to keep in mind the main purpose of Medicaid, and that is a safety net for some of the less wealthy in our country.

In that regard, I would just be curious to know a little more of how you are going to protect people, with greater flexibility, to make sure they continue to have the mandatory benefits currently under Medicaid, whether it is hospitalization, for example, or nursing home care, immunizations, and other medically necessary services. You know the list.

Are those folks, with all this flexibility, who are currently getting those mandated benefits going to continue to get them? I suppose, under the law, we have to. So I am asking you, are you suggesting that we relax which benefits are mandated and which ones are not?

Governor HUCKABEE. We are not suggesting that, Senator. I am very happy to be able to say that that is not the proposal that we are bringing. It is not the intention of the governors to see how many people we can take away from access to medical care. It is exactly the opposite.

But the current system is unsustainable, because not giving us the management tools that are available to CEOs in the private sector means that we are going to be forced to spend money that may not be as efficiently spent as it would be on increasing reimbursement rates for hospitals, which in our State has not been changed since 1996 because we are operating under constrained budgets.

The issues that we do face are, give us the tools so we can better take the monies that are available, making sure that we cover those mandatory populations. But there are many optional programs that, while optional, we would like to be able to run so efficiently that we could make sure they are available in our States.

Senator BAUCUS. So if I understand you correctly, it is, maintain all the mandatory benefits. No change there.

Governor HUCKABEE. The only change would be in our capacity to have participant involvement with some level of co-pay on the part of the recipient, not necessarily, but it also would be a limited co-pay, which I have addressed to Senator Lincoln's question.

Senator BAUCUS. Where does Congress draw the line here? Maybe there is a more artful way of saying it. But this is a Federal program. It is shared with the States. Clearly, there is a joint oversight responsibility here. Where do you suggest that Congress draws the line in terms of how much flexibility to give to the States and how much not?

Is there a bright line here? Clearly, governors want as much flexibility as they can possibly get. Clearly, Congress has the responsibility to make sure—and I know the governors do not want this result—that nobody is getting hurt here and people are getting good services. So, how do we draw the line?

Governor WARNER. Well, Senator, one of the things we said at the outset, just to reinforce what has been our long-term position, is that we do not by any means favor moving Medicaid to block grants, we do not favor caps, we recognize there is a tremendous need. We administer these programs, but we also see we are getting hit with a triple whammy.

We are seeing cost shifts move from the Federal Government down to the States, whether it is the increasing cost of dual eligibles, which is one of these kind of transfers that I am not sure was ever formally blessed, but is taking place.

We see employers increasingly, for economic reasons and others, decide to no longer provide health insurance to their employees, and in some cases even encourage their employees to go on the State Medicaid rolls.

We see an aging population, and occasionally we even see middle-class Americans find ways to get rid of mom and dad's assets before they go into some form of long-term care. We cannot absorb all three of those.

What we are saying is, from both a Federal and State standpoint, give us our tools. There should be lines, and we suggested, for example, no more than 5 percent of a certain income threshold of a family's income, maybe 7.5 percent at a higher threshold.

Remember, the Medicaid reimbursement levels, depending on the States, vary dramatically. Arkansas and Virginia have very low Medicaid reimbursement rates. Certain other States have much more generous rates. So, there will be that bright line, but if you have a higher amount of reimbursement levels, you might have a little more flexibility on the co-pay.

Senator BAUCUS. I appreciate that. Even more helpful, though, the more you can kind of give us a little more specific and precise guidance here so that governors know, Congress knows, the administration knows, even though I am speaking generally here.

Governor WARNER. One thing Congress has laid out is, there have been some studies out there. I do not recall the specific dollar amount of proposed savings. But we were looking at $1 to $3, was where our current Medicaid co-pays are.

There was one study that some entity in Congress did that talked about savings in a $3 to $5 or $3 to $6 range. We are talking about an incremental increase, from figures that were set in the early 1980s versus where we are today, that seems in the range of reasonable.

Senator BAUCUS. My time is up.

Governor WARNER. But let me just add one other thing. We also need some of the tools to make sure that we do look at this issue and having some sanction for people who, perhaps, over-use, for example, the emergency room, inappropriate use of certain facilities.

Because what we want to try to do is, we want to have the system more efficient, but at the same time we want to find ways—I have a million uninsured people in Virginia. I would like to find ways to make sure that they have at least some level of care. We do not offer it at this point

Senator BAUCUS. Senator Thomas?

Senator THOMAS. Thank you, Mr. Chairman.

Thank you, gentlemen, for being here. I think, certainly, we all agree that there needs to be some changes. There needs to be some changes in health care, particularly in Medicaid. The governors and the States will have a great deal to do with this.

We have to control costs, we have to provide service, we have to deal with over-utilization. I think we have to make sure that we do not allow costs to limit access to health care, which is partly what we are doing now.

So, at any rate, we need to be flexible, too. I come from a rural State, and health care delivery in rural States is different sometimes than it is in the urban areas, and we need to understand that.

You mentioned, how much of this do you see in long-term care of shift of resources to qualify? I hear that is used quite a little bit. Shift of personal resources to qualify for long-term care under Medicaid.

Governor WARNER. Senator, I am not sure. I mean, I think there have been some studies, but I have to tell you, from Virginia's standpoint, we are not sure. But what we are looking at—and this is something, I think, that goes to the overall approach—we are looking at ways that we can find savings, but we are also looking for tools and ways to reinvest.

For example, I know that Senator Grassley and Senator Lincoln introduced legislation to provide a tax credit incentive for long-term care insurance. We think that makes sense.

We think we need to change the culture in this country where we provide and incent people to purchase long-term care insurance that will allow in-home care, nursing home care, and intermediate care so that folks do not have this, in effect, gaming of the system, however much of it is done, to fall onto Medicaid rolls.

We think that the reverse mortgage option is a good one, but allowing some maintenance or some equity in the home so you have something you can pass on to your children. We think that is an incentive as well.

So, we have laid out a series of both savings and incentives to get at this long-term care issue. It is the long-term care issue that is the biggest cost driver in our Medicaid problem.

Senator THOMAS. Do you have community health centers, Governor?

Governor HUCKABEE. Yes, sir.

Senator THOMAS. Who is eligible to use those?

Governor HUCKABEE. Senator, it is done in a sliding scale basis. The community health centers in our State provide the only point of service for many, many of our citizens. As you represent a rural State, we, too, are a rural State.

Not only the community health centers, but let me also add that this goes to the heart of one of the proposals we have for the prescription drug reform, to make sure that any reforms do not come at the sole expense of the local pharmacy, but that the cost of reform is shared by all of the stakeholders, including the pharmaceutical companies. That is why we need the transparency of the system, because our community health centers are a point of service.

But, quite frankly, in many of our communities where we do not even have a community health center, our local pharmacists may be the only real point of service to do blood pressure checks, blood sugar checks, and to provide some type of basic medical information to a very rural group of people.

Senator THOMAS. As we provide these services, of course, we are talking about Medicaid, as we should. But we are talking about the whole health care system. I am told, talking to our providers, that the fact—they claim, at least, and I think it is probably true—that Medicaid, or even Medicare, does not pay the full cost in the regular community hospital.

Therefore, the cost is shifted to the insured people who have private insurance, and therefore we are driving up the cost of insurance for others. What do you think about that? Does Medicaid pay the costs the providers charge?

Governor HUCKABEE. It is a huge problem for many of us, because in some cases the reimbursement rates are nowhere near the actual costs. The problem is, without the kind of management tools that we have come together today to seek, we cannot increase those reimbursement levels because the resources are simply not available to do it.

Senator THOMAS. But there are other impacts from that, are there not?

Governor HUCKABEE. There are many impacts, not the least of which is a cost shifting to the private sector, which then drives that private sector cost up and forces many private sector and small business people to no longer offer their employees benefits, and that drives them to the Medicaid program. It is a vicious cycle, and that is why we are here.

Senator THOMAS. We do have to look at the overall, even though we are focusing on one part.

Governor Warner, we get different kinds of information. You mentioned, I believe, that States' cost of Medicaid is more than education. Our report says, on average, States spend more than 3 times their State dollars on education than they do on Medicaid, 26 percent for elementary, 13 for higher, and Medicaid is 12.

Governor WARNER. Well, no, sir. Medicaid averages right now, most recent figures, at least, that I have, are 22 percent. That ex-

ceeds, in aggregate, the cost for K–12. There are some States, I have seen within the last 2 weeks, higher numbers. For example, in Tennessee, it was 33 percent of their budget. I think Missouri was 30 percent. There are a host of States in the high 20s. We in Virginia are down at about 15.

But the costs have risen dramatically. Earlier in my testimony, I indicated that Medicaid in 1990, in Virginia, cost a billion dollars. Medicaid, at the end of this budget cycle that we are currently in, will cost $5 billion in Virginia. We have not dramatically increased the quality with those increased costs.

Now, part of that, as you made mention, Senator, is not simply a Medicaid issue, it is the overall health care-related issue. While we have laid out today Medicaid-specific reforms and some other reforms so that we can encourage more folks, particularly in small businesses and others, not to fall upon Medicaid rolls, to at least have some modified benefit package that we could make available, we are going to have to be part of a longer health care debate.

Senator THOMAS. We are looking at that. And you mentioned being a little chagrined. When you go to the budget and look at these, 60 percent of this is paid by the Feds. So, we have a little budget chagrin.

Governor WARNER. Not in Virginia. I wish it was 60 percent.

Senator THOMAS. Well, I will not argue with you. But we need to get those figures, because we have different figures than you are talking about today. We need to find out.

Governor WARNER. Well, as you know, the maximum ranges from 70 and 80 percent, with some down to around 50 percent, in many of our States in terms of the Federal match.

Senator THOMAS. 60/40, generally.

The CHAIRMAN. I am willing to skip over myself and go with everybody else, but I ought to be able to have 5 minutes to ask questions.

Senator BAUCUS. Yes. I would say so.

The CHAIRMAN. So I am going to go to Senator Kerry, but what I would like to do is make sure that, by 11:15, I get 5 minutes to ask my questions. So, we have Senators Kerry, Rockefeller, Smith, and Crapo to ask questions, and Hatch, maybe.

All right. Go ahead.

Senator KERRY. Thank you, Mr. Chairman. That was very generous of you. I appreciate it. Let me try to move right through it.

If I could very politely correct you, Governor, on that figure, Senator Thomas is actually correct. We were talking about it a moment ago. The figures are 22 percent when you add the Federal and local dollars to the State. The State dollars alone are about 12 percent. So, the State contribution, in total, for Medicaid is 12 percent when we are talking about the State's problem.

What I want to try to focus on here is sort of what the really large choices are that we face. I think the proposals that you have brought forward are important, and I think they are a great introduction to the discussion.

But in candor, taken as a whole, unless cost-sharing, benefit package flexibility, waiver reforms, and judicial reform are tantamount to cutting the current mandated programs and to significantly doing the cost-shifting that you just mentioned, which will

have an impact on the private sector, they are not going to cure the problem of either $10 billion, or the larger problem that we are looking at in Medicaid. They are just not going to do it.

And it is not your fault. It is just 5.8 million people were added to Medicaid between 2000 and 2003; 4.8 million people lost their private health insurance, and the numbers are going to continue to grow.

So the question is, what are we really going to do in larger terms? Now, I have been here 22 years and I have listened to governors come up here and say, we need help to do this and that. We tend to provide a significant amount. I have also watched them do tax cuts in their home States and get reelected, accordingly.

The revenue stream is getting narrower while the problem is getting bigger. There is a fundamental conflict here. What would you say if the Federal Government could say to you, we will relieve you of the burden of Medicaid up to 100 percent of poverty.

We will take over Medicaid at the Federal level. We will do automatic enrollment of all children. You go to school, you are enrolled. You go to day care, you are enrolled. If you go to child care, you are enrolled, whatever.

From 100 percent of poverty up to 300 percent of poverty, the States would agree to expand the SCHIP program and coverage so that we take people up to 300 percent of poverty, about $47,000 for a family of three. That would be a net savings to you in your States of a total of $6 billion across the country.

In the State of Virginia, we would return $128 million to you, while we provide 100 percent coverage of children. In Arkansas, we would provide $62 million back to you. You would have a net savings of $62 million and 100 percent coverage for all children. You currently have, I think, 77,000 kids uncovered in Arkansas; you have 202,000 in Virginia.

We can cover all of them. We can eliminate your headache of Medicaid. We can return dollars to you and your States and relieve you of this fiscal burden. But to do it, we cannot give people earning more than $300,000 the next tranche of the tax cut. What is your choice?

Governor HUCKABEE. Senator, I think, first of all, you would have a very receptive audience with governors to propose something that would take over that role of the children. I think we would have to also add the discussion of what do we do with long-term care, because that is where a lot of our costs are, a huge level of our costs, and also legal protections.

I think I speak for all of our governors when we tell you that what we have presented today is not the extent of all the reforms that are needed in Medicaid from the State or the Federal level.

What we have presented are the reforms that we have had 100 percent agreement on from Democrat and Republican governors, and that we can bring to the table in good conscience, as genuine reforms, that have been vetted out through a thorough process. It is the starting place, not a finish line.

Senator KERRY. Well, I respect that. You said that in your testimony, and I really appreciate that. But a lot of us here are getting kind of frustrated with staying at the starting line. I mean, we have to get to a finish line here some day. This problem is going

to get worse before it gets better. If our solution is to squeeze people down out of Medicaid, we are not solving anything at all.

Let me share with you. I sent an e-mail to people who have been supportive of this Kids First concept. Twenty thousand people responded, leaving telephone messages on this.

Here is what they said from Manassas, Virginia. Matthew said, "What I don't understand is how we are to be the richest and most powerful country in the world.

"Why are we forgetting about the people who are less fortunate than ourselves, those who don't have health insurance, children who are living in poverty, children who are living without parents, not knowing where the next paycheck is going to come from?

"Why is it only the people who make the money can afford health insurance, the only ones who are getting it? Poor people are people, too, and children shouldn't have to suffer because their parents bust their butts every single day and only can afford to live paycheck to paycheck.

"Why is it that children in the richest country in the world are going hungry and are living with disease and germs that will affect them and could eventually kill them because they can't get the proper medicine, the proper medical care? Why is it, in the most powerful country in the world, our children are having to live with these disgusting diseases that can be cured?"

In Arkansas, a woman named Allison: "If we don't start taking care of the people in America, and mainly the children in America, we are going to turn around one of these days and find that we are a third world country. Charity begins at home, and the little children, they need us now."

So would you, in fact, join in an effort with the governors to make this choice, that for $300,000 and up we do not have a tax cut and we cover every child in America with health care, and return $6 billion to the States to relieve the fiscal burden? Would you support that?

The CHAIRMAN. Would you please give a short answer?

Senator KERRY. It only requires a yes or a no.

Governor HUCKABEE. Senator, I want to say, we have done the very thing you are talking about, and we did it 8 years ago. We started covering children, and we want to cover children. What we are here today to do, is to propose the things that will help us cover more children.

But this unsustainable cost of the current Medicaid mandates are such that it is going to prohibit doing what you want to do and what I want to do. When I grew up back in 1965, when the Medicaid program started, my parents would not get on it, but they probably qualified.

The fact is, there are a lot of people today who desperately need the kind of coverage that Medicaid, and then the expanded Medicaid programs, provide. We want to give it to them, but we want to do it in a way that does it efficiently and effectively.

Governor WARNER. And Senator, let me just add as well, one of the things I am proudest of is the fact that, in Virginia, we took a State that had one of the lowest sign-ups of children, and we have now moved where we have signed up 96 percent of our kids in Virginia. The Kaiser Foundation has recognized Virginia as one

of the most successful children's health initiatives in the whole country.

I would add, and some of you may have read about it, we actually did have a little tax reform effort going on in Virginia a year or so ago, and we stepped up to the plate in a bipartisan way and have met our State's financial needs, and are paying the commitments on health care and on education.

But clearly, even with the tax reform effort going on in Virginia, we can see over the next decade where we are headed, unless we can get a handle on these Medicaid issues and recognize that we have to also deal with the one million uninsured Virginians we are still looking at.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

With all due respect, gentlemen, neither of you answered John Kerry's very real question. We have done, whatever it is, $3 trillion of tax cuts. I vote against them, I lose, it helps me, and I regret that. But that is the choice. That is the choice.

Because this year we are either going to vote to make them permanent, which is, I think, $11.7 trillion or something, to the year 2075, or we could cure Social Security for one-third of that totally until 2075, cure Medicaid, cure Medicare. What you are doing, it seems to me—and we had a good talk about this, Governor, yesterday—we are not talking here just about an average and ordinary population.

We are talking about the very poorest people in this country who are, in fact, paying 3 times more than the so-called personal responsibility business. They are actually paying 3 times more than people that have private health insurance with respect to the proportion of their income.

Now, this is not the usual population. This is a select population of those who are particularly poor. The asset transfer thing is not a big deal in West Virginia. People love to make it a big deal. There are, of course, some examples, just as there are examples of corporations and people and all the rest who cheat on stuff.

But these are the people who need the help. This is the safety net. This is the only real safety net that we have. That is why we have to treat it specially. If you want to save money, you can save $30 billion off of Medicaid. You can do that with three things: you take the slush fund for private plans, which none of us over here like. That is $5.8 billion in 5 years.

MEDPAC has said that private plans are being paid at 107 percent of their cost. If you just put them down in private plans, which we do not like, put them down to 100 percent, you save $12.6 billion over 5 years.

If you asked them to adjust for risk in these private plans, you would save an additional, almost, $12 billion. Is Medicare on the table for you? Do you not agree with me that you do not just treat this as another—you said, Governor, that it was a policy problem. I have never believed that.

I have always believed it was a budget problem. It was a desire to cut the budget, where people who could make the least noise about it would make the least noise about it, and it would be left up to us to argue it out.

Governor WARNER. Well, Senator, let me try to address that. First of all, if we can find a way that Medicaid makes up part of what you all have dictated as $10 billion worth of savings, have at it. We would welcome that.

We said at the outset—as a matter of fact, we have been very clear from the outset—that we think this debate should be policy driven and not driven by an arbitrary budget number.

What we have tried to lay out with you here in our proposal are, yes, ways where we think we can make the system more efficient, but also ways where, over the long haul—and this is by no means a full, comprehensive health care reform package—we can start getting at particularly some of these issues that are going to break the bank: long-term care, incentives for long-term care insurance, looking at tax credits in terms of issues related to employer and employee tax credits so those folks at the margin do not fall on the Medicaid rolls.

For me personally, if you all at the Congress level want to take on a reform of the Federal Tax Code, I would be very supportive. Again, we have done it in Virginia, and would welcome you doing it at the national level.

Senator ROCKEFELLER. Well, then, that is my point. If we are going to do that where the administration, the House, and the Senate are all under the control of a single party, if we are going to do that, do you not, as governors, have to fish or cut bait on that issue, just as we had to as Senators?

I mean, you talk about Medicaid. You would not have a Medicaid problem if we had not had these tax cuts, which have had a very marginal effect on the economy. You would not have it. We would not be having this discussion today. Remember the $5.6 trillion surplus that the administration came into office on. I mean, is it not fair of us to ask you—and some would say yes and some would say no—but to go on record on it?

Governor WARNER. Senator, I think you and I would probably agree on a lot of the proposals the administration has made on tax policies maybe that are ill-timed.

But let me say, again, as you well know as a former governor, we would still have, even if the Federal Government was not facing unprecedented deficit levels, a Federal/State partnership.

There are still State dollars involved. We have close to a 50-percent match in Virginia. We have gone from $1 billion of State spending to $5 billion of State spending in the last 15 years. It is rising at a rate much more rapidly than anything else.

Senator ROCKEFELLER. My time is up. But do not tell me that Medicaid and SCHIP are the same things. There are very different financial requirements in those two. They are not the same. That is just a detail, but you made that yesterday, and I think you have made it today.

The CHAIRMAN. Senator Smith?

Senator SMITH. Governors, thank you for the bipartisan way in which you are approaching Medicaid. I think the governors can make a very important contribution. I am sorry it has become partisan here this morning.

I suppose the reason I register on this side of the aisle is in part because of the discussion which has just gone on. I am a small businessman.

When I look at the state of America's economy and the recession we have come out of, and I look across the ocean and I see our European allies with stagnant economies, with confiscatory tax rates, with no growth, with deficits that would make ours look like an easy problem, I do not think just jacking up taxes is the answer here. I suspect that in both your States, your revenues are increasing. Is that accurate?

Governor HUCKABEE. Yes.

Governor WARNER. Yes.

Senator SMITH. Is that because your economy has gone up or because your tax rates have gone up?

Governor HUCKABEE. Both.

Governor WARNER. Both.

Senator SMITH. That is not what I wanted to ask. [Laughter.] I do not want America to look like western Europe right now. I think that there are rational ways that we can keep a marketplace growing and dynamic and creating opportunity instead of depression, despair and recession.

So, in my view, just taxing our way out of this will never lead to where we need to get as a people. Many European countries, and Japan included, are my Exhibit A in that. We have a budget reconciliation of $10 billion.

It does not all have to be used in Medicaid. Maybe it will be, but it does not have to be. But it is very important to me, as a matter of principle, that we figure out the lines to be drawn that will keep serving the people and give you the flexibility.

But I suspect that the flexibility you seek is going to take a longer-term look than between now and September in order to do it right so we do not hurt the people we are trying to help.

Now, I hold up my own State in the last recession as an example of what can happen when you do not do this right. I do this with my governor's permission; he is a Democrat, I am a Republican.

But in 2003, Oregon increased premiums and co-pays and eliminated access to outpatient mental health and chemical dependency services, and the prescription drug benefit. Fifty thousand Medicaid beneficiaries lost access to care they desperately needed, and these costs did not disappear. They were just simply shifted to private plans and to other State budgets.

Instead, Oregon hospitals saw a 17-percent increase in admissions in the 3 months following the change in State policy. While the State saw increases in the number of persons with mental illnesses enter their State hospitals, the local jails and prisons, those populations also ballooned, I believe—they believe—as a direct result of Medicaid changes. In the end, the people got care. They just did not get it in a very cost-efficient way.

In 2004, Oregon reinstated coverage for outpatient services and other changes were made. Part of that was the State reimbursement Senator Rockefeller and I helped to push through this place, and those pressures have been lessened.

So what I want to ask you, as you look over your recommendations, which one of those are not so structural as to run us into the

ditch? Which one of those, or among those, are likely to get us to somewhere about $10 billion in savings that you all agree on and which we can pass in a bipartisan way? Because at the end of the day, it is going to take a bipartisan approach to get this done.

Governor HUCKABEE. Senator Smith, let me begin by saying that we have not all gone out and cut taxes and enjoyed a reckless way of cutting benefits to people. In fact, if anything, many of us—and it has been very uncomfortable for some of us as Republican governors—were forced, because of rising Medicaid costs, to actually have to go into special session and raise taxes just to cover what we already had obligated for, not to expand services, not to cover more people, which is what we would love to do. But we actually did it just to cover the things we had already been obligated for.

So, I want to make clear that it has been a very difficult situation keeping up because of what Governor Warner had mentioned, the growing numbers of people getting into the Medicaid program and the fact that the Medicaid costs are rising at twice the rate of inflation.

When we look at the specific proposals, we know that if we just paid the front-end cost of the rebates rather than wait 6 months, that would save the Federal Government $1.5 billion, and States $1.1 billion. There are certain savings that we can estimate, but we cannot score them because that is something only Congress can do.

I think it would be inappropriate for us to attempt to do the work of CBO and present some scoring, but we do believe that the proposals that we have have some cost benefits. But I want to make clear that our goal is not to reduce costs. That may be yours.

Our goal is to better administer a program for the poorest, neediest people in our States. Our focus is to do it in a way that is more efficient and that helps people rather than just simply balances the budget. But we do believe that there are benefits, overall, to be realized.

Senator SMITH. But is there any low-hanging fruit that we can get without hurting people?

Governor WARNER. We have laid out some areas. None of this is low-hanging fruit, but areas that we can work through with you on. I appreciate your comments that not all of this need come out of Medicaid. It could perhaps come out, as Senator Rockefeller indicated, from Medicare or other areas to get to your budget number.

But also, I think it is very important—and this is, by not any means, fully comprehensive—we have also put in this plan preventive actions related to long-term care, related to those workers on the edge of falling onto the Medicaid rolls with tax credits and other tools, modified benefit packages, purchasing pools, all tools that we need that we think can at least slow the rate of growth.

Ultimately, that is what this has got to be about as well, not just dealing with the short term, but I think, as Senator Rockefeller indicated, we have to deal with the long-term issue here. Some of the tools we have laid out there, I hope you will look at those reinvestment tools, as well as some of the saving tools.

The CHAIRMAN. Senator Snowe, you are going to have to direct your questions just to Governor Warner, because Governor Huckabee has to go to another committee meeting on the Hill.

Go ahead.

Senator BAUCUS. If I might, just very quickly before the governor leaves, I would just like, Mr. Chairman, to say the governors' recommendations of how we deal with TANF—TANF has got to be reauthorized soon. We either go through reconciliation or we take it outside of reconciliation.

The concern of some of us is, if it goes through reconciliation, there are going to be cuts to the TANF program that do not make sense for States and the people around our country. I was just curious about your recommendation on how we should handle that.

Governor WARNER. We would like to not see the cuts, and we would also like to see a long-term reauthorization and not simply these 3-month extensions.

Senator BAUCUS. Right. But the question is—maybe it is inside baseball here—but either we go through the reconciliation process here, it is outside reconciliation, that is, a separate authorizing bill.

The CHAIRMAN. Let me say that you want it to be outside of reconciliation.

Governor WARNER. We do.

Governor HUCKABEE. We do very much want it to be.

Senator BAUCUS. That is what I have been trying to encourage you to say.

Governor HUCKABEE. Well, Senator, we would really like for it to be outside of reconciliation for the fact that, if it is not, then it could have an adverse effect on people in our State, particularly in child care and areas where we are stretched and strained.

So, I think, even though it is not a policy adopted by the NGA and we cannot speak for all of our colleagues, I think we would be on safe ground to say that would be the position of our colleagues.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman.

I want to thank you, Governor Warner, for being here today, and Governor Huckabee, and representing a bipartisan view on a critical program that, for the first time, is going to be comprehensively reviewed and examined.

I think it is critical that we obviously get it right, because it is the first time in 40 years that we are really providing a strong overview, and we have to do it in concert and partnership with the States as well.

It is important to be both fiscally responsible, and at the same time be committed to those low-income people who have no insurance, the uninsured, who are growing in ranks and numbers across America, which I think obviously further aggravates and compounds the problems that you are facing on the front line.

Let me ask you, did the Governors Association ever consider adjusting the Federal matching, the FMAP rate, the Federal Matching Assistance rate? The reason why I ask that, in Maine, for example—and I know this happened to 28 other States as well—when they do the look-back to reflect the States' economies and financial condition on which they base the Federal contribution to the States and what the Federal share would be, it was between the years 1998 through 2000, when the economies were growing significantly.

So, as a result of all of that, the matching rate that the Federal Government will provide, for this year—for example, in Maine, it will decline by 1 percentage point; in 2006, it will further decline.

Senator Bingaman has legislation that would provide increased appropriations for those States who have faced a serious loss as a result of that adjustment because the FMAP, the way they make the adjustment for the formula, does not reflect the accurate period of time. It is so far back in the period, that by the time they make that formula applicable, it does not reflect the current economic circumstances.

Governor WARNER. Well, let me, first of all, say how grateful all of the governors were when you all stepped up the FMAP match rate a couple of years back when all of the States were in the depth of the worst fiscal crisis the States had faced since World War II, and we are grateful for that.

We adjusted the FMAP match up. As long as it was to hold harmless to all the other States, we would welcome that. But when we were looking at a budget reconciliation number that you all deemed, we did not come at that straight on because we did not think it would have much saliency up here.

We would also love to see you pick up the dual eligibles. But, again, back to Senator Kerry's point, I would love to have us experiment on children, but I would really love to have, if you all are willing, to pick up 100 percent of the cost of our seniors' population and the dual eligibles, as the original Federal/State contract laid out. But we are here trying to deal with your fiscal circumstances and our fiscal circumstances.

Senator SNOWE. Right.

Governor WARNER. But if you put forward an FMAP increase, no governor is going to turn that away.

Senator SNOWE. It is not just an automatic increase. The question is whether or not that formula reflects an accurate period of time.

Governor WARNER. I understand. Anything that you can do to make the formula more reflective of the current circumstance would be useful.

Senator SNOWE. Is that possible or not? That is what I am asking.

Governor WARNER. Technically, I do not know.

Senator SNOWE. You do not?

Governor WARNER. Let me answer a slightly different question, but I think it has some applicability, which is, we in Virginia, and a number of other States, with the Medicaid drug benefit—because you set the number in terms of the baseline of 2003, States like Virginia which have substantially increased their drug savings, for example, by use of PDL, since 2003, get none of that benefit.

So, under the clawback provision, we are penalized for doing a better job of negotiating, for example, drug prices than what the Federal Government does. So, ratcheting up the date line on the Medicaid drug benefit, and I would imagine the same on the FMAP, would be greeted favorably.

Senator SNOWE. For the FMAP currently, it is 1998 to 2000, and yet there is a downturn in 2003.

Governor WARNER. I understand. Very different circumstances today.

Senator SNOWE. That formula has triggered for today, 2005 and 2006, for a look-back period to 1998 and 2000, and does not obviously take into account the downturn that occurred in 2003.

On drug prices, because obviously that is a contributing factor, a significant factor in driving up the cost of the Medicaid program. Is that correct?

Governor WARNER. Yes.

Senator SNOWE. All right.

Now, the President has recommended using the average sales price, plus 6 percent. You are recommending an average wholesale price. Is that correct?

Governor WARNER. No. We have problems with the average wholesale price pricing formula. Our concerns with the administration approach was that it seemed to take most all of the savings out of the hides of the local pharmacists.

We think it ought to be that savings, and there needs to be more transparency in our drug pricing. And obviously, the complexity of figuring out what is the appropriate price is something that we are all trying to sort through.

But we think it ought to be borne not only by the pharmacists, but ought to be borne as well by brand pharmaceuticals. We ought to find other ways to encourage, for example, greater use of generics. There are some interesting things going on in Canada in terms of even generic definitions.

We also think that one of the things that the President had even suggested, early on in his administration, was increasing the Medicaid rebate, drug pricing rebate. If we move that, for example, I think under his own proposal, from 15.1 percent to 20 percent, there were billions of dollars of savings. So, we think all of these should be on the table.

Our concern with what it appeared to be with the administration's initial proposal was, all of these savings were simply going to come out of the pharmacist's hide. When you have a State like Maine which has large rural areas, or a State like Virginia that has large rural areas, to take it simply out of the pharmacists' dispensing fee may not be the best case.

Senator SNOWE. Thank you.

The CHAIRMAN. Governor Warner, I have questions for both you and Governor Huckabee. I am going to take my first 5-minute round now, because I was gone when my time came up. So if I ask you a question that was more in his area to answer, you can just say so and I will have him answer in writing.

Governor WARNER. That means, any tough ones, I can simply pump to my invisible colleague.

The CHAIRMAN. I guess you can, yes.

In your testimony, you talk about the importance of changing the rules of how seniors can qualify for Medicaid faster by transferring assets. Specifically, you state that Medicaid should restrict the type of assets that can be transferred.

I would like to have you elaborate on what type of assets someone can transfer so that Medicaid will pay their long-term care

costs sooner, and how you propose then closing loopholes where they could not give away those assets, or those type of assets.

Governor WARNER. What we have talked about is a longer look-back period, number one. We have also talked about one of the questions we have on asset transfer. There is a lot of debate out there. We do not know. At least from Virginia's standpoint, we do not know how much inappropriate asset transfer is going on.

The three things that we have suggested have been, number one, for example, tax credits that you and Senator Lincoln have introduced, the legislation that we would be supportive of, to encourage purchase of long-term care insurance, which we think is very important.

Number two, we have looked at the expansion of what is called the long-term care partnership program that I think is in four States right now. Opening that up to more States seems to make some sense.

Number three, we have looked at the question of reverse mortgages, but recognizing that we ought to have a more honest discussion about how we allow people, particularly with their home, to retain some equity in that home.

If they have saved all their life and they have bought a home, to be able to retain some of that equity to be able to pass it down to their children. You hear stories of people transferring their home ownership to their children or to a trust. We do not know how much of that is going on.

But if there were a way to say, yes, we are going to ask you to spend down some of that equity, perhaps in a way that can actually allow you to stay in your home for that care, but you are going to be able to retain some amount.

And the right amount is what the debate would entail, $50,000, $75,000, $100,000. I am not sure what the right number would be so that you could pass on that. That, in our mind, makes sense, getting at a problem that some have said could have many, many billions of dollars worth of savings, and others have said is not a problem at all.

The CHAIRMAN. In regard to drugs, this is somewhat different than what Senator Snowe brought up. I want to lead in by saying that States have very limited power today to control drug spending compared to the private market.

For instance, it is my understanding States cannot use closed formularies. Their ability to drive generic utilization is limited, unlike the private market, which can extensively move the market towards generics through the use of tiered co-pays. How do you believe that the use of tiered co-pays for Medicaid prescription drugs would improve the Medicaid benefit?

Governor WARNER. We have worked, and many, many States have moved, because of some of the issues related around formularies. Many of the States have moved to preferred drugs lists. We have, for example, in Virginia; we have saved $35 million, I believe, in the last year.

That was a negotiated process that we went through with our pharmaceutical providers. We think we made a step in the right direction. Our concern is, I believe we are looking at some tiering of co-pays in that PDL list. There is the tiered co-pay, so we have

some direction on trying to incent people towards purchasing, for example, the cheaper drug option.

One of the things, back to Senator Snowe's question, and one of our concerns with the administration's original proposal, was if you take it—and you are going to soon exhaust my knowledge in drug pricing here—totally out of the pharmacists' hide, there is no incentive at that point for the pharmacist to actually move to the generic drug, because if it is a percentage dispensing fee based upon the price of the drug, well, go with the more expensive drug.

So, we do need to look at more flexibility so that we can incent better drug choices, and more appropriate drug choices, without getting to the efficacy in restricting a drug that is so distinct for a person's particular condition. That is what we have tried to work through.

It seems, at least, as you move now toward the new Federal drug benefit, that a lot of that work in a lot of States, with the clawback provision, is going to be, in effect, ripped away.

The CHAIRMAN. You suggest Medicaid prescription drug reform should include increased rebates for manufacturers, at the same time asking for tools to limit access manufacturers will have to Medicaid beneficiaries. Yet, the best price statute guarantees manufacturers access to Medicaid beneficiaries in exchange for the rebates. How do you reconcile increasing the rebate, while limiting access?

Governor WARNER. What we feel—and again, the President himself proposed increasing the rebate early on in his term—that there still remains too much mystery about drug pricing. What we need, is greater transparency.

Earlier today Senator Wyden, and I guess Senator Sununu, were talking about legislation where they were trying to look at drug advertising in terms of drugs that were on the Medicaid list, and should the taxpayer be footing the drug advertising. It is an interesting concept.

But if we are going to get at that, we have to get at the more transparent nature of how these drug prices are set, and that is something that I am not sure anyone has totally figured out.

The CHAIRMAN. Thank you, Governor Warner.

Now, Senator Schumer? Then we will go to the second panel.

Senator SCHUMER. Well, thank you. I thank you for coming, Governor.

I want to follow up on the drug area. It seems to me one of the greatest places where Medicaid can save money is in the area of drugs. I know that Senator Grassley and Senator Snowe before me have asked questions. I have a few others.

The first relates to the relationship between Medicare and Medicaid in terms of drug purchasing power. Because when the Medicare prescription drug bill passed, I believe the States actually lost bargaining power in the Medicaid program because they are no longer going to purchase drugs for dual-eligible populations, but they are going to have to pay back the Federal Government for the coverage.

The way the bill is written, Medicare cannot negotiate to keep prices down, so it may actually increase what the States pay, because some of the States have been able to do more negotiating for

Medicaid on their own, and now all of a sudden the rug is pulled out from under them. So, they could end up paying more. That is moving in the exact opposite direction of where we have to move, and yet it is an unfortunate outcome of MMA.

So, let me ask you these questions. How important is it for States to be able to leverage their buying power to negotiate better prices in the Medicaid program, and what can Congress do to improve the States' ability to negotiate lower drug prices for drugs in the Medicare program? And, third, do you agree with the analysis that I just presented?

Governor WARNER. Well, first of all, Senator Schumer, we do agree with your analysis, that States like mine are being penalized for cutting a better deal than what the Federal Government is going to have cut, which again goes back to a point that Governor Huckabee made repeatedly.

We are the largest providers, in our own respective States, of health care, yet, particularly with the new drug benefit, we are restricted in our ability, like any private provider would be, to negotiate the best price possible. It does not make much sense.

Senator SCHUMER. Exactly. And yet, you have to pay back the Federal Government.

Governor WARNER. We have to pay back with the clawback provisions.

Senator SCHUMER. The MMA tied the Federal Government's hands. It said, look, it would be better if the Federal Government could negotiate with the drug companies, because they have even more bargaining power than any individual State. But the MMA says they cannot negotiate, yet you have to pay them back for their inability to non-negotiate.

Governor WARNER. Senator, I agree with your analysis. It also restricts some of the creative efforts that some States are looking at in terms of purchasing pools, where you might have the Medicaid population, the State workforce, and perhaps even some private companies trying to band together to negotiate a better price. That ability has been restricted.

And then to make matters worse, we have on top of that something that is kind of a hidden cost of a whole set of new administrative functions that are kind of layered down upon us, with no transition help to administer what would be a very, very costly new program, at least on the front end, in terms of the administration.

Senator SCHUMER. Right. So the big prescription drug bill was actually a step backward, in at least this way, in terms of getting your costs lower.

Governor WARNER. I am not going to characterize the whole bill. I will characterize the fact that, from a State standpoint, some States will benefit, some States will lose.

We constantly hear some conversation going on that there may be some effort to hold States harmless, or that the clawback will not be implemented as initially talked about. Clearly, I think it is one of the reasons why we put this in our paper. This is an issue that States are concerned about.

Senator SCHUMER. The second question relates to something that has been a pet cause of mine, which is generic drugs. Some States currently have in place a "generic first" substitution policy, which

requires the pharmacist to dispense a generic when one is available.

It is my understanding, even when these policies are in place, however, it is very easy for the doctor to request a brand drug, even if it is not medically necessary. In New York, for instance, all they have to do is check a little box. They do not need an explanation or anything else.

When Massachusetts had a similar policy, the State was spending $10 to $11 million more a month on brand drugs, when there was a generic available that would have been cheaper.

When the State implemented a stronger policy in which the doctor had to give a medical justification for the brand, and then get permission from Medicaid—which is needed in some cases, obviously—their spending on these drugs plummeted 98 percent, from $10 to $11 million per month to $200,000 to $300,000 per month, without affecting the States' ability to provide good, quality care to its beneficiaries.

Let me ask you this. What effect would the implementation of similar, effective "generics first" substitution policies in other States have on the pharmaceutical budgets, and on the Medicaid budget overall?

Governor WARNER. Again, I think you would find the overwhelming majority of governors would very strongly favor allowing us to have a stronger tool to push towards generics.

Now, let me add, though, that what we also need to do so that no one goes completely unscathed in this, as we see drugs rotate off a brand into generic categories, my hope would be that we can truly move drugs down to those generic pricing levels.

I would hope that, as we get into this drug pricing issue at a greater level, we do not end up with drugs moving from 100 percent price down to 80 percent price, and then suddenly having them called generics. There are timing issues on moving the price levels down. There are generic definitions.

Other countries like Canada have been stronger on definitions of generics. I think, again, if we are going to get into drug pricing, these are all issues that we have to be looking at.

The CHAIRMAN. Senator Rockefeller wanted to ask one last question.

Governor WARNER. Yes, sir. Because I have to go over at some point and relieve Mike Huckabee over on the House side as well.

Senator ROCKEFELLER. I will be quick.

The CHAIRMAN. Yes.

Senator ROCKEFELLER. Thank you very much, Mr. Chairman.

You indicated, and one of my worries is, so everybody gets some health care. The words "some health care" is a slam-dunk in rhetoric. The question is, how much? What does it leave out? Which leads me to this question.

I think—and I may be wrong, and you correct me if I am—that your proposal would permit State Medicaid programs to target benefits which suggest that the current Medicaid benefit requirements would no longer necessarily apply.

This seems to imply that the basic benefit for EPSDT would be eliminated. You know the importance of that program, and I am wondering what your response is.

Governor WARNER. Let me just say that that is not my implication as somebody who has spent some time at St. Mary's Hospital in Norfolk, which deals with these children who need this quality of care. That is not the implication that I have, and I do not think it is the implication that most governors have.

Senator ROCKEFELLER. That benefit does not exist in the private sector. It does exist in Medicaid. I am worried that it falls into the so-called "optional" part. Therefore, my concern is that some governors might drop it, while going on and saying everybody is covered by health care.

But you and I know, Governor—and you, in particular; your testimony this morning has been superb, deeply knowledgeable—that what is not included becomes terrifically important. I cannot think of anything more important than EPSDT.

Governor WARNER. Senator, I agree with you. But also, working through this process on EPSDT, I do not think you are going to see any governor walk away from that.

But I think what you do not need is to somehow say, because of our need to make sure that these children need the best quality care possible, that we are going to use that as a reason that we cannot have some type of flexible benefit package at all, and look at expanded flexible benefit packages for other subset populations. I would say we cannot use the protection of that initiative as a reason to say we cannot even look at flexible benefit packages. So, there is some back and forth that we have to work through on all of this.

Senator ROCKEFELLER. Hence my worry. But I thank you, sir.

Governor WARNER. Yes, sir.

The CHAIRMAN. Governor Warner, before you go, let me thank you. I think today is evidence of the good-faith commitment you made, I think, way back in February when you and I had a rump session, and Senator Baucus was there, and there were other governors there.

Governor WARNER. Yes, sir.

The CHAIRMAN. And you said you were going to work real hard on this. You surely have, and I thank you for that.

Governor WARNER. Well, Mr. Chairman, thank you. Thank the members of the committee. We end with where we started. We appreciate the opportunity to be before you. This is a bipartisan approach.

We want to be your partners in making our health care system, our Medicaid system, more efficient, but also recognizing that we have to improve the quality of care for the tens of millions of Americans who need this care desperately.

The CHAIRMAN. Can I also say, and this is not detracting from anything you have said, it is just meant to be an expression of my point of view, when we are dealing with this program and we are talking about a 1 percent reduction, a lot of people see that as something that just cannot be done.

If we would put up the proposition that not 1 percent could be found in the Defense Department, everybody would think it is ludicrous. It is just as ludicrous to think that, in a program as big as Medicaid, that if we cannot find 1 percent savings some way, that they ought to send somebody else here to the U.S. Senate, because

it can be. There can be more efficiencies in defense, as well as this program.

Thank you.

Governor WARNER. Thank you.

The CHAIRMAN. Now, our second panel. The first witness is Alan Weil, executive director and president of the National Academy for State Health Policy. Next is Jeanne Lambrew, senior fellow at the Center for American Progress. Finally, Stuart Butler, vice president, Domestic and Economic Policy Studies, The Heritage Foundation.

I thank you all for agreeing to testify, and we will go in the order that you were introduced.

So, Dr. Weil?

STATEMENT OF ALAN WEIL, J.D., EXECUTIVE DIRECTOR AND PRESIDENT, NATIONAL ACADEMY FOR STATE HEALTH POLICY, PORTLAND, ME

Dr. WEIL. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to appear before you today to discuss the Medicaid program.

My name is Alan Weil. I am the executive director of the National Academy for State Health Policy. We are a nonprofit, nonpartisan organization based in Portland, ME, dedicated to helping States achieve excellence in health policy and practice.

Before I took my current position, I was a center director at the Urban Institute, and before that, director of the Colorado Department of Health Care Policy and Financing, which is the Colorado Medicaid agency.

As members of this committee, you are familiar with the many roles Medicaid plays, serving poor children, families, people with disabilities, and the elderly. But from a State perspective, there is an important additional factor to consider when paying attention to Medicaid.

For good or ill, Medicaid has become the foundation on which much of our health care system is built. Medicaid is now intertwined with State mental health systems, developmental disability systems, school-based health, Child Protective Services and foster care, juvenile justice, public health and welfare reform.

Medicaid serves as a source of catastrophic coverage that helps make private health insurance more affordable. We often hear that 43 percent of Medicaid costs are for services for people with disabilities, but this is a very heterogeneous category.

It includes people with severe mental illness, developmental disabilities, degenerative neurological diseases, traumatic injuries, AIDS, conditions such as cerebral palsy, people who insurers generally seek to exclude from coverage.

The point is, changes to Medicaid can have ripple effects through health and social service systems and can make it more or less likely that your other efforts, for example, to reduce the number of Americans without health insurance, will succeed. To put it bluntly, Medicaid changes are highly subject to the law of unintended consequences.

Now, I am pleased today to be able to present to you the results of an 18-month project that we completed earlier this year with

major funding from the David and Lucile Packard Foundation, and support from the Robert Wood Johnson Foundation, AARP, and the Agency for Health Care Research and Quality within the U.S. Department of Health and Human Services.

The project was called "Making Medicaid Work for the 21st Century." I should just note, it began long before the current budget deliberations and was not intended to speak directly to the budget situation that you face.

In our project, we convened a group of State officials and national experts with a broad range of expertise in the Medicaid program to develop recommendations to make the program more effective and more successful. I have provided you with a list of the workgroup members.

Our organization serves State officials, and those officials have a great deal of experience with the Medicaid program. But the State perspective must be balanced against other critical perspectives, including those of the more than 50 million Americans who are enrolled in the program.

The Medicaid program has certainly been strengthened by the lessons learned from State experimentation, and certainly States have a tremendous stake in Medicaid's success. But States are not the only ones with such a stake.

I would say that our deliberations benefitted greatly from the inclusion of multiple perspectives to assure that, in looking out for the interest of States, we did not fail to consider the interests of others.

Before I describe the substance of our recommendations, a quick note on our process. The report that we prepared was as a result of a consensus process. No individual member should be viewed as having adopted the recommendations as his or her preferred position. They represent a total package that reflects a complex balancing of interests and preferences.

In particular, the group paired areas of increased State flexibility with areas of stronger Federal standards. And while some parties may advocate one side of this balance more than the other, once they are separated they no longer reflect the consensus of the workgroup.

Our final report runs about 80 pages, and you have been provided with a copy for your consideration. But I will run, quickly, through the key recommendations in the areas of eligibility, benefits, and financing.

With respect to eligibility, the workgroup regarded as its most significant recommendation that Medicaid should provide comprehensive health care coverage for the poorest Americans, all people with incomes at or below the Federal poverty level without regard to age, family structure or health status.

This new national minimum eligibility level would apply in all States and would replace the current system of categorical eligibility. This one change would dramatically simplify eligibility and eliminate the last residue of Medicaid's ties to the old welfare system.

Now, the workgroup also recommended that current requirements to cover children and pregnant women with incomes above the poverty level be preserved, and it recommended continuing the

existing option for States to extend Medicaid coverage to eligibility groups with income above those Federal requirements.

We focused equal attention on acute and long-term care, and that is an important aspect of the work of the group. The workgroup concluded that States should be given new options for setting financial and functional criteria to qualify for long-term care services.

States should be permitted to modify income and assets tests to allow applicants seeking community-based care, who are most likely to use up their resources within a short time if they enter a nursing home, to qualify for Medicaid-financed acute and community care services while they are still in the community.

States should also be permitted to set different functional criteria for institutional and community-based long-term care services.

In the area of benefits, the workgroup recommended that all individuals covered up to the new national minimum eligibility level be entitled to the same set of acute, primary care and long-term care benefits provided under current Medicaid law, with continuation of current rules that limit cost-sharing to nominal levels.

For individuals above the mandatory levels, States should be allowed to offer the current package, or a lesser, but still comprehensive, set of benefits that meets certain benchmark standards, and with higher levels of cost-sharing. We do propose allowing States to offer acute and preventive care, but not long-term care, to those optional populations.

States could also choose to offer a different long-term care package to optional eligibles than they do to the mandatory eligibles. The workgroup recommended that States have the option of converting home- and community-based service waivers into an ongoing program with Medicaid, and that parents of Medicaid-eligible children be able to enroll their children in CHIP so long as certain enrollee protection standards are met.

With respect to financing, the workgroup evaluated the current financing structure, where the Federal Government matches qualifying State Medicaid expenditures, and rejected the need for a radical restructuring of this approach. Specifically, the workgroup recommended against converting Medicaid into a block grant.

The workgroup recommended revisions to the formula and process for establishing the Federal Medicaid Assistance Percentage, the FMAP. The FMAP does need to be set in a way that more quickly and accurately reflects changes in the economy and the fiscal capacity of States.

The group suggested that the Federal Government should provide more support to States for Medicaid costs associated with low-income persons enrolled in Medicare, and this support should be provided in conjunction with efforts to improve care coordination and program management between Medicare and Medicaid. This is a complex and important area that we describe in much more detail in the report.

We propose the Federal Government provide an enhanced match to States for the costs associated with simplifying and expanding eligibility to everyone below poverty; that States be given new opportunities to coordinate Medicaid coverage with private employer-sponsored insurance through what are called premium assistance

programs, specifically allowing States to implement these programs without being required to meet certain waiver standards.

Further, States should be allowed to require employers to enroll their Medicaid-eligible employees in employer health plans at times other than their open enrollment period.

We made an additional recommendation with respect to extending the policy of reimbursing States 100 percent of the cost of services provided to American Indians and Alaskan Natives in the Indian Health Service or tribal facilities, regardless of where the services are delivered.

As we carried out our Making Medicaid Work for the 21st Century project, we identified, we believe, many opportunities to strengthen and improve the Medicaid program.

These opportunities are designed to make the program more efficient and effective, not simply shift costs to other payors, or worse yet, to the poor and vulnerable people the program is designed to serve.

I should say that, in our conversations, the people who work most closely with the program are most skeptical of grand claims for large savings. Particularly, they are skeptical of claims of savings associated with a general term like "flexibility."

Flexibility is not the same as efficiency. Those who propose flexibility should bear the burden of presenting evidence to support concrete steps they will take with their new-found flexibility to make the program more efficient. If cuts are necessary, that is a decision that you and others will have to make, but cuts should not hide behind vague language like flexibility.

On behalf of the National Academy for State Health Policy and the many people who volunteered many hours to help us prepare our work, I am pleased to be able to share with you the results of our deliberations that we approached also in a bipartisan—or I would really say a nonpartisan—way.

We stand ready to assist you in any way possible to strengthen and improve the Medicaid program as you continue your discussions.

The CHAIRMAN. Thank you, Dr. Weil.

[The prepared statement of Dr. Weil appears in the appendix.]

The CHAIRMAN. Now, Dr. Lambrew?

STATEMENT OF JEANNE LAMBREW, PhD, SENIOR FELLOW AT THE CENTER FOR AMERICAN PROGRESS, WASHINGTON, DC

Dr. LAMBREW. Thank you. My name is Jeanne Lambrew, and I am a senior fellow at the Center for American Progress, as well as an associate professor at the George Washington University.

I appreciate the opportunity to appear before you today to discuss the future of Medicaid. In this statement and in greater depth in my testimony, I will cover three topics.

First, I will discuss some of the major cost drivers in Medicaid and what to do about them; second, I will discuss the need for broader reform, since Medicaid's problems are the system's problems; and, third, I will raise concerns about some of the proposals that have come up in the course of the discussion today.

To put these ideas into context, it is useful to review this program's goals. Medicaid was designed to remove financial barriers

to health and long-term care for vulnerable populations. Because spending follows need rather than a pre-set budget, it has adapted to changing times.

Medicaid protected coverage and preserved jobs during the recent recession. It funded Disaster Relief Medicaid in New York after 9/11. It is becoming increasingly important in rural areas, where the aging of America has already begun.

Yet, Medicaid faces challenges. It is not serving all vulnerable populations. More than half of all poor adults are not eligible for Medicaid. Its quality of care, especially in long-term care, could be improved, and, as has been stressed today, its costs are straining budgets.

To get behind this issue of cost, the Center for American Progress commissioned papers on prescription drugs, long-term care, and high-cost cases in Medicaid. In advance, I thank Kathleen Gifford, Sandy Kramer, Judy Feder, Andy Schneider, and Yvette Shenouda for writing these papers and letting me draw on them today.

Starting with drugs, this service category continues to drive Medicaid costs. Expenditures on drugs doubled between 1998 and 2002, and they continue at very rapid growth rates.

While States have been aggressive in trying to reduce drug costs, the Federal Government has been largely absent as a partner in containing these costs.

There are several ways that Congress could help reduce drug costs in Medicare and the Nation. First, it could provide States with information to improve their reimbursement policies.

As we heard earlier, States operate largely in the dark in setting drug cost reimbursement. There are several measures that the Federal Government could provide to States to make them better purchasers of drugs.

Second, Congress could update the Medicaid drug rebate. Required by Federal law, this rebate has not been modified for over 12 years, despite rapid growth in costs. Governor Warner and Governor Huckabee mentioned the fact that there really could be some additional work in this area. In addition, oversight over the accuracy of the self-reported manufacturing price data will make a big difference in ensuring appropriate pricing.

Third, Congress could increase its investment in research to promote evidence-based coverage of drugs. In the long run, research on the relative effectiveness and the relative cost of similar drugs and other health services will be key to improving outcomes and efficiency. Information on comparative effectiveness is a better way to set a preferred drug list than looking at price considerations alone.

The last point I will make about drugs is to underscore a concern most recently raised by Governor Warner. On January 1st, Medicare will assume primary drug coverage for Medicaid beneficiaries also eligible for Medicare, known as dual eligibles.

Because no redundancy was built in, Medicaid funding ends on the day that the Medicare funding begins, and the most vulnerable population could experience some lapse in coverage. Keeping Medicaid funding available during this transition, as has been proposed

by Senator Rockefeller, should be considered in any Medicaid legislation this year.

Perhaps a greater long-term cost issue than drugs, though, is long-term care. A large and growing number of Americans needs long-term care, and its costs are high. Clearly, the Nation needs an extensive, fairly financed long-term care insurance system. However, this system does not exist today in either the private or the public sectors.

Sales of private long-term care insurance are growing, having tripled in the 1990s. But private long-term care insurance is unaffordable for many, inadequate relative to the cost of care, and unreliable, since few States guarantee that the investment in insurance will be returned if that company folds in the future.

Public programs also fall short of ensuring insurance protections. Medicare covers very little long-term care, and Medicaid, which pays for close to half of all long-term care expenditures, only pays for people who are low-income or who have exhausted their resources.

A number of policies have been proposed to address the long-term care problems generally, and Medicaid specifically. Most experts suggest that the Nation adopt a long-term care social insurance program in which everybody contributes to financing, and resources are allocated based on need.

Short of this, Congress could improve Medicaid's home care coverage and promote so-called partnerships. Currently, four States have this long-term care partnership program and would like to expand that nationwide.

A better option might be to partner Medicare with private long-term care insurance rather than Medicaid. With Medicare's broad financing and eligibility, it may be the program on which we should build to try to encourage a public/private partnership.

But it is important to recognize that private insurance will not, any time soon, be a substitute for Medicaid, and reform in this area will likely increase, not decrease, costs.

Turning from services to people, my colleagues and I decided to follow the money and look at Medicaid beneficiaries who were responsible for most of that program's costs.

Our results were sobering: 72 percent of Medicare spending was attributable to only 10 percent of Medicaid beneficiaries in the community. This is more concentrated than in Medicare or private insurance, and these high-cost beneficiaries are more likely than other Medicaid beneficiaries to be older, women, poor, non-Hispanic whites, and rural residents.

Many of these high-cost beneficiaries have chronic health problems, such as heart disease, asthma, and diabetes. Over half were hospitalized in the last year, and their spending on home health care actually exceeds their spending on drugs.

Lastly, it is important to recognize that Medicaid actually pays for one-fourth of the top 10 percent most costly individuals in America. This is 30 times more than the number of people served by medical high-risk pools nationwide.

So what do we do about this? One option is to promote better medical management of high-cost cases. Some States have established programs for beneficiaries with conditions such as asthma,

heart disease, diabetes, or schizophrenia. Medicare has begun demonstrations in this area, and Medicaid should follow suit.

Management of people with multiple chronic conditions would be aided by implementing an electronic infrastructure in the health system. An electronic health record would ensure coordination across multiple providers and settings, it would facilitate the use of evidence-based guidelines, and it would allow for monitoring through telemedicine in rural areas. Congress could accelerate this by applying a higher matching rate to such investments.

Prevention is also important, since similar conditions affecting these high-cost beneficiaries can be avoided or managed to make them milder. Federal policy could create incentives for effective prevention models, but prevention, like care management and information technology, while likely to improve the quality of care and health outcomes for Medicaid beneficiaries, may not result in the kind of short-term budget savings that Congress is seeking.

I would like to turn from looking at these specific Medicaid cost drivers to briefly discuss the cost drivers system-wide. There is a growing crisis in the U.S. health care system. Since the year 2000, the number of uninsured has risen by 5 million, to 45 million Americans.

The lack of coverage exacts a large personal toll, hurts our businesses, and results in billions of dollars in uncompensated care costs that get passed through the health care system. Uninsurance is perhaps the most important, but not the only, problem in the system. Health costs are affecting all payors in the U.S., and as such, Medicaid's costs are the so-called "canary in the coal mine," only pointing to the larger systemic failures.

We at the Center for American Progress think that the answer is not Medicaid reform, but health system reform. Fixing only Medicaid will not prevent a further erosion in private coverage, and vice versa. Stabilizing private coverage will not be sufficient to meet Medicaid's coverage and financing deficits.

To this end, we propose a plan that calls for expanding coverage to all, improving it for all through better quality and efficiency, and paying for these investments through a small, dedicated tax. The program is described on our website.

However, since Congress is discussing Medicaid reform and not comprehensive reform, I would like to end with a note of caution. The budgetary and political environment may take good ideas off the table and steer towards others that could weaken, rather than strengthen, this vital program.

The governors, this morning, proposed increasing cost-sharing and reducing benefits for people currently eligible for Medicaid. These may produce some budget savings, but at a cost in economic and human terms.

Many studies have shown that, for people with very limited income, any cost-sharing can deter the use of care, whether that care is necessary or not. If needed care is deferred, it could result in preventable hospitalizations or emergency room use. This would increase the overall cost of the system through uncompensated care, if not through Medicaid directly.

It could also exact a human toll. The Congressional Budget Office warned, after reviewing the evidence, that poor individuals facing higher co-payments displayed worse health on some measures.

The governors' call for benefit flexibility could also create some problems. In Medicaid, if an individual does not need a service, Medicaid does not pay for it. Those who do need a wide range of services are those 10 percent of the population who account for most of this program's cost. Cutting benefits for these people would be penny wise but pound foolish, yet exempting them means that there are very little savings that could result.

There is a role for cost-sharing and benefit flexibility for higher income people enrolled in Medicaid, as Alan discussed. However, this is not the vast majority of people enrolled in the program today.

For them, higher cost-sharing and partial benefit packages will likely render them effectively uninsured. This is because, in truth, there is no such thing as partial access: you have it or you do not. If Medicaid beneficiaries do not have access, then the program has failed in its mission.

In closing, improvements can, and should, be made in Medicaid's provision of high-quality, accessible care to all vulnerable persons. A number of policy options exist, and many have been outlined today.

While these proposals could help in the short run, Medicaid's problems are the system's problems, and broader reform is needed.

In the meantime, caution must be taken, given the budget constraints, to avoid the path of least resistance, reducing coverage and access for the lowest-income and sickest in our Nation.

Thank you.

Senator SNOWE. Thank you very much, Dr. Lambrew.

[The prepared statement of Dr. Lambrew appears in the appendix.]

Senator SNOWE. Dr. Butler?

STATEMENT OF STUART M. BUTLER, PhD, VICE PRESIDENT, DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION, WASHINGTON, DC

Dr. BUTLER. Thank you, Madam Chairman. I want to thank the committee for the invitation to testify, and also to follow the two governors, because I think the National Governors Association has shown how well-intentioned people from both parties can come together and develop initiatives to move us forward on health care.

I would also like, at the beginning of my remarks, to make three points about the context in which these discussions of Medicaid are necessarily taking place. One, of course, is that we all know that health costs in Medicaid, Medicare, and in the private sector are driving up the costs of Federal spending over the long term.

Over the next 25 years, we will see, according to the GAO and Congressional Budget Office, that the proportion of our Nation's resources on Federal spending will rise, from about 20 percent today to about 30 percent in 25 years' time.

That will mean either huge deficits, huge tax increases, or else we have to look at some ways of reforming the way we do spend

money in order to spend money smarter and to have measurable outcomes.

The second point of context is something that has been agreed on very broadly this morning, that Medicaid cannot be seen in isolation. Governor Warner stressed this. Dr. Lambrew has just said the same thing. When we look at Medicaid we must do so in the general context of looking for broader health coverage for Americans.

The third point of context I want to make is that the increasing polarization in Congress and in Washington means that, in order to make bipartisan progress, it is very important to look at strategies that appeal to the flanks of the political system, as well as to the center.

It is very important to have enthusiastic buy-in across the political spectrum as we try to move forward, just as we are seeing the importance of buy-in from the States in how we move forward.

I believe an enhanced approach to Federalism, to really work more closely with the States, is the key to achieving progress to reach our general goal of improved coverage.

In my testimony, I summarize a proposal that was developed by myself and Henry Aaron from The Brookings Institution. I would suggest to the committee, anything that Heritage and Brookings can agree on is probably worth noting.

Let me summarize the four key elements of that very quickly, and then talk about the context, specifically, of Medicaid.

The first is that Henry Aaron and I argued that Congress has to establish very broad and measurable goals for improving coverage generally, and for describing the protections that have to be in place for vulnerable groups. Senator Baucus alluded to this just a few minutes ago.

Second, Congress should enact what we call a "policy toolbox," in other words, a set of Federal initiatives and legislative waivers that really do appeal to those on the left as well as the right.

I think the National Governors Association has shown how combining proposals that are favored by left and right can be done, and allow us all to move forward. I think this is the case of log rolling that would be very beneficial for everybody, and we are suggesting specific proposals that could be included in this toolbox. This should be tested to see how effective they might be as a possible model for broader reform in the future.

Let me give some examples of the kind of things that we mean. There have been discussions of looking at Medicaid and who is eligible for Medicaid, and perhaps looking at maybe an income-based threshold rather than a welfare-based threshold for Medicaid.

I think that is something that should be looked at in Federal legislation and might be applied in a State to see exactly how effective that is in reaching our general goal of improving coverage.

Ideas for improving the structure of affordable health insurance also should be considered to be put in place in particular States that wish to try them. I think proposals like Senator Lincoln's idea for an approach modeled on the FEHBP for small businesses is the kind of proposal that should be made available to States to try, with the agreement of the Federal Government, to see exactly how effective it is.

Senator Frist's proposal for a Healthy Mae as a way of restructuring and providing reinsurance is another example of this. Similarly, an enhanced approach to refundable tax credits, to have large tax credits in particular places, to see how effective they might be.

There are a number of proposals like this that are bottled up in Congress right now. Henry Aaron and I suggest that we agree to allow them out to be tried in the States willing to put them into place, in conjunction with the Federal Government.

The third element of our proposal is that States would offer innovative proposals utilizing some of these toolbox items, as well as their own commitments and their own approaches, to be tried in their State.

We have argued that the decisions as to which of these proposals should be implemented should come under some form of semi-independent commission, we think, in order to build trust as to what should be tried and how it is going to be evaluated.

We do need some independent body to help Congress to do that. We think that that body ought to be comprised of governors, key legislators, and members of the administration, so that there is a clear bipartisan support for these approaches.

Then the fourth element of our proposal is payment by results. States that really do achieve the broad objectives that they agreed to with the Federal Government to improve coverage generally in the context of Medicaid changes, or whatever else is on the table, ought to be rewarded for their achievements.

Either some of the savings that are achieved should be reprogrammed into State initiatives, or, if there is new Federal money available in the future, that should be tied to progress in reaching agreed steps forward in improving coverage.

In a sense, this is rather similar to some of the elements of the 1996 welfare reform legislation, which set broad goals, broad protections and requirements, and then essentially allowed States to begin to look at alternative ways of reaching those goals.

Considering Medicaid within this broad objective of improving coverage, I just want to make a couple of points, or to reemphasize a couple of points.

One is that I really do feel very strongly that in order to get buy-in from the governors, as well as the Minority in Congress, as well as the Majority, then any steps that really look at significant reforms and significant changes in the Medicaid system must be seen as fair and balanced.

That is one of the reasons why I strongly feel that some form of commission—that is, a strong political body—is extremely important to develop a partnership and an agreement to move forward. These members of that commission, I feel, need to be voting partners. They need to really bring political strength to the table.

I know the current Medicare Commission is not exactly designed to do what we have been proposing, but I think the reluctance of governors and some members of Congress to take part is an indication that, unless it has clear independence and political clout, it is unlikely to get buy-in.

The last point I want to make is that whatever you do in Congress to try to reach the goals of savings in Medicaid by making changes in the program, I think it is critically important that

States be able to propose alternative ways of reaching those goals and those savings, while improving coverage.

That means that some States might be able to implement a change, for example, that might actually make larger reductions in Medicaid, but the quid pro quo might be explicit Federal funding for a refundable tax credit for some other provision that, in conjunction, means that the Medicaid population and the rest of the population in the State actually enjoys more coverage than previously.

Flexibility of this kind, with the ability to mix and match Federal funding, is absolutely critical to moving forward, not just on Medicaid, but to establishing working models that might actually be ones that we want to apply more generally.

Mr. Chairman, we have heard from the governors today. We have heard, as I said when you were out, an example of Republicans and Democrats at the State level coming together, putting elements into the equation that appeal to one side and the other, and coming up with a proposal that allows us to move forward.

I think we can do that at the Federal level in the way that I suggested. I think, also, by looking at a fresh approach to the relationship between the Federal Government and the States, I think it is possible for us to really begin to achieve the goals that have alluded us for so long.

[The prepared statement of Dr. Butler appears in the appendix.]

The CHAIRMAN. Well, thank you very much. You can tell that we were dividing up time here so I could go vote, and now Senator Snowe is going to go vote. I think maybe Senator Rockefeller is going to come back and want to ask some questions, too.

So, let me start out, please. If I ask you to repeat something that was in your oral testimony because I did not hear it, feel free to say so, and then I will just go back to the record so you will not have to repeat yourself.

The governors testified—and this is for Dr. Weil—of the importance of their having greater flexibility in determining eligibility in designing benefits. Theoretically, your members all work for governors, so I am curious. How does your group differ from the governors on State flexibility?

Dr. WEIL. Well, I think our proposal does differ in some important ways at the level of details, but perhaps it would be more helpful to describe the differences first in terms of concept.

The flexibility we include in our report is quite structured, and at least as I understood it, particularly as I read their written document, the governors were looking for a very high level of flexibility around benefits and eligibility with very, very few constraints, the ability to impose cost-sharing from the outset, the ability to reduce benefits for very, very low-income people. I did not get the impression that there were limits.

As I read their document, for example, a limit of 7.5 percent of income for a family at 150 percent of poverty, means that perhaps a family making $25,000, $30,000 is going to pay $2,000 or more. We were not looking at options that went up to that level.

So the first difference, I think, is we view a much stronger road map from the Federal Government in terms of how the flexibility will be structured. Second, and this is equally important, is that,

as I indicated, our proposals are a package, and we paired flexibility with a requirement that States, in their Medicaid programs, expand coverage to everyone below poverty, that that would be a Federal standard, and States would bear a share of the cost of that expansion.

I am not surprised that governors, given their fiscal circumstances, do not feel that they can bring those two together, but in our deliberations, it was very clear that flexibility should be combined with some responsibility on the part of States.

Third, and this I say with some caution, only being somewhat familiar with the governors' proposal, when you think about savings in Medicaid, there are really only three ways to get savings.

You can shift costs to someone else, and reducing prices is a form of that, you can shift costs to the enrollees in cutting benefits and increasing what they have to pay as a form of that, or you can try to actually design a more efficient way to deliver services to people in the program.

And as I listened to the governors' flexibility, it is primarily flexibility oriented to the first two of those kinds of changes, which is not to say that they are inappropriate, but they are more about shifting and reducing and not driving at how we deliver care to people.

Now, I do believe that the governors feel that, behind the flexibility they ask, they have examples of ways to improve how care is delivered. But I see a greater disconnect.

I would say our workgroup focused much more on how to improve coordination between Medicare and Medicaid, how to deliver long-term care services earlier, before people need institutional care, how to bring disease management and integration of public and private dollars so that people are getting care early, instead of waiting and getting it at the back end.

So, at least from my perspective, we were looking much more at how care is delivered, trying to make the program more efficient. I see fewer examples of that in the document that I saw this morning from the governors.

The CHAIRMAN. I thank you.

On another point, dealing generally with fraud and abuse, one area that was not focused on by the National Academy proposal, so I am curious why not, is the area of fraud and abuse.

I am very concerned about the low level of funding allotted at the Federal level to investigate fraud and abuse. It is my understanding that, of the $742 million for the health care fraud and abuse control program, only $14 million were used for Medicaid in 2004.

This is a small share compared to the $720 million used to ferret out fraud in the Medicare program. This is particularly troubling, given that the Office of Inspector General has estimated that $1 spent on Medicaid fraud and abuse nets $3 in return.

I know that the States have made some significant inroads. I read about Medicaid fraud in the papers on a weekly basis, but I am wondering whether the Federal Government should not be putting more resources into this area.

Do you think fraud and abuse are potential areas of savings in the Medicaid program?

Dr. WEIL. Mr. Chairman, the States and the folks that we work with share your concern on this issue. I should note that, although I gave you an overview of our recommendations in both my verbal and written testimony, our full document does include a number of specific recommendations with respect to a few areas, including particularly how Medicare and Medicaid could work better together in addressing concerns about fraud.

After all, it is the populations and the providers associated with the dual eligibles that account for a large share of both of these programs. We do talk about how the Federal Government funds fraud prevention services, how States are required to pay for certain information from the Federal Government, how inappropriate payments are collected, so we do have some attention to this issue in our report, though perhaps not as much as is warranted. But I would say that the States are very interested in doing that.

Just from a personal perspective, not trying to speak on behalf of my organization, when I ran the Medicaid agency in Colorado, despite the statistics that you cite showing the one-for-one payoff associated with these kinds of investments, at the practical level, when I was sitting in front of my State-level equivalent of the Finance or Budget Committee, getting additional staff was very hard, because we had caps on FTEs and caps on State positions, even if we thought that we would save more than the cost of the salary.

So I think Federal encouragement and assistance in this area could help States overcome some of the barriers they find in addressing this concern.

The CHAIRMAN. Thank you.

Now, Dr. Lambrew, in your testimony you state that much of the Medicaid spending is concentrated on very high-cost beneficiaries. Specifically, you state that 10 percent of the beneficiaries accounted for 61.5 percent of the Medicaid spending, and that was in the year 2001.

Since Medicaid is a State-based program, I am very interested in your thinking on how States can better coordinate care of the high-cost beneficiaries. What policies should we put in place then to get States to better coordinate care?

Dr. LAMBREW. That is a very good question. There are lots of ideas, and this is a huge area of potential, trying to figure out how to take these high-cost cases and manage their care better.

Just as a note, this high-cost care management is different than our historical case management in that it typically focuses on diseases, like diabetes or heart failure, or is triggered by people who trip into the high-cost category. So, it is focused on a small set of people.

Models often include evidence-based medicine, trying to use technology to coordinate care, electronic medical records, call centers to make sure that an individual, when they need to ask a question, has somebody to call when their doctor is not available.

So, there are several models out there. We have seen, in Kansas, an aggressive asthma program that has been developed to provide education and monitoring to prevent children with asthma from going to the emergency room.

In Maryland, there is a program that looks at rural people with diabetes. How do we actually ensure that they are doing the moni-

toring of their blood sugars to prevent them from having complications?

In Massachusetts, they have, for years, had a program that targets those dual eligibles, those people who are eligible for Medicare and Medicaid, and coordinates all their services, plus services not covered by either program.

There are several State models out there. In the MMA, there was this new Medicare Chronic Care Improvement program that will actually test this out—how do we do this, what works, what does not—and get good, hard numbers as a result, which is going to be a breakthrough, because the truth of the matter is, the Congressional Budget Office wrote a 34-page memo that said, we are not sure yet. We do not quite know what works and what does not. We really need to get beyond that.

What can Congress do? Well, I think it is interesting. In the details of the report that the governors released, there is this idea of doing a National Healthcare Innovations Program.

I am just reading this today, so I am not familiar with the details. But it would invest in 10 to 15 States to have large-scale demonstrations. They list, among these types of demonstrations, using innovative strategies to coordinate care, provide disease prevention, use evidence-based practices, et cetera. So, I think that is one idea out there.

It is somewhat similar to what Dr. Butler was talking about with his State-based demonstrations. But the truth is, this is what the 1115 Section is for, demonstrations on how do we implement effective and innovative ways to, as Alan said, improve the efficiency of Medicaid. So, there are waiver options.

There is a new proposal put on the table by the governors, and there is the old-fashioned idea of looking at Federal matching rates, to figure out if we can incentivize this type of care.

The CHAIRMAN. Thank you.

Now I would like to ask Dr. Butler a question. From the testimony by the governors, it appears that their approach is consistent with your approach on greater State flexibility. Why do you think State flexibility is the key, and I think is primary in your judgment, to the future of Medicaid?

Dr. BUTLER. Well, I think it is for two related reasons. One is that we do not really know the answer on how to really get better value for money in Medicaid. We cannot be certain of what the answer is. So, it is very important to try different things and different approaches in different States. That is one of the reasons why I think the governors' proposal is so important. Flexibility does allow the Federal Government, in negotiating with particular States, to really try approaches.

The second reason is that we do need to have some differences, some variations that recognize differences between the States. That might mean that what works for Medicaid in one State is not precisely what would work in another State. It is very important to have flexibility to adjust to that.

But, as I said at the beginning, a precondition for flexibility is that there has to be some agreement on what the overall goals are of allowing that flexibility, and what the protections must be for particular populations in that flexibility.

I think the governors would agree with that, but I think that is critically important. This is not a case of handing over a check and keeping your fingers crossed that they all do the right thing.

The CHAIRMAN. Also, you argue that we link performance-based goals with any additional flexibility. Why are performance-based goals needed, and how would they impact how States exercise that greater flexibility?

Dr. BUTLER. Well, by performance I mean that, if there is an agreement between the Federal Government and a State to achieve the agreed objective to improve coverage, savings in Medicaid, and so forth—and by performance-based, I mean we have to see those outcomes as we allow flexibility—there has to be, first of all, a plausible approach and proposal to achieve those objectives, with a timeline. I think the release of funds or the agreement that savings should be reprogrammed ought to be linked directly to achieving the timelines in that agreed proposal.

The CHAIRMAN. If Senator Rockefeller does not come in just a couple of minutes, I want to give a short summation here. If he does not come, then we will adjourn.

First of all, I thank the governors, and I thank you for your appearance. We appreciate your time and insight on a very complex issue. I think that we have learned a great deal, and probably have a lot more to learn, but it has been valuable input from our witnesses.

As the committee continues its work on Medicaid, I believe that we need to more carefully scrutinize the way that Medicaid funds are spent. We know that there are hundreds of millions of dollars in fraud, waste and abuse draining the program of much-needed resources. These funds could instead be used to assist Medicaid beneficiaries.

With that in mind, we are going to hold a 2-day hearing June 28 and 29 on fraud, waste and abuse in the Medicaid program. Also, as a reminder to staff, as well as to you as witnesses—and I did not say this to the governors—but Senators, if they have any questions for the record that they would ask you to respond to in writing, they should be submitted by this Friday at the close of business this week. Thank you all very much.

The committee hearing is adjourned.

[Whereupon, at 12:31 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Statement of U.S. Senator Max Baucus
United States Senate Finance Committee Hearing
"The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net"

Thank you, Chairman Grassley, for holding this important hearing. Medicaid's importance as a safety net program in our health care system can't be overstated. And yet this critical program is often overlooked.

Aside from shutting down some abuses in the program, Congress hasn't spent much time debating Medicaid changes in recent years. Little attention has been paid to long-term reforms necessary to maintain Medicaid's viability for future generations. Today, our nation's governors will share their views on this vital safety net. As stewards of state Medicaid programs, their voice is critical.

Absent Congressional action on Medicaid, states have sought changes through aggressive use of the 1115 waiver authority. This authority was designed to allow demonstrations and experimentation. But states – with HHS' permission -- have used waivers to make wholesale reforms. So I am glad that Congress has entered the debate. Greater legislative oversight is long overdue.

But it concerns me that we discuss Medicaid today in the shadow of a budget that may cut $10 billion over 5 years from the program. I voted against the budget and am uncomfortable with substantial cuts to Medicaid. The governors have done some difficult work to find consensus on Medicaid reforms, and I commend them for that.

The National Governors Association's (NGA) plan recommends reforming pharmacy payments. I agree that reforms are needed. And we must ensure that the states receive appropriate savings from manufacturers.

I also agree that Medicaid should be reserved for the neediest among us. It should not become a program for those who can hire clever estate planners to maneuver their assets and qualify for Medicaid.

NGA is right to consider ways to increase private investment in long term care, particularly as we debate other aspects of retirement security, including pensions and Social Security. And I agree that Medicaid should encourage quality improvement.

But I am concerned about some of the specifics of NGA's proposal, starting with cost-sharing. Onerous cost-sharing requirements can harm access to care. While personal responsibility is important, we should not place unduly high barriers to access through changes in cost-sharing.

Governor Warner, you recognized that cost-sharing for CHIP in Virginia could undermine access to care for needy children and you stopped that policy. The studies I have seen suggest that increasing cost-sharing can undermine access to care. We need good evidence that access won't be compromised before going down this road.

On benefit flexibility, I do not believe that access to primary care -- without appropriate access to specialists or hospital care -- constitutes proper coverage. Nor do I believe that fundamental aspects of Medicaid should be waived. That's why I have pushed legislation to prevent abuse of the 1115 waiver authority.

Finally, the NGA proposal recommends judicial reforms that appear to undermine the very nature of Medicaid's federal-state partnership. We should be very careful about making changes here.

Mr. Chairman, I am glad we are having this hearing. Welcome to our distinguished governors, NGA Chair and Vice Chair, Governor Huckabee and Governor Warner. I also look forward to hearing from other witnesses, who have a wide range of views on Medicaid.

Before closing, let me raise one other topic: TANF. At the end of June, the 9th extension of current law will expire and a 10th extension will be needed. The Finance Committee has passed a bipartisan bill supported by both the Chair and Ranking Member. I commend the Chairman for his efforts.

Yet there are no plans for floor action. I know that Chairman Grassley shares my sense of frustration. As governors who administer state TANF programs, you must also be frustrated. And I assume you would not support moving TANF through the budget reconciliation process.

Thank you again, Mr. Chairman, for holding this hearing. I am glad for the opportunity to closely examine our health care safety net. I look forward to the discussion.

PREPARED STATEMENT OF STUART BUTLER, PHD

My name is Stuart Butler. I am Vice President for Domestic and Economic Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation

Summary of Testimony

- Potential savings in Medicaid should be considered within the general goal of increasing coverage. And the key to achieving that goal is to explore new ways of using our system of federalism.

- Political polarization in Washington requires us to think of achieving legislative progress less in terms of building out from the center and more in terms of building in from each flank. An enhanced federalism strategy, such as that developed by Stuart Butler of Heritage and Henry Aaron of the Brookings Institution, recognizes this.

- Utilizing this approach involves the following core elements:

    - Congress establishes broad and measurable goals for increasing coverage while using funds more effectively, and protections or policy boundaries for vulnerable populations.

    - Congress enacts a "policy toolbox" federal reforms or programs that would be available to states, not required. The aim would be a "logrolled" toolbox package of federal initiatives and legislated waivers that represented the preferred options of liberals and conservatives as well as centrists in Congress.

    - States could offer innovative proposals to achieve the goals, utilizing selected federal toolbox items and state initiatives. An independent commission would select a slate of proposals that would be implemented, subject to an up-or-down vote in Congress for the entire slate.

    - Using the principle of pay for performance, states would receive funding according to an agreed timeline for achieving the agreed goals in the proposal.

- In the context of the current debate over Medicaid, the uninsured, and the federal budget, Congress should consider the following:

    - To the extent that there might be additional federal funds for increases in coverage, this money should be focused on a small number of creative federal-state initiatives rather than spread thinly over the entire nation.

    - Whatever changes Congress finally makes in the Medicaid program to comply with the Medicaid budget target, states should have the opportunity to propose creative ways of achieving those targets within the goal of generally

increasing coverage. Enhanced federalism offers a procedure to do that. The 1996 welfare reform legislation contained a similar structure – there was a "default" federal reform but states could propose alternative ways of achieving their intent of the federal reforms.

- There will be buy-in by the governors and the minority only if they believe the process for selecting state initiatives will be fair and balanced. That is why selections should be undertaken by a commission, not by the Secretary of HHS. But using a commission to choose a slate of state initiatives to reduce uninsurance, or to propose savings in Medicaid, requires the commission to be truly bipartisan – with voting representatives selected by governors, and by the congressional minority and majority.

- Large-scale demonstrations are often seen as the means of attracting "outlier" votes to win passage of legislation. The enhanced federalism approach uses large demonstrations as the centerpiece of legislation in order to test a range of innovative proposals.

- Rather than trying to establish a formula for how states would be rewarded, state proposals to the commission should include a "bid" regarding federal funds. If new federal funds were available for increasing coverage, then a federal funding request would be included as the bid. If the national funding goal were only to reduce federal costs in Medicaid, then the bid would involve net federal savings expected from restructuring programs within the proposal. The commission would engage in rounds of negotiation so that the final slate of proposals was in line with budget requirements.

- "Outlier" proposals from states, such as approaches based on a form of single payer model or a strong consumer-choice model, could be undertaken within a limited geographic area of for only certain categories of state resident.

Mr. Chairman, the states face a daunting budget challenge in maintaining existing service levels under Medicaid and other health programs, especially as education and other state obligations compete for limited resources. But it is also the states that face the immediate pressure to address the health needs of working-age Americans who lack insurance coverage. Yet budgets are also strained at the federal level. The result: states find themselves in a financial shell game with the federal government rather than involved in a process of constructively searching for a resolution. Meanwhile promising ideas that might lead to ways of organizing and delivering care more effectively and efficiently remain bottled up in Congress.

The current tension over Medicaid underscores the need to introduce a more creative and comprehensive approach; one that encourages both states and the federal government to seek ways of delivering the Medicaid promise at less cost while launching approaches that would reduce the general level of uninsurance. This can be done only by considering changes in Medicaid not in isolation but within the context of the goal of reducing uninsurance. And the key to achieving that goal is to explore new ways of using our system of federalism. If we were to do that we might trigger more creativity in the search for effective and efficient ways of reaching our health care goals and "unlock" promising approaches now bottled up in Congress. Yet even if the immediate goal is narrower – achieving net savings for the federal government – the same approach would achieve that goal with less disruption to those currently covered by Medicaid, and perhaps in some states an increase in Medicaid or equivalent coverage.

The Environment for Improving State-Based Coverage

There are several reasons why the prospects today are generally considered to be unfavorable for bold and fresh initiatives on health care for working age Americans. Among the most important:

1) Absence of Political Enthusiasm

Wile many Republican lawmakers and leaders have offered health proposals with great enthusiasm, it is still fair to say that health care does not rank as highly with Republicans as it does with Democrats, in terms of budget priorities or political urgency. There is also reluctance among Americans to the idea of significant new health programs. Survey analysis by Robert Blendon[1] and Daniel Yankelovich, among others, indicates this ambivalence among the public. While Americans express the desire to address uninsurance and related health care problems for working-age households, and they are concerned about the continuity of their own coverage, they not yet willing to accept what experts see as the necessary tradeoffs. In particular, Americans today are unwilling to accept the argument that major additional resources are needed to address the goal of reducing uninsurance.

---

[1] Robert J. Blendon, John M. Benson, and Catherine M. DesRoches, "Americans' Views of the Uninsured: An Era for Hybrid Proposals," *Heath Affairs*, Web Exclusive, August 27, 2003

2) Political Polarization

Polarization in Congress is another obstacle. The heightened political partisanship in recent years makes the prospects seem especially bleak for progress on health care. In particular, the traditional vision of "build-out-from-the-center" bipartisanship is far less tenable today. The cadre of conservative Democrats and liberal Republicans that once led on health care has shrunk considerably. Today's partisanship means that many congressional health initiatives have a more pronounced ideological aspect to them. But these tend to languish in Congress. Partly this is because of partisan opposition. But partly it is because proponents of more ideological proposals are less open to winning passage by accepting "watered-down" versions that lack key but controversial component, because they fear these might fail and cast doubt on the original idea. So all too often today, congressional "debate" consists of presenting dueling computer simulations of ideal proposals rather than crafting compromise bipartisan legislation.

Reasons for Optimism

Despite these obstacles to broad action on health, there are some trends that suggest there may be possible ways of achieving progress in this environment.

1) Republican interest in state experimentation

Republican support for state experimentation, through waivers, does mean that diverse approaches could be tried if these are proposed by the states – albeit within the limitations of statutes and Administration political priorities. Such openness to state experimentation means that proposals that would not make it through a polarized Congress if they were advocated for the whole country could perhaps be tested in the field within one state.

2) Bipartisan support for individual health care subsidies

While debate continues about the design and eligibility for refundable tax credits for health insurance, there is still broad bipartisan support for the idea. This represents an important commitment by Republicans as well as Democrats for direct subsidies to enable families to afford coverage. Since federal tax credits could be used in tandem with other approaches, including state-based initiatives for insurance pooling or Medicaid and SCHIP changes, this commitment could make possible an array of possible federal-state partnerships.

3) Wide support for insurance pooling, reinsurance and risk-adjustment

There is also broad bipartisan support for spreading the cost of high risk individuals across wider populations, meaning that there is the potential to craft an insurance infrastructure that makes coverage affordable (with some subsidies) to all income and risk groups. Such ideas range from Senator Kerry's federal reinsurance proposal, to state-sponsored high-risk pools, to risk-adjustment system systems, to Bush-supported health associations for small businesses and non-business associations. To be sure, there are intense policy disputes about which approach is best, and what the practical consequences of rival proposals would be, but these are "engineering design" arguments rather than a dispute about the principle of spreading risk beyond merely employment-based pools.

4) Some openness to modifications of low-income support programs

There is also an increasing willingness to contemplate a variety of novel ways of fulfilling the purposes of Medicaid/SCHIP – providing the eligibility of individuals is maintained or widened and equivalent services are provided in a manner that assures quality and continuity. One way to do this, for example, might be to use a portion of the existing Medicaid budget for an individual, in combination with a federal refundable tax credit, to enable that individual to enroll in employment-based coverage instead of Medicaid. This would free up the remaining Medicaid money to fund part of the cost of the coverage for another individual. Or a federal tax credit might be used by a family to "buy into" Medicaid, or in combination with some Medicaid funds to purchase private coverage through a state-sponsored pooling arrangement. Proposals from the National Governors Association argue that we should consider giving at least some individuals on Medicaid the option of using a federal refundable credit for private insurance.

Using Enhanced Federalism to Achieve Progress With Limited Dollars

An enhanced approach to federalism is likely to be the most effective way of moving forward in this checkered environment, by circumventing political obstacles at the national level and enabling creative and potentially more efficient proposals to be tried. While the idea of state demonstrations and waivers is of course not new, permitting more sweeping state initiatives – particularly federal legislation that would also make new and modified federal programs available in state experiments – could break the political logjam that impedes action today.

A version of enhanced federalism has been laid out by this author and Henry Aaron of the Brookings Institution.[2] To summarize the Aaron-Butler approach:

> "We propose that Congress provide financial assistance and a legal framework to trigger a diverse set of federal-state initiatives. To help break the impasse in

[2] Henry J. Aaron and Stuart M. Butler, "How Federalism Could Spur Bipartisan Action on the Uninsured," *Health Affairs* Web Exclusive, March 31, 2004

> Congress over most national approaches, we propose steps designed to enable "first choice" political ideas to be tried in limited areas, with the support of states and through the enactment of a federal "policy toolbox" of legislated approaches that would be available to states but not imposed on them. Our view is that elected officials would be prepared to authorize some approaches now bottled up in Congress if they knew that the approach would not be imposed on their states."[3]

The Aaron-Butler vision of enhanced federalism contains the following core elements:

Goals and protections: Congress would establish broad and measurable goals for federal-state initiatives, such as reducing the percentage of uninsured in a state. Goals could incorporate quality as well as quantity: many lawmakers and organizations, as well as the National Governors Association, advocate initiatives to improve the quality of health services and coverage as well as broadening coverage. Congress would also place some protections or boundaries on what would constitute success. These boundaries would include some definition of what constitutes adequate "coverage" and specify any groups of Americans that should in general be held harmless by any initiative (e.g. some mandatory populations currently covered by Medicaid or some categories of workers covered by employer-based insurance).

A "policy toolbox" of federal policies and programs: A major reason for gridlock today is that a Member of Congress who opposes introducing a certain approach in his/her state will block a national initiative that would have that result. This tendency is accentuated by the increased partisanship in Congress (where ideological opposition becomes more of a factor). Ironically, since many states have developed their own initiatives to improve coverage, there is also the fear in some states that Washington's 'heavy helping hand' would disrupt these initiatives.

The idea of a "policy toolbox" is that instead of imposing new or changed programs on the entire nation, a package of congressional measures that would be blocked if designed to apply nationwide is instead made available only to states wishing to utilize the measures within a federal-state initiative. Items in the toolbox would be available to states, but not required in any state without its permission. Politically this encourages a productive form of what one might call "ideological logrolling", with left-right partisans agreeing to support each other's policy tools in order to achieve the chance to field-test a reasonably pure version of their own proposal. An important political feature of this approach is that these ideological lawmakers in both parties would be a countervailing pressure against the general tendency of Congress to micromanage bipartisan health care agreements.

Examples of proposals that might be legislatively unlocked in this way include some form of health association (perhaps with agreed exemptions from state mandates rather than federal preemption); permitting new populations to be covered by the FEHBP and VA programs or some equivalent arrangement; providing a large tax credit for

---

[3] Op. cit.

coverage; expansions of permitted Medicaid populations or utilizing Medicaid funds to enroll individuals in other forms of coverage to achieve net savings; insurance reform to create statewide, risk-adjusted pools; and extending tax benefits to employees picking certain plans not sponsored by their employer.

State proposals with federal approval: A state wishing to take part in this enhanced federalism would prepare a formal proposal to make progress towards the goals established by Congress. Such proposals would select some items from the federal policy toolbox in tandem with state initiatives designed to make progress towards the proposal's goals. A procedure would be established by the federal legislation for choosing proposals to implement, negotiating necessary administrative waivers to 'fine-tune' each proposal, collecting data, and monitoring performance. Proposals would be approved for a specific and standard period, say five years – although proposals might be approved for longer periods if they involved large changes in programs or health arrangements in a state.

Funding linked to goals: The principle for rewarding success would be "pay for performance." To the extent that new funds were made available, states would receive money if they succeeded in extending coverage or meeting related goals, and nothing if they did not. If the proposal were to require the use of federal funds from other programs to achieve improved coverage while meeting a goal for federal savings in, say, Medicaid, then federal funds would be released in line with the achievement of agreed milestones in expanding coverage.

Crafting A Viable Legislative Proposal

The devil of any approach to build momentum for health care legislation lies of course in the political and technical details. Within the general framework of enhanced federalism there are several key design issues that would have to be resolved. How one does resolve them depends as much if not more on political judgments as on technical considerations.

1) Federal funding goals – net savings or net increases

The Aaron-Butler approach envisioned a pool of new federal money for reducing uninsurance. Hence the assumption was that state proposals would vie for available new funds. But the same approach is adaptable where the federal funding objective is to achieve reductions in the growth of a program, such as Medicaid. In that case the state proposals would be designed to meet the reduced federal budget allocation for the state in a manner that had the least impact on state residents currently with insurance or Medicaid coverage – and perhaps even achieved net savings in innovative ways that actually increased coverage.

2) The number and scale of state initiatives – the need for focus and ideology

Budget and political trade-offs are inextricably linked in determining the ideal number and scale of the state initiatives. In today's environment it is wiser to assume that the available budget for health initiatives (likely to be modest) will determine the technical and political design of the approach rather than assuming the design will determine the federal budget. The presumption here is that pool of available resources would include some existing funds or proposals already on the budget table. The pool thus might include part of any reserve fund created to finance President Bush's initiative on the uninsured, a portion of projected savings from Medicaid, perhaps some portion of federal funds for uncompensated care (matched with additional federal funds), as well as some new funds.

Whatever the available funds, there are political tradeoffs in selecting the number and size of state proposals. Proposing to spread funds broadly but thinly over many states might seem attractive to gain the support of more states, but then each individual state would see less of a funding incentive to support the idea. However the flexibility and availability of new federal programs would be powerful incentives to support the approach even without the prospect of major new federal funding. The critical test for a state would be whether the combination of flexibility in using existing and new federal funds, combined with the opportunity to undertake launch a creative initiative with the federal government to expand coverage, proved sufficient to warrant the political and other risks involved. That is an empirical rather than theoretical question.

The ideological dimension of possible initiatives plays into the possible calculation at both the congressional and – perhaps to a lesser degree – at the state level. The opportunity for congressional partisan supporters of what one might call "paradigm" ideas to see them truly tested in the field likely would make supporters inclined to focus new federal funds on a small number of state initiatives – although there could be other initiatives primarily using existing program funds in creative new ways. To be sure, there might seem to be little incentive for states as a whole to support an approach that concentrates new federal money on a few states. But a governor who supports a paradigm approach (such as a significant expansion of Medicaid, or large tax-based subsidies to individuals) might well be open to another state receiving federal funds if that could lead to a convincing demonstration of the approach and its subsequent availability to all states.

Initiatives and modest new federal funds could also be focused on proposals to cover less than an entire state, assuming the scale of the experiment reached a critical mass. This option could build political support among states. For instance, for a certain level of funds, several large states could have funded proposals limited to certain counties, rather than using the funds for only one statewide proposal. Moreover, cross-border joint proposals covering metropolitan or rural areas could generate broader state support.

3) Selecting successful state initiatives – a bipartisan, full-voting "base closing commission"

An approach that involves selecting a limited number of federal-state initiatives from competing state proposals raises obvious political challenges, especially where there is an ideological dimension to some proposals and there is new federal money. In particular, how could we secure broad political support for the approach – especially from the minority party in Congress?

It seems very unlikely that many minority party Members of Congress or states could be persuaded to support legislation that allowed the Secretary of Health and Human Services (HHS) to choose among competing state proposals that could mean large changes in state health systems – including perhaps Medicaid and SCHIP. The reluctance of Democrats and governors to join the recently enacted Medicaid Commission underscores the political dangers of making the HHS Secretary in any administration the gatekeeper for recommendations.

The key to generating wide political support is a process for selecting initiatives that is considered fair and balanced by everyone. This cannot be achieved if the Secretary of HHS makes the final selection. In the article authored last year by Aaron and Butler, we emphasized that these decisions had to be made by an independent body that was truly bipartisan, with the decisions certified by Congress. We recommended a newly created commission with full voting members selected by Congress, the Administration and the states, perhaps with technical advice from the General Accountability Office. States would submit formal draft proposals to the commission to evaluate. These proposals would include federal toolbox items as discussed below. The commission would discuss and negotiate the elements of the proposal with the state, to assure that it met the congressional guidelines and complemented other state proposals. The commission would then present a recommended "slate" of proposals to Congress for an up-or-down vote without amendment. The HHS Secretary's role would be restricted to negotiating final administrative details with the successful states. This is essentially a "base-closing commission" solution.

The legislation setting up this procedure would essentially instruct the commission to come back with a slate that complied with certain guidelines. The legislation would set the total federal budget limits for the slate. Rather than giving the commission *carte blanche* to select the slate, the legislation might require the commission to include certain categories of paradigm state proposals envisioned in the federal policy toolbox and reflecting the ideas favored by congressional constituencies that were key to bipartisan support. So the commission might be directed to include at least one proposal to expand Medicaid and/or SCHIP, and an equivalent of large individual tax credits or vouchers and purchasing pools, among other proposals. While any directions from Congress can easily degenerate into micromanagement and the inclusion of pet demonstration projects, the political need for strong advocates of paradigm proposals to be assured of seeing a valid, "clean" demonstration of their proposal could mean a degree of *détente* when it came to adding excessive requirements.

A variant of the Aaron-Butler commission idea would be for the commission to propose a slate to the Secretary. But in this case, governors and Members of Congress from both parties would have to feel confident that the members of the commission had such political stature and bipartisanship that, politically, the Secretary could not ignore the slate of recommendations. The 1982 Social Security commission and the recent 9-11 commission are examples of how a politically powerful commission can build momentum for its recommendations.

4) Designing the federal policy toolbox – symmetry and logrolling

The federal "policy toolbox" described earlier is a key part of an enhanced federalism approach, both politically and technically. From a policy perspective, the toolbox is important because it provides a major federal policy dimension to complement state initiatives to improve coverage. Items in the toolbox can be seen in some cases as new or expanded federal programs that would be available in selected states, and in some cases as statutory waivers – or 'super-waivers' – to permit significant variations in existing programs and the use of their funds.

Today is it fairly common to include a limited demonstration program in a larger piece of legislation when the political support of a group of lawmakers is necessary for passage but others would balk if the program were applied nationwide. For example, when it was clear that introducing vigorous competition into Medicare as part of the recent drug legislation could cost critical Republican votes and doom the bill, the leadership included it instead as a demonstration program. This was enough to retain conservative supporters but left Republican as well as Democratic opponents secure in the knowledge that the competition initiative would not apply to their states.

The toolbox idea converts such demonstrations from a minor political necessity to retain lawmakers in a coalition to a core logrolling strategy to build a bipartisan majority for radical state-based initiatives.

To accomplish logrolling there has to be symmetry so that ideological members of each party could support the package. Thus it would be important to assemble pairs or groups of proposals that would appeal to a broad ideological spectrum, balancing philosophy and the allocation of funds. For instance, costly expansions of Medicaid or SCHIP might be balanced in the toolbox with a similarly funded refundable tax credit or voucher (designed to mimic a tax credit); a health association program might be balanced with a government-led health alliance; opening up the FEHBP in some way might be balanced with a VA-like single-payer option. The federal toolbox would be hammered out in Congress and enacted before the states and the commission considered proposals.

5) Protections and boundaries – guidelines with flexibility

Creating a bipartisan coalition necessitates assuring key constituencies and lawmakers that they can acquiesce in radical changes they do not support because they can be sure that certain principles will be protected and certain lines will not be crossed.

Like other requirements of a bipartisan agreement, it would not be easy to agree on these protections and boundaries. But supporters of innovative and ideological initiatives would know their own ideas would be blocked if they were unreasonable about demanding detailed protections for other proposals.

One such protection or boundary issue concerns the very definition of "coverage," or the meaning of "insurance." The amount of family financial exposure before comprehensive insurance reimbursement (or government provision) kicks in is one area that would need to be resolved satisfactorily for all sides, as would the nature of benefits that constitutes "insurance." The Aaron-Butler proposal recommended setting an actuarial minimum and allowing wide variations in state-required benefits. States would be free to design plans with different benefits at or above that minimum, including high deductible insurance plans with perhaps partly funded health savings accounts.

Some level of protection for individuals already covered would also have to be resolved (particularly those in Medicaid or state programs, and those in most employer-sponsored plans). Achieving the goal of a decrease in uninsurance by dropping high-cost individuals and replacing them with a larger number of healthier people probably would not pass muster. Aaron-Butler proposed no reduction in the degree of coverage for currently insured populations, most notably those in Medicaid – though it would not rule out major changes in Medicaid. A state could provide the functional equivalent of Medicaid, for instance, by utilizing a tax credit in combination with a federal tax credit or voucher to enable some currently on Medicaid to enroll in an employer-based plan or individual coverage (perhaps within a statewide pool). But even with reductions enacted in the growth of Medicaid, there could be protections included for certain populations covered by the program. However the coverage protection issue was resolved, it is critical for the overall political and policy success of enhanced federalism that Congress set only broad guidelines.

6) Determining and rewarding success – trust but verify

Another difficult issue is how to determine what constituted success in a state initiative and how success should be rewarded.

Rather than setting out detailed objectives for proposals, the essence of enhanced federalism is for Congress to establish only broad goals for the improving the degree and quality of coverage. How a state envisioned the goal and sought to reach it would have to be agreed with the federal government within the guidance of the statute. The state proposal would need to contain a timeline of targets and outcome measures. If a commission were to select a "slate" of proposals for federal approval, that would be an additional assurance that the state's interpretation of the goal was reasonable, and its plan and timeline realistic.

But how to agree on and verify success, particularly if that triggered a federal financial bonus for a state? On the other hand, what if the funding objective of the

federal government involved achieving a reduction in the baseline cost of Medicaid? What elements would have to be in the equation?

One element is an agreement on information. To the extent that certain base information on coverage was needed to confirm progress, Congress would be wise to include funding for appropriate surveys and data collection. Standard data collection methods across state lines would be essential, especially with some funding contingent on success in reaching goals, to avoid disputes between states and with the federal government. A state's willingness to assist in the collection of data could be a factor in selecting proposals for implementation.

Another element is an agreement on who decides success or failure. One of the lessons of the experience with state welfare reform demonstrations prior to the 1996 reform legislation was that the state and the federal authorities agreed to third party measurements of results. Similar "arbitration", conducted rigorously by an independent body, would be critical to the willingness of states and the federal government to agree on a plan and on whether there was adequate progress. Third-party assessment also would reduce the need for detailed and standardized measures to be agreed nationally or placed in legislation; instead the details would be agreed between the three parties. The state and the federal government would jointly select the third party assessing progress for each proposal. This might be a private analytical organization. It might also be a federal agency, such as the GAO, or even a state body if the selection was agreeable to both parties.

A third element is an agreement on the allocation of federal funding or the use of some portion of savings. New federal funding is not the heart of the enhanced federalism approach – the most important feature is freedom and flexibility in design and use of existing funds to reach agreed goals, which might include savings in a program such as Medicaid. But some federal funding to offset evaluation and design costs and provide bonuses for success likely would be needed to induce states to offer major proposals. And federal funds would be appropriate where a proposal hinged on creating or expanding a program that had a federal component (such as Medicaid) or that incorporated a federal initiative (such as a refundable federal tax credit). On the other hand, elements of the state proposal could be designed to save federal funds, with some portion of the savings reprogrammed into initiatives intended to increase coverage.

Bidding for federal dollars. Perhaps the least attractive way of allocating any new federal funding would be through a strict allocation formula tied to congressionally determined performance standards. That would invite damaging formula fights. But can that be avoided? A way to do so might be through the selection process for the commission's slate of proposals. Let's say the individual states put in an initial public "bid" to the commission, indicating the degree of federal funding it felt was needed and fair to accomplish the proposed goal, bearing in mind the total funding available under the program and the congressional guidelines. The proposal would perhaps focus on reducing uninsurance among particular groups, such as children or older workers, and the financing bid would reflect the targeted population. With a set of proposals containing

bids for federal funding before it, the commission could engage in successive rounds of discussions or negotiations with states to produce a final set of recommended proposals within the total budget. Through such a bidding procedure and negotiating rounds, the process would produce funding formulas agreeable to the chosen states.

A successful bidding "market" of this form could be an alternative to the daunting task of trying to develop a federal funding formula adjusted for regional differences, categories of individuals newly covered etc. And even if it were thought that a nationwide funding formula would ultimately have to be created, a bidding market of this kind would produce a "market-tested" outline for such a formula.

This is actually less radical than it may seem. In reality most large federal grant programs operate a little like a bidding market – just not one as structured as proposed here. For example, when a city develops a proposal for a federally supported mass transit system, it requests a certain level of federal dollars to achieve a certain result – much as recommended here for a set of state proposals. Moreover, the city typically structures the transit proposal not just in the context of the program's budget allocation but also based on its knowledge of other city's bids under the program.

Would states propose only initiatives that involved large infusions of federal money under such an arrangement, to maximize out-of-state funding? Would states avoid initiatives that expanded coverage primarily by using existing funds more creatively? Perhaps. But the federal government would have the opposite incentive and so a balanced commission would have an inclination to give strong consideration to proposals that did not require heavy federal funding. Indeed a state might include a larger bonus within its bid as "profit" for a proposal that sought to reduce uninsurance at relatively low federal cost.

Perhaps the additional bonuses for reaching or exceeding goals – as opposed to the release of federal funds associated with direct costs – could be linked to a congressional formula based on goals for particular political groups. But those bonuses would be relatively small and less likely to spark the level of congressional heat that accompanies major federal commitments to programs like Medicaid.

Bidding for savings. The same bidding model can be adapted for a situation in which the federal funding objective is a reduction in projected outlays for Medicaid or another program. The aim in that case would be to craft a proposal to meet a federal funding target for the state in ways that kept reductions in coverage to a minimum or actually increased coverage. The analog is the welfare reform legislation of 1996. Whatever "default" changes are put into place, the state would be able to propose an alternative method of reaching the same goals. Thus a state could propose changes, including utilizing items from the federal toolbox that achieved the same savings in a number of ways – for example, by inducing employers to enroll workers or dependents who might otherwise be eligible for traditional Medicaid. In some instances those methods of reducing Medicaid costs might include new federal outlays for other forms of coverage (e.g. refundable tax credits), such that the net federal outlays for the state met

the target for Medicaid. In this case the bid would involve a request for increased funding elsewhere to achieve larger Medicaid savings (with the net federal outlays meeting the goal for Medicaid).

7) Designing outlier proposals – the art of the possible

The more radical the proposal being considered by a state, the more disruptive it would be to existing arrangements and thus the more politically challenging. A statewide single-payer initiative, for instance, would mean closing down all employer-sponsored plans. A pure consumer-choice individual market initiative would mean suspending Medicare and the VA system within state borders. Clearly this is not likely to be accepted in the foreseeable future in Congress or in any state.

But the objective of testing the more radical ideas favored by the left and the right could in some instances be achieved by limiting the population involved and so reducing disruption and political opposition. The critical thing is to have an initiative that is seen by supporters as a true test of the idea, not necessarily a statewide initiative covering everyone. So a state might design an initiative approximating a single-payer system while exempting ERISA plans, perhaps with a proposal to make Medicaid or VA coverage the only state-approved coverage for the non-ERISA population in some counties. Or another state might propose federal-state vouchers for all the non-elderly and non-ERISA population in a few counties or statewide in order to test the functional equivalent of a refundable tax credit.

****

The Heritage Foundation is a public policy, research, and educational organization operating under Section 501(C)(3). It is privately supported, and receives no funds from any government at any level, nor does it perform any government or other contract work.

The Heritage Foundation is the most broadly supported think tank in the United States. During 2004, it had more than 200,000 individual, foundation, and corporate supporters representing every state in the U.S. Its 2004 income came from the following sources:

Individuals	56%
Foundations	24%
Corporations	4%
Investment Income	11%
Publication Sales and Other	5%

The top five corporate givers provided The Heritage Foundation with 2% of its 2004 income. The Heritage Foundation's books are audited annually by the national accounting firm of Deloitte & Touche. A list of major donors is available from The Heritage Foundation upon request.

Members of The Heritage Foundation staff testify as individuals discussing their own independent research. The views expressed are their own, and do not reflect an institutional position for The Heritage Foundation or its board of trustees.

Answers by Stuart Butler to questions on Senate Finance Committee Hearing "The Future of Medicaid" on June 15

Senator Rockefeller

Question: Mr. Butler, do you believe there should be a federal floor on benefits and cost-sharing requirements below which no state can deviate? If the federal government is putting in a majority of the dollars, shouldn't we have some federal minimum standards for all Medicaid beneficiaries?

Answer: I agree that if the federal government is contributing the majority of federal dollars to Medicaid then it is appropriate for there to be basic federal requirements on the benefits package provided by Medicaid. The issue is what should be the form of that federal requirement.

In my article with Henry Aaron of Brookings we made the argument that specifying even a floor in much detail would frustrate the objective of innovation and make it harder for states to tailor coverage to particular needs. We favored setting an actuarial value to the package and allowing states wide latitude to vary benefits and cost sharing. On the other hand, we argued that states should submit the benefits for federal approval in the context of achieving a federal-state goal for coverage. So the state would have to demonstrate that a particular benefits package and level of cost sharing was consistent with coverage goals and protections for Medicaid recipients.

Senator Bingaman

Question: Senator DeWine and I have recently introduced legislation entitled "Ending the Medicare Disability Waiting Period Act." Currently, people who are severely disabled and qualify for Social Security Disability Insurance, or SSI, must wait two years after receiving their first disability check to receive Medicare coverage. An estimated 40 percent of those people stuck in the waiting period, who by definition are severely disabled, receive Medicaid coverage at a cost of several billion dollars a year to the Medicaid program until Medicare finally kicks in.

House Ways and Means Chairman Bill Thomas recently questioned this policy as well. What do you all think about eliminating the two-year Medicare disability waiting period, as it would save the Medicaid program billions of dollars while also improving care and treatment for some of nation's most vulnerable citizens?

Answer: I agree that the waiting period does create a burdensome process for disabled individuals to qualify for Medicare, especially when the goal is to ensure those who eventually qualify get the care they need. However, it is imperative that, alongside any

reduction in or end to the waiting period, strict and enforceable rules are put in place to deter unscrupulous individuals from misusing and defrauding the program.

Question: According to the HIV Medicine Association in Mississippi, the Mississippi Medicaid program has implemented a "policy beginning July 1 that will limit prescription drug coverage for adult Medicaid beneficiaries to just two brand-name drugs per month with absolutely no exceptions." If the standard of care for HIV disease calls for a combination of at least three antiretroviral drugs to effectively suppress HIV, how does this square with providing states with added flexibility?

Answer: The current Medicaid law allows the states great flexibility to make unilateral decisions regarding the coverage for those deemed "optional" populations. In my view, as noted in my written testimony, providing greater state flexibility should be within the context of achieving agreed federal-state goals for coverage and for the protection of specified groups. Within that framework states would be able to design benefit packages that are tailored to individual needs, especially those with chronic conditions, and ensure that those populations receive the care they need. But a proposed change would have to be shown to be consistent with the agreed goals for the population. The standard of care certainly would in most instances be the default presumption for coverage. But within a limited budget, and competing needs of other populations, some adaptation of the standard might have to be considered – again, assuming the adaptation was consistent with the overall goals of coverage.

Prepared Statement of Hon. John F. Kerry

Thank you, Chairman Grassley, for calling this important hearing and for allowing a balanced panel of witnesses to come before us today. I am anxious to dialogue with these experts on ways for us to strengthen the Medicaid program.

Medicaid is the crown jewel of the safety net. It is the nation's largest health care program - providing health and long-term care services to 53 million low-income pregnant women, children, individuals with disabilities, and seniors. Medicaid serves those for whom, if the program did not exist, they would not receive care anywhere else. It is called a safety net because it serves the poor and vulnerable and we have a special obligation to strengthen and protect it.

Under the Bush economy, this program has grown more vital than ever. Medicaid costs and enrollment figures have grown because the economy's recession has created such a demand for its services. People who once had jobs with health coverage are either losing their jobs or losing their health benefits and Medicaid is the backstop to ensure that those in greatest need are not simply added to our uninsured rolls - a figure that already stands at 45 million Americans and is a mark of shame on this great nation. Health care should be a right, not a privilege.

It is inconceivable to me that the United States Congress continues to exercise budget restraint not by saying no to large tax cuts for the wealthy, but by going after programs like Medicaid to find budget savings. Trimming the fat from government programs is one thing - but for a program already as lean as Medicaid, this results in scraping at the bones. Real lives are harmed by the decisions we make.

We can sit here and have an intellectual discussion about how changing or "reforming" the program can produce this or that amount of savings, but when it comes down to it, the question we really must ask is who we are hurting by our decisions - because every dollar taken out of this program, whether it be $10 billion or even a million, results in fewer services for someone in need.

I was reminded in church by this Sunday's readings the reasons why we have an obligation to the vulnerable in society. In the 10th chapter of Matthew's gospel we are told, "Without cost you have received, without cost you are to give." My priest cautioned us that our talents, our wealth, our achievements are nothing we have earned - they are all from God's graces - and we should therefore freely give of those graces to others. But when it comes to programs like Medicaid, we are very stingy givers.

I think we are missing the mark in our discussions today. While I do not disagree that some of the suggested reforms should be considered and perhaps even implemented to improve the workings of the program, the idea of making changes just to hit budget savings targets is all wrong.

I believe we should instead be having a discussion about the need to right-size the federal-state partnership under Medicaid. The federal government should give more and expect more.

We could cover every one of the nation's 11 million uninsured children AND give states needed fiscal relief if we got creative with our policies.

I have proposed legislation called, "KidsFirst," which would federalize all Medicaid costs for beneficiaries under age 21 that are below poverty. In exchange, states agree to expand their health programs for children in higher income families and reduce the barriers to enrollment that keep so many of our eligible children unenrolled.

The result? Universal coverage for children and additional resources for states to address other health care needs. This compact would provide states with an estimated $6 billion annually more than what they are required to spend in their expansion programs.

More than 700,000 Americans have signed a citizens' petition in support of the KidsFirst bill; another 20,000 phoned in and recorded their personal stories on why this legislation is so crucial; and it has gained the endorsement of leading health and children's organizations that represent more than 20 million Americans nationwide.

If we cannot find the common ground for bipartisan agreement to cover all of our children with good health care, we are really failing as a nation.

I look forward to the day when we return to making decisions in this Capital that reflect forward-thinking, progressive policies that improve the lives of millions of Americans.

Thank you again, Chairman Grassley, for gathering us here today for this discussion and I welcome the opportunity to continue this dialogue after our witnesses give their testimony.

Testimony of

Jeanne M. Lambrew, PhD

Senior Fellow, Center for American Progress

Associate Professor, Department of Health Policy
School of Public Health and Health Services
George Washington University Medical Center

"Medicaid, Costs, and Health System Reform"

Before the

Committee on Finance
United States Senate

Hearing on:

"The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net"

June 15, 2005

Chairman Grassley, Senator Baucus, and Members of the Committee, I thank you for the opportunity to appear before you today to discuss the future of Medicaid. This debate is timely, as both state and Federal officials are focused on Medicaid costs. My testimony, after reviewing Medicaid's goals, describes what factors drive Medicaid's costs and what to do about them. It also discusses the need for broader reform, since Medicaid's problems are the system's problems. Addressing only Medicaid will not prevent a further erosion in private coverage, and stabilizing private coverage will not reduce Medicaid's coverage and financing deficits. Finally, having this debate in the context of a restrictive budget resolution, with politics pushing against policies such as lowering drugs prices, could result in reduced coverage, not costs. This would not only weaken access to care for vulnerable populations but could exacerbate the nation's health financing crisis.

The ideas included in this testimony are drawn from two initiatives of the Center for American Progress. First, on June 8, we released three papers on cost drivers in Medicaid in an effort to inform the current discussion; ideas and direct passages from those reports are included in this testimony.[1] Second, we proposed a plan to improve and expand health coverage for all in the U.S., hoping to reignite the debate over systemic reform.[2] The Center for American Progress is a nonpartisan research and educational institute dedicated to promoting a strong, just and free America that ensures opportunity for all. We aim to serve as a resource for policy makers on current topics, and welcome additional requests for information. All opinions expressed in this testimony are my own.

Overview: Medicaid's Mission

Today's debate is primarily driven by concerns over cost, but it is useful to review the program's goals to put the policy options into context. The first sentence of Title XIX, which governs Medicaid, essentially guarantees assistance to families, persons with disabilities and seniors whose income and resources are insufficient to meet the costs of necessary medical services.[3] Three often-overlooked points about this goal are:

- Medicaid is primarily focused on vulnerable populations; although states can use options and the State Children's Health Insurance Program to expand coverage to low-income working populations, such expansions are not its primary purpose;

- Medicaid is designed to remove financial barriers to care, which can take the form of uncovered benefits or cost sharing that is prohibitively high; and

- Medicaid is a guarantee; because its costs follow need rather than a budget, Medicaid spending unexpectedly dropped then increased in the last decade mirroring the economic swings; Federal funding increased in New York after 9-11 to fund Disaster Relief Medicaid; and its funding is shifting to rural areas where the aging of America has begun.

Because of this mission, Medicaid faces challenges other than costs: millions of poor people are either ineligible or not enrolled in the program; some who are enrolled continue to have access problems due to low provider participation or limited benefits;

and the quality of care could be improved, especially in long-term care.[4] Medicaid also has strengths that often go unnoticed. It contributes to reduced racial disparities; improved birth outcomes; higher educational attainment among children; and greater independence among persons with disabilities.[5] Thus, Medicaid reform should aim to improve quality, access, and innovation as well as program efficiency.

What's Driving Medicaid Costs

While Medicaid costs can be assessed in a number of different ways, we at the Center for American Progress chose to focus on four cost drivers. The first and second are the service categories that rank the highest in their current and future potential cost growth: prescription drugs and long-term care. Third, we worked backwards: identifying those individuals responsible for most Medicaid spending to understand how and why they are costly. Fourth, we examine the pressures put on Medicaid by a deteriorating coverage system in the U.S. The facts plus possible policy options are described below.

Prescription Drugs

When compared to other health insurance programs, Medicaid has both low spending per capita and low per-capita growth, especially when adjusted for the sickness of its beneficiaries. A study that adjusted for the different health profiles of enrollees found that Medicaid's costs are lower than those of private insurers, making it the preferred way to expand coverage to low-income populations.[6] A different study found that the annual rate of growth per enrollee in Medicaid between 2000 and 2003 was 6.1 percent, lower than the comparable Medicare spending growth per beneficiary and spending growth per privately insured person.[7] Medicaid has higher managed care penetration than Medicare, and lower administrative costs than private insurance programs.[8]

However, one service that continues to drive Medicaid costs is prescription drugs. Medicaid expenditures on prescription drugs doubled between 1998 and 2002, increasing from 8 to 11 percent of total Medicaid expenditures.[9] While Medicaid drug spending growth is projected to decelerate to 7.1 percent in CY 2004 – largely due to state cost containment efforts, it is still higher than other services' growth.[10]

The Federal government has been largely absent as states have implemented policies to contain Medicaid drug costs. States and the Federal government jointly fund Medicaid, and therefore rising Medicaid prescription drug costs also have adverse fiscal consequences for the Federal budget. In recent years, the Centers for Medicare and Medicaid Services (CMS) has taken some steps to support states with their pharmacy cost containment activities. For example, CMS issued guidance to states supporting supplemental rebate programs and identifying selected best practices.[11] However, more could be done at the Federal level to assist states and promote efficiencies across the country. This background and most of the ideas below are directly drawn from a paper by Kathleen Gifford and Sandy Kramer that includes additional options as well; since passages from this paper are used, these authors should be cited as appropriate.[12]

Provide Information and Assistance to States in Setting Drug Reimbursement. Federal policy could assist states in becoming more prudent purchasers at the retail pharmacy level. States largely operate "in the dark" in setting drug cost reimbursement without access to the actual drug acquisition costs paid by pharmacies. States typically cover over 50,000 National Drug Codes – each with its own price that can change unpredictably. It is therefore a challenge to find adequate current information to set drug reimbursement rates at levels that fairly compensate pharmacies without overpaying them. Recent reports by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) have highlighted the millions of dollars lost to states and the Federal government each year due to Medicaid overpricing.[13] Below are two of several options to provide states with better information to set retail pharmacy reimbursement policies.

- **Provide states with accurate and timely "Average Sales Prices" (ASPs) for Medicaid covered drugs.** The MMA required that, for drugs covered under Medicare Part B,[14] Medicare move to a reimbursement system based on ASP. "ASP" is the weighted average of all non-Federal sales from manufacturers to wholesalers (net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product), and is based on quarterly pricing data supplied to CMS by drug manufacturers. While some critics argue that the ASP does not accurately reflect a retail pharmacy's actual acquisition cost, the ASP is likely a better starting point for estimating that cost than the "Average Wholesale Price" (AWP). Note: since ASP is untested, there may be a better market-based measure of acquisition costs.

  President Bush's 2006 Federal budget proposal would require states to adopt an ASP plus 6 percent payment methodology (consistent with Medicare Part B) and estimates Federal savings of $542 million in 2006 and $5.4 billion over five years. Moving to an ASP methodology in Medicaid, however, would be a significant and costly undertaking that would be difficult for states to accomplish on their own. To enable all states to benefit from this methodology, the Federal government, acting through CMS, should handle the data collection and timely pricing of the over 50,000 National Drug Codes commonly covered by state Medicaid programs. This is an expansion of its role since, currently, CMS collects manufacturer data on only 5,700 National Drug Codes to price 550 Part B drugs. States would also need CMS to provide timely pricing information on new drugs entering the market and for manufacturer price adjustments that occur from time to time (currently, CMS provides only quarterly updates for Part B drugs subject to ASP pricing). Ultimately, the benefit to states of moving to an ASP methodology would depend heavily upon the effectiveness of CMS in calculating and reporting the ASP prices. Lastly, states should retain flexibility on how to use ASP in their reimbursement; it may be that ASP plus 6 percent results in overpayments, may not appropriately pay pharmacists, and provides incentives to prescribe high-cost drugs.

- **Change Federal law to allow the release of AMP information to the states.** The "Average Manufacturer Price" (AMP) data provided to CMS by drug manufacturers to support the Medicaid Drug Rebate Program may be the most accurate drug pricing

data currently available to CMS for non-Medicare Part B drugs. A limited disclosure of these data to states could be required by Federal law to help states set drug cost reimbursement at appropriate levels, as has been recommended by the OIG.[15]

Maximize Manufacturer Rebates. The methodology for the required rebate that drug manufacturers must pay to participate in Medicaid has not been modified for over 12 years, despite rapid growth in costs. This has forced a growing number of states to seek supplemental rebates, which can sometimes be difficult for a state to enact. The following proposals describe Federal policy changes to the current rebate formula that would increase rebate revenues.

- **Increase the minimum Federally-required rebate.** Some states do not have the size or circumstances to negotiate supplemental rebates. Moreover, when the new Medicare prescription drug benefit is implemented in 2006, direct Medicaid drug expenditures will be cut in half. The lost prescription volume will likely decrease the market leverage that states have to negotiate supplemental rebates. An updated brand-drug minimum rebate would help states compensate for the loss of market leverage and ensure that all states, as well as the Federal government, pay a fair price for prescription drugs covered by Medicaid. The National Governors Association, on a bipartisan basis, supports increasing the rebate.[16]

- **Implement systematic oversight of self-reported manufacturer pricing data to ensure the accuracy of Medicaid drug rebates.** Currently, the calculation of Medicaid drug rebates relies upon self-reported AMP and "best price" data supplied to CMS by drug manufacturers. In recent years, a number of drug manufacturers have agreed to pay millions of dollars in legal settlements to resolve allegations involving the underpayment of Medicaid rebates arising from the failure to properly report best price.[17] A recent report from the Government Accountability Office (GAO) also found that current rebate program oversight by CMS does not assure that manufacturer-reported drug prices are consistent with applicable laws and program policies.[18] Consistent with GAO recommendations, CMS should implement a plan to systematically scrutinize AMP and best price data reported by manufacturers to enforce the accurate payment of Medicaid drug rebates to states.

Promote Evidence-Based Coverage for Drugs. In the long-run, research on what drugs work better and/or cost less than other will be key to improving outcomes and efficiency. After four years of widespread, continuous efforts to cut Medicaid drug spending growth, a consortium of 15 organizations, including 13 states, has formed to create the Drug Effectiveness Review Project (DERP) whose purpose is to carry out systematic reviews of drug classes to inform state drug coverage decisions, usually in connection with a state's Medicaid preferred drug list (PDL). These systematic reviews, conducted by Evidence-Based Practice Centers (mostly university-based), array, evaluate and summarize the aggregate results of published and unpublished studies pertaining to the drug class under review. By May 2005, the DERP had completed 18 reviews and states were using its information as the primary or one of many sources in setting their PDLs.[19]

- **Greater Federal leadership and funding for comparative effectiveness research.** Medicaid along with its beneficiaries would benefit from an expansion in the base of evidence-based research. Information on comparative effectiveness will allow states to define "smart" PDLs rather than rely too heavily on price considerations when making PDL coverage policies. This could take the form of full funding of the existing authority to fund such research. Section 1013 of the MMA requires the HHS secretary to set priorities and target areas where evidence is needed to improve the quality, effectiveness and efficiency of health care provided by Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). While the MMA authorized $50 million in FY 2004 to carry out Section 1013, only $15 million was actually budgeted for this effort in 2005 and the President's 2006 budget maintains funding at the $15 million level. At a minimum, funding to carry out Section 1013 should be increased to the amount authorized by the MMA. However, the Center for American Progress's health plan calls for not only a substantial increase in the Federal investment in this type of research but consideration of creating a quasi-governmental agency to set the agenda, gather private as well as public resources, and conduct research on a range of health services.

Address Costs and Transitions in the Medicare Drug Benefit. In the short run, the issue most pressing for states regarding drug costs may be the implementation on the Medicare drug benefit. On January 1, 2006, Medicare will assume primary coverage for prescription drugs for Medicaid beneficiaries also eligible for Medicare (known as "dual eligibles"). Why this may increase state Medicaid drug costs and options for preventing this are described below.

- **Effective Medicare cost containment to reduce state Clawback payments.** When the Medicare prescription drug benefit takes effect in January 2006, state Medicaid programs will no longer provide drug coverage for dual eligibles, but will continue to help finance a substantial portion of the new Medicare drug coverage through the "Clawback", a type of maintenance of effort payment. The Clawback formula includes future annual adjustments based upon per capita spending growth for the Medicare drug benefit.[20] Thus, states have a direct interest in how the Medicare drug program is managed: higher per capita growth in Medicare drug spending means a larger Clawback obligation for states.

  Section 1860D-11(i) of the Social Security Act, as added by the MMA, bars the secretary of HHS from interfering with the negotiations between drug manufacturers and pharmacies and sponsors of prescription drug plans, or from requiring a particular formulary or price structure for covered Part D drugs. The Congressional Budget Office (CBO) has estimated that there would be negligible savings if this provision was struck,[21] but others disagree. They point to the substantial discounts obtained by other countries who negotiate on behalf of their citizens and by the U.S. Veteran's Administration as compelling evidence of the savings potential for Medicare.[22] Even if HHS chose not to exercise its authority to negotiate for better prices (or exercised its authority poorly), the repeal of Section 1860D-11(i) may, nevertheless, promote better drug pricing for Medicare by changing the context in which drug pricing

decisions are made – pharmaceutical manufacturers may be more likely to exercise restraint in their pricing decisions to avoid provoking a response from HHS.

- **Transition.** On January 1, 2006, Medicare will become the primary payer for drug coverage for dual eligibles, and Federal matching payments through Medicaid for such individuals will end. This transition will involve: extensive education about the change in the nature of the drug coverage; major data matching activity to ensure that no beneficiary falls through the cracks in the transition; assistance for dual eligibles in selecting a private insurance plan and recognizing that they will be default enrolled into a plan if they do not actively select one; and, once enrolled, ensuring an understanding of how a closed formulary works and how to access drugs not on that formulary.[23] The experience of de-linking Medicaid from welfare resulted in significant transition problems in some areas.[24] Last week, concerns were raised by reports of thousands of low-income seniors receiving empty envelopes rather than information on the transition to the Medicare drug benefit.[25] State Medicaid directors themselves have raised major concerns over their ability to carry out this major transition in such a short time window.[26] Because there is no back-stop or "emergency break" in case problems do occur, Congress should consider legislation such as that proposed by Senator Rockefeller (S 566) and Representative Allen (HR 1144) to allow Federal Medicaid funds to continue during the transition.

Long-Term Care

As the nation ages, the growing need for long-term care will strain health and retirement security as well as the Federal budget. A paper by Judy Feder outlines the problems and potential options; since passages from this paper are used, her paper should be cited appropriately.[27] Today, 10 million people of all ages are estimated to need long-term care. Among the roughly 8 million who are in community settings, 1 in 5 report getting insufficient care. The cost of paid care exceeds most families' ability to pay. In 2002, the average annual cost of nursing home care exceeded $50,000, and of home care (four hours per day) was estimated at $26,000. Clearly, the need for extensive, paid long-term care constitutes a catastrophic expense. Intensive family care-giving also comes at considerable cost—in employment, health status and quality of life—and may fail to meet care needs. As such, the answer appears to be long-term care insurance.

However, a vigorous private long-term care insurance market has not emerged. Sales of private long-term care insurance are growing (the number of policies ever sold more than tripled over the 1990s); about 6 million people are estimated to currently hold any type of private long-term care insurance. The demographic aging of America, especially of the segment with significant resources, will create the potential for substantial expansion of that market. But, private insurance for long-term care remain a limited means to spreading long-term care risk. Private long-term care insurance: (1) is not affordable to the substantial segment of older persons with low and modest incomes; (2) limits benefits in dollar terms in order to keep premiums affordable, but therefore leaves policyholders with insufficient protection when they most need care; and (3) lacks the premium stability and protection to prevent lapses in coverage and loss of the investment.

Public programs also fall far short of ensuring insurance protection. Medicare, which provides health insurance to many who need long-term care, covers very little long-term care (19% of total U.S. spending). Medicaid plays the primary role in financing the long-term care. In 2002, Medicaid paid for close to half of long-term care expenditures; despite the fact the vast majority of Medicaid beneficiaries are low-income adults and children not needing such services, long-term care accounted for about a third of Medicaid spending.[28] But, unlike what we think of as "insurance," Medicaid pays for services only if and when there are no other options. Because the cost of long-term care is so high relative to most people's income and resources, there is ample opportunity to "spend down" to eligibility—spending virtually all income and assets in order to qualify. As Dr. Feder has put it, it is the "last remaining estate tax standing". Yet, most nursing home users who qualify for Medicaid have such limited resources that they satisfy Medicaid's income and asset eligibility requirements on admission. Only about 16 percent of elderly nursing home users begin their nursing home stays using their own resources and then become eligible for Medicaid as their assets are exhausted.

Despite Medicaid's essential role in financing long-term care, it has limitations. A large share of Medicaid's long-term care spending is for nursing home care, an important service for some, but not the home care services preferred by people of all ages. In the last decade, Medicaid home care spending has increased from 14 percent to 29 percent of Medicaid's total long-term care spending, but still is insufficient to meet the demand. Further, most states have expanded home- and community-based care through programs that "waive" some statutory Medicaid requirements, including the entitlement to service for people who qualify due to need for care. The ability of states to limit, through waivers, the number of people who can receive assistance leaves large numbers in need of assistance without service. And, Medicaid's protections vary considerably from state to state. An analysis by the Urban Institute found that, among 13 states, long-term care spending per aged, blind, or disabled enrollee was four times greater in the highest-cost relative to the lowest-cost states.[29]

A number of options exist to address long-term care problems generally and Medicaid specifically. Most experts, including Dr. Feder, suggest that the nation adopt a long-term care social insurance program, in which everybody contributes to financing the system and resources are allocated based on need. Among developed nations, the number of countries with universal public protection for long-term care (Germany, Japan and others) is growing.[30] Two options short of this include:

- **Medicare Long-Term Care Partnership Program.**[31] Four states currently operate "Partnerships for Long-term Care" programs, which allow benefits paid by private insurance to offset (or protect) assets for Medicaid users who purchase approved long-term care insurance policies. These partnerships have been advocated as a means to save Medicaid money by encouraging people to purchase private long-term care insurance which could delay the need for Medicaid. Experience with these policies in four states has produced only limited purchases, primarily among higher-income people, and has affected too few people for too short a period to assess its

impact on Medicaid spending.[32] The Partnership Program has contributed to improved standards for long-term care insurance policies and more Partnership policies are being sold to more modest-income people as the standards that apply to them are also applied to the broader market. However, if these policies simply substitute for policies individuals would otherwise have purchased, they may increase rather than decrease Medicaid expenditures.

A better option might be to create such a partnership with Medicare rather than Medicaid. As a broadly-financed, social insurance program, Medicare may be the better program on which to build a long-term care insurance system. The proposed policy would give Medicare beneficiaries the option when they sign up for Medicare or Social Security retirement benefits of receiving an income-related Medicare long-term care catastrophic benefit if they simultaneously purchase a high-quality, private long-term care insurance policy. The Medicare catastrophic benefit would be available once private coverage is exhausted. This could be a new benefit, or financed by substituting the new catastrophic protection for the existing Medicare home health benefit, which would be covered by the private insurance policy. The goal is to refocus Medicare's limited long-term care investment to both encourage a better relationship between private and public coverage and protect beneficiaries from the catastrophic costs of chronic illness. In so doing, private long-term care insurance should become more affordable since Medicare would act as a reinsurer, limiting the liability of private insurers – to a greater extent for lower-income people -- and allowing them to offer better coverage (longer and higher quality) compared to existing products.

- **National, Federally-funded Medicaid home care benefit.** Federalizing home care for low-income people who need long-term care is a logical "next step" in long-term care financing. Creating the opportunity for individuals to receive long-term services and supports in the community—irrespective of where they live—would improve the quality of life for beneficiaries and for their family caregivers, even if eligibility levels remain relatively low. To achieve this goal, the Federal government could fully fund a "community support services" benefit for all individuals with income below a specified, nationwide eligibility level (similar to the fully-Federally funded income floor provided by Supplemental Security Income). States that wanted to expand enrollment above this level could do so. However, the new program would create a nationwide safety net to ensure a minimum level of protection for people in need.

High-Cost Cases

While policy makers have focused on the size and growth of Medicaid spending, few have examined the beneficiaries who are responsible for most costs. Studies of high-cost enrollees have been conducted for Medicare and private insurance spending. Recently, CBO examined the role played by high-cost Medicare beneficiaries in Medicare spending. It found that Medicare spending is highly concentrated, with the highest-cost 10 percent of Medicare beneficiaries accounting for 61.5 percent of all Medicare

spending in 2001.[33] A similar study examined the distribution of spending among non-elderly people with some private employer-sponsored insurance. It found that the top 10 percent of cases accounted for 63 percent of expenditures.[34] In a paper by Andy Schneider, Yvette Shenouda and me, we found even more concentrated spending in Medicaid (passages from this paper are below).[35] Specifically:

High-cost cases account for nearly three-fourths of Medicaid spending in the community. Seventy-two percent of Medicaid spending was attributable to only 10 percent of Medicaid beneficiaries in the community. Medicaid spending is more concentrated among its most expensive beneficiaries than is Medicare or employer-sponsored health insurance spending. Medicaid spending on these individuals during 2002 equaled or exceeded $7,770. These high-cost beneficiaries are more likely than other Medicaid beneficiaries to be women, poor, non-Hispanic white and rural residents. Nearly one in three of the top 10 percent of high-cost Medicaid beneficiaries is also eligible for Medicare as well (i.e., dual eligible).

Most Medicaid spending for high-cost beneficiaries in the community is for hospital care and home health services. Nearly two-thirds of all the costs paid by Medicaid for high-cost beneficiaries in the community were for hospital care (40 percent) and home health (24 percent). Another 18 percent of spending for this population was on prescription drugs. Over half (56 percent) of high-cost Medicaid beneficiaries were hospitalized in the last year.

Chronic illnesses are common among high-cost beneficiaries in the community. A large fraction of high-cost beneficiaries in the community have chronic health problems that require medical management, including heart disease (28 percent), asthma (25 percent) and diabetes (19 percent).

Medicaid is a major payer for high-cost people in the U.S. Among all individuals in the community, not just Medicaid beneficiaries, Medicaid pays for about one-fourth (24 percent) of the top 10 percent most costly individuals. To put this in perspective, this is over 30 times more than the number of people served by medical high-risk pools nationwide (181,441).[36] These data understate Medicaid's role in paying for high-cost cases because they exclude nursing home residents and other institutionalized beneficiaries, for whom Medicaid is the dominant payer.

Three policies could improve the quality of care, and possibly reduce the costs, for high-cost cases in Medicaid.

- **Medical management.** One policy option for Medicaid reform is better medical management of high-cost cases. Analysts in Georgia[37] and Washington[38] have recommended that their state Medicaid programs focus case management on high-cost Medicaid beneficiaries or on beneficiaries with conditions that are associated high Medicaid expenses, such as asthma, diabetes, and heart failure. In a letter to state Medicaid directors, CMS has clarified the circumstances under which Federal matching funds are available for disease management.[39] A number of states have

implemented disease management programs that target high-cost Medicaid beneficiaries, such as high-cost individuals with schizophrenia and other mental health conditions.[40] While it seems plausible that medical management of high-cost Medicaid beneficiaries can reduce overall Medicaid expenditures, there is no good evidence at this time on the magnitude of such savings.[41] There is little doubt, however, that medical management is far more likely to improve the quality of care and health outcomes for high-cost Medicaid beneficiaries than raising cost-sharing or reducing benefits.

- **Electronic medical records**: In the Center for American Progress's health plan, we call for greater Federal investment and leadership on implementing an electronic infrastructure in the health system. The use of computerized prescriptions can halve prescribing errors,[42] and computerized records can dramatically lower days spent in intensive care.[43] It can also reduce total health care costs through administrative and clinical efficiencies. Given its concentration of spending among a few, medically complicated individuals, Medicaid could especially benefit from such information technology. Demonstrations of reimbursement and programmatic changes specifically designed to encourage the implementation of such technologies could be financed through Medicaid. To encourage the development of the information technology infrastructure, Medicaid could apply a 90 percent matching rate to such investments which would contribute to the coordination of care for high-cost cases.

- **Improved prevention**. High-cost beneficiaries typically have multiple, chronic conditions, some of which may be prevented. The Center's health plan calls for a national focus on wellness, carving it out of existing programs to centrally finance while encouraging local delivery system innovation. Short of this, states could, through demonstration waivers, develop such community-based prevention models to improve rates of immunization and screening for diseases like diabetes and high-blood pressure, for example. Medicaid might also benefit from aggressive efforts to curb the rise in obesity, which one study suggests accounted for 27 percent of the all U.S. inflation-adjusted, per-capita spending increase between 1987 and 2001.[44] About 4 million children on Medicaid are obese; these children's health could be improved and Medicaid costs reduced by early interventions.[45]

Costs Driven by Deteriorating U.S. Coverage System

Lastly, one cost driver in Medicaid that we did not discuss in our recent Medicaid papers, but do so in our overall health plan, is the growing crisis in the U.S. health care system. Since 2000, the number of uninsured rose by 5 million, to 45 million or nearly 16 percent of all Americans.[46] There are more uninsured Americans than the total population of Canada or people living worldwide with AIDS.[47] The lack of coverage exacts a large personal financial toll, running up debt and contributing to personal bankruptcy.[48] And, it results in billions of dollars in uncompensated care costs that get placed on and passed through the health system.[49] Uninsurance is perhaps the most important, but not the only, problem in the system. In 2004, the cost of employer-based health benefits increased at a rate five times higher than that of wages; since 2000, the family share of such coverage

increased by over 60 percent.[50] This not only strains the middle class but affects Medicaid. Since 2000, employers reduced health care coverage by 4.8 million people and Medicaid enrollment increased by 5.8 million.[51] Some of this rise in the uninsured reflects a worsening economy, with higher unemployment and lower income. Indeed, poverty rose for the third straight year in 2003, and median income has failed to rise.[52] It also reflects fewer small firms offering coverage, a decline in dependent coverage in firms, and a rise in the uninsured even among large firms.[53] As such, Medicaid's problems are the "canary in the coalmine" for larger, systemic failures.

We at the Center for American Progress think that the answer is not Medicaid reform but health system reform. We agree with the Institute of Medicine: we should commit to covering all Americans by the year 2010.[54] Fixing only Medicaid will not prevent a further erosion in private coverage, and vice versa: stabilizing private coverage will not be sufficient to meet Medicaid's coverage and financing deficits. And the vexing problem of health costs in the U.S. can only be addressed by looking at the entire system. To this end, our plan calls for expanding coverage to all, improving it for all through better quality and efficiency, and paying for these investments, through a small, dedicated value-added tax. The full plan is described elsewhere;[55] its major coverage components are described below.

- **Simplify and increase Federal support for Medicaid**. Under the proposal, Medicaid would be simplified and strengthened to fulfill its role as a safety net for all low-income people. The plan would extend Medicaid to cover all individuals below a certain income level (e.g., 100 to 150 percent of the poverty level). As such, it would end the complex and state-specific eligibility categories in favor of a simple means test. In doing so, the would increase the share of program costs paid for by the Federal government so that state costs of this Federal-state partnership program would not increase. By financing this expansion through a broad-based tax, it would spread the cost of this expansion across all states, not expecting poor states with large uninsured problems to come up with new financing.

- **Stabilize private group coverage.** The plan would strengthen employer coverage and would supplement it with a pool modeled on the Federal Employees Health Benefit Plan. This new pool would be open to (1) anyone who lacks access to job-based insurance – a problem for about 80 percent of all uninsured people;[56] (2) the 6 percent of non-elderly Americans who purchase coverage in the individual market today;[57] and (3) all employers, irrespective of size. Reinsurance in the pool would be used to prevent unexpectedly high premiums due to enrollment of high-cost individuals. Beyond the pool, the Center's plan would ensure that no individual pays more than a certain percent of their income (e.g., 5 percent of income) on health insurance premiums. This protection, administered as a refundable tax credit, would apply to employer-based health insurance as well. Since employer contributions would continue to be excluded from employees' taxable income, irrespective of where they purchase coverage, employers' voluntary contributions toward the cost of health benefits likely would not change substantially. Taken together, these policies would reinforce and expand private, group insurance.

Concerns about the Upcoming Debate

As important as it is to engage in a discussion of ideas around Medicaid, it is equally important to recognize the context for the debate. The budgetary and political environment may take good ideas off the table and steer toward others that could weaken rather than strengthen this vital program. Four such concerns are outlined below.

Constraints of Budget Resolution

While this hearing has focused on the rich array of Medicaid reform options, this Congress is focused on deficit reduction. Rather than raising revenue to finance an improved and expanded health system, the resolution calls for reducing revenue and cutting Medicaid. Indeed, it can be argued that the $10 billion, five-year Medicaid cut is not balancing the budget but, instead, partially financing the resolution's $70 billion tax cut which will likely disproportionately benefit the wealthiest Americans.[58] The constraints of the resolution also probably mean that any policies that increase Medicaid spending must be offset through Medicaid cuts. This could force a morally troubling use of "savings" from policies like higher cost sharing for poor children, parents, and persons with disabilities to finance expansions to higher-income populations. As such, the fact that Medicaid reform is being considered in the context of the budget resolution does not just restrict but could distort policy options.

The Governors' proposal, recognizing this context, suggests that some of the likely tax cuts be directed toward health and long-term care insurance, to alleviate the pressure on Medicaid. But, the reverse could happen. The President's tax credit for insurance in the individual market will not be a substitute for many, if not most, Medicaid beneficiaries. The $1,000 for individuals will be insufficient for policies that typically cost much more than that, and individuals with health problems are unlikely to find an affordable policy if they are offered any policy at all.[59] Thus, states will be left with that small set of high-cost cases regardless. Moreover, a number of economists suggest that this specific tax credit could cause a drop in employer coverage and shift toward the individual market and, inadvertently, Medicaid, thus increasing its costs.[60] Lastly, in both the health and long-term care policies, most of the tax subsidies would go to people who already have insurance. In particular, the $25 billion over 10 years spent on the long-term care insurance tax deduction would primarily go to high-income people who would likely never qualify for Medicaid anyway. These precious taxpayer dollars could – and should – be better spent.

Policy versus Politics

As a former budget official, I believe that an efficient Medicaid is a strong Medicaid, and support policies that target and reduce any excess spending. That said, experience suggests that finding such policies and steering them through the political process is easier said than done. Failure to find an acceptable Medicaid offset that is one-fifth the

size of the cuts called for by Congress has blocked the bipartisan Family Opportunity Act for five years.[61] And, while Congress supported a new, controversial commission to find $10 billion in Medicaid cuts, it rejected its existing bipartisan Medicare commission's call for $20 billion-plus in savings from overpayments to managed care plans.[62] Arguably, this reflects the power of politics to shape the options under consideration. These same forces will likely exert themselves against some of the policies to reduce Medicaid costs. Pharmacists oppose the pharmacy reimbursement cuts; AARP oppose tightening asset transfer policies; and surely the drug industry would oppose some of the policies regarding the drug rebate I raised in this testimony. This could lead to few options except for coverage reductions to achieve the $10 billion in savings. Alternatively, it could revive the idea of making difficult spending reductions behind the veil of caps in Federal funding. Two years ago, the President proposed granting the types of flexibility the Governors now request in return for an upper limit on spending for some or all Medicaid services. Such caps could leave states as well as beneficiaries with inadequate assistance and unmet needs.[63]

Erosion of Access

Independent of the budget cuts called for by Congress, the Governors propose increasing cost sharing and reducing benefits for people currently eligible for Medicaid. This may produce some budget savings but at a cost -- in economic and human terms – that may be too high. Myriad studies have shown that, for people with very limited income, any cost sharing can deter use of care – whether it is necessary or not. If needed care is deferred, it could result in preventable hospitalization that increase the overall costs of the system, through uncompensated care, if not Medicaid costs directly.[64] It also contributes to the challenges that poor people have in escaping poverty. The Institute of Medicine documented the productivity loss due to lack of coverage;[65] cost sharing that prevents timely use of care will similarly lock people in the bottom wrung of the economic ladder. It also could exact a human toll: the Congressional Budget Office warned, after reviewing the evidence, that "poorer individuals facing higher copayments displayed worse health on some measures."[66]

The Governors also calls for flexibility to design specific benefits packages for different populations. This policy was not included in the CBO options for deficit reduction, probably because it is hard to design a policy in this regard that saves money. If an individual does not need a service, Medicaid does not pay for it. Those who do need a range of benefits are the 10 percent of beneficiaries who account for nearly three-fourths of Medicaid spending. Cutting benefits for these people is "penny wise but pound foolish," probably resulting in higher hospitalization and nursing home costs. Yet, exempting them means that very little savings will result. Moreover, the idea raises a question about whether variation is always desired; should a child with cystic fibrosis get a different set of services depending on where she lives; what are the different benefit needs of a poor senior in Maine versus Florida?

There is a role for cost sharing and benefit flexibility for certain populations in Medicaid. Low-income workers covered through expansions may be able to afford premiums and

cost sharing. Because it targets only children above poverty, such flexibility – within limits – is allowed in SCHIP. However, these expansion groups are very different than those at the core of Medicaid's mission: poor, disabled veterans, seniors who live on extremely limited Social Security benefits, families whose income is less than 60 percent of the poverty threshold, the median upper income level for families in Medicaid today. Some state officials recognize this; the National Academy of State Health Policy working group on Medicaid reform did not recommend reduced coverage for people below poverty.[67] This is because, in truth, there is no such thing as partial access – you have it or you don't, and if Medicaid beneficiaries don't, then the program has failed in its mission.

Reduced Accountability

My last concern about the options under consideration is that the legal underpinnings of Medicaid may be weakened. The Governors' proposal calls for automatic and fast-track Section 1115 waiver approval. Such waivers, while intended to test models for improving Medicaid's achievement of its goals, have frequently been used to circumvent key elements of Medicaid law, according to the Government Accountability Office.[68] In 2001, about 20 percent of all Medicaid spending was governed by waiver terms and conditions at the discretion of the Secretary of Health and Human Services – more than the entire budgets of the Departments of Agriculture and Veterans Affairs.[69] Putting 1115 waivers on "autopilot" would weaken the role of Congress as a partner in this important program. Another policy in the Governors' proposal that could have even more far-reaching effects is the proposed limitations on judicial consent decrees and other court orders. This proposal could make it difficult for individuals, providers, and even Federal authorities to seek enforcement of Medicaid law. This would be a dangerous precedent to set for Medicaid, as well as and other state-Federal partnership programs.

In closing, it is appropriate that Congress is examining Medicaid's progress, prospects and problems in 2005, the year of its 40th birthday. Improvements can and should be made in its provision of high-quality, accessible care to all vulnerable people. In terms of its cost drivers, a number of policy options exist to reduce prescription drug spending, address the gaps in the long-term care system, and manage care for high-cost cases. While these policies could help in the short-run, Medicaid's problems are the system's problems, and broader reform is needed. In the meantime, caution must be taken given the context for the discussion – a restrictive budget resolution – and the pressure that may come to take the path of least resistance and reduce coverage – and access – for the lowest income and sickest in our nation.

Notes

[1] For a description of the event and access to the reports, see http://www.americanprogress.org/site/apps/nl/content3.asp?c=biJRJ8OVF&b=593305&ct=927753

[2] For a description of the initiative, see http://www.americanprogress.org/site/pp.asp?c=biJRJ8OVF&b=477169

[3] Section 1901. *[42 U.S.C. 1396]* "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of

necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."

[4] A. Davidoff, A. Yemane and E. Adams, *Health Coverage for Low-Income Adults: Eligibility and Enrollment in State Programs, 2002*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, February 2005; S. Zuckerman et al., "Changes in Medicaid Physician Fees, 1998-2003," *Health Affairs Web Exclusive*, June 23, 2004; D. Grabowski, J.J. Angelelli, and V. Mor, "Medicaid payment and risk-adjusted nursing home quality measures," *Health Affairs* 23(5): 243-52, September 2004.

[5] M. Lillie-Blanton and C. Hoffman, "The Role of Health Insurance Coverage in Reducing Racial Disparities in Health Care," *Health Affairs* 24(2): 398-408, March-April 2005; L. Dubay et al., "Changes in Prenatal Care Timing and Low Birth Weight by Race and Socioeconomic Status: Implications for the Medicaid Expansions for Pregnant Women," *Health Services Research*, June 2001; Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in American*. Washington, D.C.: National Academy of Sciences, June 2003; J. Crowley and R. Elias, *Medicaid's Role for People with Disabilities*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, August 2003.

[6] J. Hadley and J. Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40(4): 323–342, 2003; Policy Brief, *Medicaid: A Lower-Cost Approach to Serving a High-Cost Population*, Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, March 2004.

[7] J. Holahan and A. Ghosh, "Understanding the Recent Growth in Medicaid Spending," *Health Affairs* W5 52-62, January 26, 2005.

[8] See Centers for Medicare and Medicaid Services "Managed Care Trends" http://www.cms.hhs.gov/medicaid/managedcare/trends03.pdf; and http://www.cms.hhs.gov/medicaid/managedcare/trends03.pdf; administrative costs discussed in Hadley and Holahan, op. cit..

[9] B. Bruen and A.Ghosh, *Medicaid Prescription Drug Spending and Use.* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, June 2004.

[10] S. Heffler, et al., "U.S. Health Spending Projections for 2004 – 2014," *Health Affairs Web Exclusive*, February 23, 2005.

[11] Dear State Medicaid Director letter dated September 18, 2002 accessed at http://www.cms.hhs.gov/states/letters/smd91802.pdf.; *Safe and Effective Approaches to Lowering State Prescription Drug Costs: Best Practices Among State Medicaid Drug Programs (9/9/04).*

[12] K.D. Gifford and S. Kramer, *Federal Policy Options to Contain Medicaid Drug Costs*. Washington, D.C.: The Center for American Progress, June 2005.

[13] Department of Health and Human Services, Office of Inspector General, *Variation in State Medicaid Drug Prices,* OEI-05-02-00681, September 2004; see also, testimony presented at hearing on *Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much* before the Subcommittee on Oversight and Investigations, Energy and Commerce Committee, U.S. House of Representatives, December 7, 2004.

[14] Part B drugs include drugs furnished incident to a physician's service, durable medical equipment drugs, and other drugs covered by statute, such as oral immunosuppressive, cancer, and antinausea drugs.

[15] Department of Health and Human Services, Office of Inspector General, 2004, op. cit.

[16] National Governors Association. 2004. EC-3. Medicaid Drug Rebate Program. http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION^D_3716,00.html

[17] J.R. Wilke, "Cases, Fines Sour in Fraud Probes of Drug Pricing," *Wall Street Journal*, A1, June 7, 2005.

[18] U.S. Government Accountability Office, "*Medicaid Drug Rebate Program: Inadequate Oversight Raises Concerns about Rebates Paid to States,"* February 2005, GAO-05-102.

[19] R. Padrez, J. Blum and D. Mendelson, *Use of Oregon's Evidence-Based Reviews for Medicaid Pharmacy Policies: Experiences in Four States*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2005.

[20] Pub. L. 108-173, for a description, see A. Schneider, *The "Clawback": State Financing of the Medicare Drug Benefit.* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, June 2004.

[21] CBO Letter dated January 23, 2004 to the Honorable William H. Frist, M.D. accessed at http://www.cbo.gov/showdoc.cfm?index=4986&sequence=0.

[22] G. Anderson et al., "Marketwatch: Doughnut Holes and Price Controls," Health Affairs Web Exclusive, W4-396-404, July 21, 2004.

[23] R. Jensen, *The New Medicare Prescription Drug Law: Issues for Enrolling Dual Eligibles into Drug Plans.* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, January 2005.
[24] U.S. General Accounting Office, *Medicaid After Welfare Reform.* Washington, D.C.: GAO HEHS-99-163, September 1999.
[25] J. Rovner, "Snag in Mailing of Medicare Drug Notices," *National Public Radio*, June 7, 2005.
[26] V. Smith, K. Gifford, and S. Kramer, *Implications of the Medicare Modernization Act for States: Observations from a Focus Group Discussion with States.* Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, January 2005.
[27] J. Feder, *Long-Term Care and Medicaid: The Critical Role of Public Financing.* Washington, D.C.: The Center for American Progress, June, 2005.
[28] E. O'Brien and R. Elias, *Medicaid and Long-Term Care.* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2004.
[29] J. Holahan, "Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?" Chapter 6 in J. Holahan, A. Weil, and J.M. Wiener, *Federalism and Health Policy.* Washington, D.C.: The Urban Institute Press, 2003.
[30] M. Huber and P. Hennessy, OECD, Directorate for Employment, Labour and Social Affairs, "Financing Long-term Care: International Comparisons," presented at Academy Health 2004 Research Meeting, San Diego, CA.
[31] Note: this idea is developed in a draft paper by A. Tumlinson and J. Lambrew, "Linking Medicare and Private Insurance for Long-Term Care," submitted to the Robert Wood Johnson Long-Term Care Financine Project, September 2003; it is not part of Dr. Feder's paper or recommendations.
[32] A. Ahlstrom, E. Clements, A. Tumlinson and J. Lambrew, *The Long-Term Care Partnership Program: Issues and Options.* Washington, D.C.: Pew Charitable Trusts' Retirement Security Project, George Washington University and The Brookings Institution, December 2004.
[33] Congressional Budget Office, *High-Cost Medicare Beneficiaries.* Washington, D.C.: CBO, May 2005.
[34] L. Blumberg and J. Holahan, "Government a Reinsurer: Potential Impacts on Public and Private Spending", *Inquiry*, Summer 2004.
[35] A. Schneider, J. Lambrew and Y. Shenouda, *Medicaid Cost Containment: The Reality of High-Cost Cases.* Washington, D.C.: The Center for American Progress, June 2005.
[36] Council on Affordable Health Insurance. *High Risk Health Insurance Plans: Past, Present and Future*, November 2004.
[37] K. Minyard and K. Gardner, *"...1% of Medicaid Members Generate 23% of Expenditures..." An Argument for Case Management*, Georgia Health Policy Center, October 2003.
[38] S. Lerch and J. Mayfield, *High-Cost Medicaid Clients.* Washington State Institute for Public Policy, December 2000.
[39] Letter from D. Smith, Center for Medicaid and State Operations to State Medicaid Directors, SMDL #04-002, February 25, 2004.
[40] S. Gelber and R.H. Dougherty, *Disease Management for Chronic Behavioral Health and Substance Use Disorders.* Princeton, NJ: Center of Health Care Strategies, Inc., February 2005.
[41] A CBO review of published studies concluded that, with respect to disease management programs for congestive heart failure, coronary artery disease, and diabetes mellitus, "there is insufficient evidence to conclude that disease management programs can generally reduce the overall cost of health services." Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs*, October 13, 2004.
[42] D.W. Bates et al., "Effect of Computerized Physician Order Entry and a Team Intervention on Prevention of Serious Medication Errors." *Journal of the American Medical Association* 280(15): 1311-16, 1998.
[43] W.E. Hammond, *Electronic Medical Records: Getting It Right and Going to Scale,* January 2004, www.cmwf.org/publications/publications_show.htm?doc_id=221459 (31 January 2005).
[44] K. Thorpe et al., "Trends: The Impact of Obesity on Rising Medical Spending," *Health Affairs Web Exclusive*, W4-480-86, October 20, 2004.
[45] J. Rosenthal and D. Change, *State Approaches to Childhood Obesity: A Snapshot of Promising Practices and Lessons Learned.* Portland, ME: National Academy for State Health Policy, April 2004.
[46]J. Holahan and A. Ghosh, *The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003,* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, September 2004..

[47] J. Lambrew, "Uninsured Americans: 45 Million Uninsured Americans." Washington, D.C.: The Center for American Progress, August 26, 2004.
[48] D.U. Himmelstein et al., "Marketwatch: Illness and Injury as Contributors to Bankruptcy," *Health Affairs Web Exclusive*, W5-63-73, February 2, 2005.
[49] J. Hadley and J. Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured , May 10, 2004.
[50] Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2004 Annual Survey*. Washington, D.C.: Kaiser Family Foundation, September 2004.
[51] Holahan and Ghosh, 2004, op. cit.
[52] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, 2003.* Washington, D.C.: U.S. Government Printing Office, 2004.
[53] Kaiser HRET, 2004, op. cit.; S. Glied, J.M. Lambrew, and S. Little, *The Growing Share of Uninsured Workers Employed by Large Firms.* New York: The Commonwealth Fund, October 2003.
[54] Institute of Medicine, *Insuring America's Health: Principles and Recommendations*. Washington, D.C.: National Academy of Sciences, January 2004.
[55] J.M. Lambrew, J. Podesta , and T. Shaw, "Forging Change in Challenging Times: A Plan for Extending and Improving Health Care," *Health Affairs* W5-119-132, March 23, 2005.
[56] B. Garrett, *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility and Participation Patterns in 2001*, Washington, D.C.: The Urban Institute, July 2004.
[57] Holahan and Ghosh, 2004, op. cit.
[58] J. Horney, *Assessing the Conference Agreement on the Budget Resolution*. Washington, D.C.: Center on Budget and Policy Priorities, May 6, 2005..
[59] J. Gabel et al., *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets*. New York: The Commonwealth Fund, May 2002; J.D. Reschovsky and J. Hoadley, "The Effect of Tax Credits for Nongroup Insurance on Health Spending by the Uninsured," *Health Affairs Web Exclusive*, February 25, 2004.
[60] J. Gruber, *Cost and Coverage Implications of the President's Health Insurance Tax Credit and Tax Deduction Proposals.* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, March 2004; J. Sheils, *Bush and Kerry Heath Care Proposals: Cost and Coverage Compared.* Washington, D.C.: The Lewin Group, September 21, 2004.
[61] S. 622, the Family Opportunity Act, as scored by the Congressional Budget Office on September 10, 2003.
[62] Daily Health Policy Report, "MedPAC Agrees To Draft Recommendations, Including Elimination of $10B Fund for Medicare PPOs," Kaisernetwork.org, April 22, 2005.
[63] J. Holahan and A. Weil, *Block Grants Are the Wrong Prescription for Medicaid.* Washington, D.C.: The Urban Institute Health Policy Online, 2003; C. Mann, M. Nathanson and E. Park, *Administration's Medicaid Proposal Would Shift Fiscal Risk to States.* Washington, D.C.: Georgetown University Institute for Health Policy Research and Center for Budget and Policy Priorities, 2003; J.M. Lambrew, "Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals" *Milbank Quarterly* 83(1): 41-63, March 2005.
[64] Newhouse, *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996. See also S. Artiga and M. O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2005 and Ku, *The Effects of Increasing Cost-Sharing in Medicaid: A Summary of Research Findings*. Washington, D.C.: Center on Budget and Policy Priorities, May 31, 2005.
[65] Institute of Medicine, 2003, op. cit.
[66] Congressional Budget Office, *Budget Options*, Washington, DC: CBO, February 2005.
[67] National Academy for State Health Policy, *Making Medicaid Work for the 21st Century*, January 2005.
[68] U.S. General Accounting Office, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*. Washington, D.C.: GAO-02-817, June 2002.
[69] Kaiser Commission on Medicaid and the Uninsured, *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview.* Washington, D.C., July 20, 2001.

Responses to Questions from the Senate Committee on Finance's Hearing: "The Future of Medicaid: Strategies for Strengthening Americans' Vital Safety Net"

Jeanne Lambrew, July 10, 2005

Senator Baucus

1. Based on your research, how would you propose to create savings while improving quality and protecting access to care? What information is available about the experience with innovative state programs to support moving in this direction?

My research has not focused on quality improvement, but a number of studies have looked at state policies in this regard; some are referenced in the footnote.[1]

2. Which options should we consider to improve access to quality long-term care services for all Americans? Any reaction to the governors' proposals in this area?

Numerous studies have documented concerns about the quality of care in our nation's nursing homes, which are predominantly financed by Medicaid. One of the major recommendations to improve such quality – increasing the ratio of nurses to patients – has not been systematically implemented. In addition, existing rules are not effectively and aggressively enforced.[2] Moreover, as more care has moved from institutions to homes and communities, new methods to monitor and ensure quality are needed. The report from the National Governors Association entitled, "Medicaid Reform: A Preliminary Report," is silent on the topic of long-term care quality. That said, the discussion of Medicaid reform should include policies such as strengthening enforcement tools and a creating a pathway toward higher nurse ratios to improve the quality of care for those covered by Medicaid today.

Senator Rockefeller

1. Can you talk about why this [applying CHIP rules to Medicaid] is not a one-to-one comparison, since Medicaid families, by definition, have lower incomes than CHIP families and tend to be sicker? I am specifically interested in your thoughts on applying a 5 percent or 7.5 percent of income limit on cost sharing. Wouldn't this be much more burdensome for Medicaid families since they are sicker and much more likely to meet the cap?

---

[1] K. Ladenheim et al. (October 2000). *State Purchasing for Health Care Quality*, National Conference of State Legistures, http://www.ncsl.org/programs/health/forum/quality/Quality.htm; J. Verdier et al. (July 2004). *Quality-Related Provider and Member Incentives in Improving the Performance of Medicaid Managed Care*, Center for Health Care Strategy; S. Comden, J. Rosenthal. (2002). *Statewide Patient Safety Coalitions: A Status Report*, NASPH.

[2] B. Wright. (May 2005). *Enforcement of Quality Standards in Nursing Homes*, AARP Public Policy Institute, http://www.aarp.org/research/longtermcare/quality/fs83r_homes.html.

There are major differences between the populations served by Medicaid and the State Children's Health Insurance Program (SCHIP). Families eligible for SCHIP, while still low-income, have some attachment to the workforce and can afford some, limited cost sharing. In contrast, the median upper limit for Medicaid eligibility for parent is 70 percent of the poverty threshold, with some states covering parents only to 13 percent of the poverty level. Research suggests that cost sharing does not affect all populations equally; even small copayments can deter needed as well as unneeded care.[3] As such, allowing cost sharing into Medicaid for poor people could render them effectively uninsured, undermining the goal of the program, to improve access to care.

As to the limit on cost sharing as a percent of income, the proposed thresholds are relatively high. A recent study found that privately insured adults with incomes over 200 percent of poverty spend only 0.7 percent of their income on out-of-pocket spending.[4] The governors are seeking to allow cost sharing at over 10 times this percent for SCHIP. Moreover, on a service-by-service basis, cost sharing could be prohibitive even with the annual cap. For example, a family earning $1,000 per month could pay up to $600 per year under the 5 percent limit for Medicaid cost sharing. This could mean $50 copayments for brand-name drugs, a $100 copayment for a specialty visit, and a $250 hospital deductible – amounts potentially too high to be paid and thus resulting in unmet need. If needed care is deferred, it could result in preventable hospitalization that increase the overall costs of the system through uncompensated care, if not Medicaid costs directly.

Senator Bingaman

1. What do you think about eliminating the two-year Medicare disability waiting period, as it would save the Medicaid program billions of dollars while also improving care and treatment for some of the nation's most vulnerable citizens?

There is solid evidence suggesting that this proposal will save states money by offsetting Medicaid costs. It will also help rationalize the health care system since these individuals will eventually be insured by Medicare.

2. According to the HIV Medicine Association in Mississippi, the Mississippi Medicaid program has implemented a "policy beginning July 1 that will limit prescription drug coverage for adult Medicaid beneficiaries to just two brand-name drugs per month with absolutely no exceptions." If the standard of care for HIV disease calls for a combination of at least three antiretroviral drugs to effectively suppress HIV, how does this square with providing states with added flexibility?

---

[3] Newhouse, *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996. See also S. Artiga and M. O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2005 and Ku, *The Effects of Increasing Cost-Sharing in Medicaid: A Summary of Research Findings*. Washington, D.C.: Center on Budget and Policy Priorities, May 31, 2005.

[4] Ku, op. cit.

By definition, a standard of care means that there is an evidence-based, medically-sound regimen of care that should be followed in most circumstances. One could argue that Medicaid should be less flexible rather than more flexible in areas where there are proven standards of care, ensuring that recommended care is covered rather than letting state officials make such decisions.

3. If you look at just state-funding budgets by program area, elementary and secondary education is actually 26 percent compared to 13 percent for Medicaid. Is that a better way to look at state spending?

When comparing Medicaid spending to other items in state budgets, the state share of program costs should be used to ensure an accurate comparison. According to the Congressional Research Service study, states continue to spend more on education than Medicaid. If, however, one is interested in looking at the entire Medicaid program cost (for example, when comparing total Medicaid to Medicare costs), then the combination of the Federal and state share should be used.

4. Do you believe there should be federal floor on benefits and cost-sharing requirements below which no state can deviate? If the federal government is putting in a majority of the dollars, shouldn't we have some federal minimum standards for all Medicaid beneficiaries?

My personal belief is that states should have flexibility in delivering care, managing long-term care, and testing innovations to improve quality and efficiency. I also think that states should determine how best to insure individuals caught in the nexus between public and private coverage (e.g., people with income between 150 and 250 percent of the poverty threshold). That said, the only way for Medicaid to fulfill its promise as a safety net is by ensuring access to care for all poor and disabled people, no matter where they live. Because creating national benefit and eligibility minimums will raise costs, the Federal government should finance such an expansion. This idea is included in the comprehensive reform proposal of the Center for American Progress.[5]

[5] J.M. Lambrew, J. Podesta , and T. Shaw, "Forging Change in Challenging Times: A Plan for Extending and Improving Health Care," *Health Affairs* W5-119-132, March 23, 2005.

STATEMENT OF SENATOR GORDON H. SMITH
Finance Committee Hearing on Medicaid
June 15, 2005

Mr. Chairman, thank you for holding this hearing to continue the discussions related to Medicaid and how to make it a better program.

Medicaid is a vital safety-net for 54 million elderly, disabled, chronically ill and poor Americans who rely on it for their health care. As we consider proposals intended to respond to the budget reconciliation instruction and deliberate ways to improve the overall Medicaid program, we must proceed with caution and extreme sensitivity.

It is my experience as both the President of the Oregon State Senate and a member of the United States Senate, that much good can be accomplished when we work together and remain focused on the people this program helps. Unfortunately, because of its complexity and the severity of many beneficiaries' health status, much damage can also be done if Medicaid is not approached the right way.

That is why I look forward to hearing from our witnesses today, especially NGA Chair Governor Mark Warner and Vice Chair Governor Mike Huckabee, about their proposals for improving Medicaid and finding ways to make it more efficient. Governors certainly know first-hand the importance of this program to their state and struggle every day to make sure their budget is balanced.

However, we also must take steps to include other key stakeholders such as state legislators who prepare the budget, advocates and beneficiaries and providers. All voices must be heard because all have an important and unique perspective to bring to the table.

For instance, the experiences of states like Oregon can illustrate both the good that can be done and also the damage. I was honored to be a part of creating the Oregon Health Plan. I believe it is a shining example of the ingenuity states have in making this program more efficient, higher quality and more responsive. But Oregon also is an example of what can go wrong when bad policy is put in place to save a couple of dollars.

In 2003, the state made significant changes to its program. It raised premiums and copayments, it eliminated benefits such as outpatient mental health and chemical dependence services and the prescription drug benefit for many optional beneficiaries. The result:

- 50,000 people lost coverage;
- Sixty percent of those who left Medicaid reported an unmet health need;
- Of those who remained in Medicaid, 1/3 reported an unmet health need resulting from co-payments; and
- The number of emergency room visits by uninsured patients increased by 17 percent in the three months immediately following the Medicaid changes.

Further, state mental hospitals and local jails and state prisons started to see increased cases of people who because of loss of care and prescription drug coverage ended up in other state institutions. The impact was so dramatic that the state reversed course in August 2004 and reinstated the outpatient mental health and chemical dependence treatment and the prescription drug benefit.

You see, Oregon realized that they had been penny wise and pound foolish. They ended up spending tens of thousands of dollars more to care for these people in 24-hour institutional settings instead of paying for much lower-cost outpatient services like counseling and prescription drugs.

As we move forward, I hope we can learn from the mistakes that have been made. There are many ways to approach this challenge. I for one see a value in looking for bipartisan approaches that can address the reconciliation instruction, while reserving action on the much bigger reform proposals, such as premiums, copayments, benefit structures and other issues inherent to the operation of Medicaid until a much more thorough review of this program is made.

In doing so, we also will provide an opportunity for all stakeholders to be heard and allowed to share their ideas. Only then will we truly honor the most important rule of medicine: "First, do no harm."

Thank you, Mr. Chairman.

Senate Finance Committee:
"The Future of Medicaid: Strategies for Strengthening America's Vital Safety Net"

Senator Craig Thomas (R-WY) Statement for the Record

June 15, 2005

Mr. Chairman, thank you for holding today's hearing to talk a little bit about Medicaid reform. We have been debating how to restructure and modernize various entitlement programs in the Senate. Frankly, Medicaid is facing a lot of challenges. Everyone agrees the program is not sustainable. When Medicaid was created, it was basically a welfare benefit. Today, Medicaid provides primary, acute, and long-term care to millions of medically needy, poor, elderly, and disabled Americans. These specific populations have serious, chronic, and very costly health care needs. In fact, total federal and state spending topped out at $273 billion in 2003.

In many instances, Medicaid also now provides coverage for higher-income working families who simply need mainstream health insurance coverage, but cannot afford to pay private market premiums. Clearly, we need to make some changes in order to manage our limited financial resources and serve folks better. This Committee's challenge is to come up with ways we can all agree on to help this critical safety net program work more effectively and efficiently.

I have long believed that we in Congress are going to have to start making some tough choices in order to reduce the over $400 billion federal deficit. Many criticize the deficits, but then vote to increase spending or expand federal programs. It is our constitutional obligation to appropriate hard-earned taxpayer dollars. This is a duty I take very seriously. Often, federal government programs become institutionalized. They seem to become permanent fixtures receiving more and more resources with less and less accountability for quality or proven outcomes. No one knows if the programs Congress creates continue to perform year after year after year. I would argue some, but not all, become unnecessary, duplicative, inefficient, and outdated. Other programs simply do not move with the times. Medicaid law has remained virtually unchanged for decades -- stifling the states' ability to build innovative, collaborative, and data driven programs that meet community needs.

I expect there will be several different plans put on the table to strengthen Medicaid. I stand committed to finding solutions that improve the program's viability and accountability. The Administration and Secretary Leavitt shared their thoughts on managing program growth and eliminating waste, fraud, and abuse. I support their efforts to give states flexibility to design innovative, collaborative, and quality programs that stretch every dime to serve as many of our neediest, most vulnerable citizens as possible. It is our responsibility to ensure taxpayer dollars are spent wisely and resourcefully.

Today we will hear from the National Governors Association (NGA) and other expert witnesses about the reforms they believe are necessary to improve the Medicaid program. I look forward to hearing their testimony. It is critical we keep dialoguing with all interested parties to find solutions that help us more effectively and efficiently manage Medicaid growth while protecting essential beneficiary services.

STATEMENT OF GOVERNOR MARK R. WARNER, CHAIRMAN

AND

GOVERNOR MIKE HUCKABEE, VICE CHAIRMAN

ON BEHALF OF THE

NATIONAL GOVERNORS ASSOCIATION

Mr. Chairman, Senator Baucus and distinguished members of the Finance Committee. Thank you for requesting that we testify today on ways to address the significant challenges confronting the Medicaid Program. Today we are releasing a preliminary policy paper that outlines the recommendations of the National Governors Association for Medicaid Reform. The recommendations represent work by eleven governors on a Medicaid Working Group with additional input by most governors, including their Medicaid Directors. These recommendations are preliminary in that we will continue the working group over the next year so that we can complete our work and provide Congress and the administration with further clarifications of our policy as well as our further recommendations. We also look forward to working with the Medicaid Commission and have offered Secretary Leavitt the NGA Center for Best Practices to assist him in the Commission's work.

It is also important for us to stress the fact that we see today's release of policy recommendations as the beginning, not the end, of the process. We hope that both your committee and your staff will be willing to work closely with NGA and the working group governors as you develop policies to make the nation's public health insurance programs more efficient, accountable, and responsive. Given that this working group will continue, it will be able to not only provide you with more detail on our recommendations, but also comment on alternative approaches you wish to discuss.

THE PROBLEM

It is difficult to overstate the impact of Medicaid on state budgets. It now represents about 22 percent of the average state budget and is a larger percentage than all elementary and secondary education. If you add health care spending for state employees and other programs, state health care spending totals about one-third of all spending, and is equal to spending on all education—elementary, secondary and higher.

The problems of Medicaid are three fold. First is that the Medicaid program is increasingly serving populations with very serious and expensive health care needs. Low-income frail seniors, people with HIV/AIDS, ventilator-dependent children, and other individuals with serious mental and physical disabilities represent only about 25 percent of the Medicaid population, but account for more than 70 percent of Medicaid's budget. The average cost of providing health care to seniors and people with disabilities is more than six times the cost of providing care to pregnant women and children. Medicaid provides expensive chronic care and long-term care services that are largely unavailable anywhere else in the health care system. Meanwhile, those who are dually eligible for both the Medicare and the Medicaid Program account for 42 percent of total Medicaid spending. Demographic trends suggest that these cost pressures will continue to increase.

Second, the caseload has increased 40 percent over the last five years. While much of this growth has been in the relatively healthy populations of pregnant women, children, and families—an influx of 15 million beneficiaries in a five year period presents a fundamental challenge to states.

The caseload has been rising as the percentage of people under age 65 covered by employer-sponsored health care is falling dramatically. At first this was due to declines in U.S. economy, but it has continued as the economy recovered because fewer of the new jobs being created offer health insurance. Small businesses in particular are finding it increasingly more difficult to afford health insurance for their

employees. Families that are losing coverage are concentrated among low-income individuals primarily below 200 percent of poverty.

The population of seniors and people with disabilities, who already account for 70 percent of Medicaid's $330 billion annual budget, will grow considerably over the next 20 years. Specifically, the over age 65 population will grow 64 percent, by 2020 and the over age 85 population will grow 3.1 percent per year over the next two decades. The Congressional Budget Office estimates that over the next ten years, growth in the elderly and disabled populations will comprise practically all of the Medicaid caseload growth.

However, since Medicaid is the primary safety net, unless something is done, the case load will continue to grow in the high single digit rate and perhaps even higher over the next two decades as increasing costs shift individuals from private coverage to Medicaid, or to the growing ranks of the uninsured.

The third problem is that the consumer price index for health care has been increasing 2 to 3 times the average price index. Medicaid, like all insurers, has been faced with these rising costs. It is the combination of these problems—caseload growth and health inflation—that makes Medicaid unsustainable in the short-run let alone the long-run.

THE VISION

The policies that are outlined in our paper do not represent comprehensive health care reform. Medicaid, however, is inextricably linked to the rest of our health care system and its payers. Consequently, the scope of our paper is wider than the existing Medicaid program as it focuses both on populations that may become Medicaid eligible as well as some underlying cost drivers in the overall health care system. In terms of Medicaid itself, this paper offers important short-term reforms that will help modernize, streamline, and strengthen this vital program.

The recommendations to make Medicaid more efficient and effective were not developed to generate any particular budget saving number. Instead, they were developed as effective policies that would maintain or even increase health outcomes while potentially saving money for both the states and the federal government.

The non-Medicaid recommendations had three goals. First, to increase quality and health outcomes by applying modern technology and accountability to our health care system. Second, to develop alternative, more effective policy tools that would assist individuals and employers to obtain and maintain private health insurance as opposed to having these individuals become Medicaid eligible. Third, to improve financing and delivery of long-term care by developing incentives for quality private long-term care insurance products, community-based care, innovative chronic care management, and alternative financing approaches. Specific health care policies are organized around four objectives:

1. Reforming Medicaid
2. Enhancing quality and containing costs in the overall health care system
3. Strengthening employer-based and other forms of private health care coverage
4. Slowing the growth of Medicaid long-term care

REFORMING MEDICAID

The paper outlines several areas of reform which gives states additional flexibility to streamline their programs.

1. **Prescription Drug Improvements.** The current system is flawed and must be replaced. A number of policy changes must be enacted that will help decrease costs and improve quality and efficiency of care. The goal of reducing both state and federal expenditures will require policy changes that impact all segments of the pharmaceutical marketplace, including (but not limited to) increased rebates from manufacturers, reforms to the Average Wholesale Price (AWP), policies that increase the use and benefit of more affordable generic drugs, and tiered, enforceable co-pays for beneficiaries. States must have additional tools to properly manage this complicated and critical benefit.

2. **Asset Policy.** While Medicaid remains a vital source of long-term care coverage for many individuals who cannot receive that care elsewhere, there is growing concern that many individuals are utilizing Medicaid estate planners or other means in order to shelter or transfer assets and therefore qualify for Medicaid funded long-term care services. Medicaid reform must include changes that increase the penalties for inappropriate transfers, restrict the types of assets that can be transferred, and encourage reverse mortgages, as well as other policies that encourage individuals and their families to self-finance care rather than rely on Medicaid.

3. **Cost Sharing.** Medicaid's cost-sharing rules, which have not been updated since 1982, prevent states from utilizing market forces and personal responsibility to improve health care delivery. These provisions should be modified to make Medicaid look more like the State Children's Health Insurance Program (SCHIP), where states have broad discretion to establish (where appropriate) enforceable premiums, deductibles, or co-pays. As in SCHIP, there should be financial protections to ensure that beneficiaries would not be required to pay more than 5 percent of total household income (no matter how many family members are enrolled in Medicaid) as a critical balance to this proposal. For higher-income households (for example, those above 150 percent of the federal poverty level), a 7.5 percent cap should be applied.

4. **Benefit Package Flexibility.** Medicaid's populations are very diverse, ranging from relatively healthy families and children to the frail elderly, to individuals with serious physical and developmental disabilities. The types of services and supports needed by these populations are quite different, yet the Medicaid benefits package remains "one-size-fits-all." Many states have found that the flexibility built into the SCHIP program allows for greater efficiencies without compromising quality of care. Extension of this flexibility to services for appropriate Medicaid populations would allow states to provide more targeted services while managing the program in a way that prevents sweeping cuts in the future.

5. **Comprehensive Waiver Reforms.** Waiving various portions of the federal Medicaid statute has become the norm—rather than the exception—for states. Reforms are needed to increase efficiency and reduce costs, increase the ease with which states obtain current waivers, expand the ability to seek new types of changes, and change the federal statute to eliminate the need for many waivers altogether.

6. **Judicial Reforms.** The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers that impede this fundamental management tool. Also, U.S. Department of Health and Human Services officials should have to stand by states when one of their waivers is questioned in the judicial system and should work with states to define for the judiciary system that any state has a fundamental right to make basic operating decisions about optional categories of the program.

7. **Commonwealths and Territories.** The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years, to the extent that some of the jurisdictions are financing over 80 percent of their Medicaid costs, and many of the Medicaid expansions such as transitional medical assistance are not available. The imbalance affects quality of care issues and creates increased financial stress. Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.

ENHANCING QUALITY AND REDUCING COSTS OF THE OVERALL HEALTH CARE SYSTEM

We must increase the efficiency, productivity and quality of the entire health care system and believe that states are able to tailor solutions unique to their cultures, institutions and health care markets, but large enough to experiment with system wide reform. Accordingly, Congress should establish a National Health Care Innovations Program to support the implementation of 10 to 15 state-led, large-scale demonstrations in health care reform over a three- to five-year period. States would serve as the lead entity for these demonstrations, but they would have to partner with the private sector. Some of these demonstrations would be for statewide provider networks while others would be for networks in major metropolitan areas. Using information technology to control costs and raise quality would be a core objective of these demonstrations. The financing of these demonstrations should not come at the expense of Medicaid funding.

STRENGTHENING EMPLOYER BASED AND OTHER FORMS OF HEALTH CARE COVERAGE

Governors recommend a federal refundable health care tax credit for individuals as well as an employer tax credit for small employers. There is also a recommendation for the federal government to fund state alliances or purchasing pools which in combination with individual tax credits and the utilization of the S-CHIP benefit package for additional populations should also help create more competition in the health care marketplace. Finally, there is a recommendation to develop a catastrophic care/reinsurance model to address unsustainable "legacy costs."

SLOWING THE GROWTH OF MEDICAID LONG-TERM CARE

The paper includes a number of recommendations on assisting individuals in the purchase of long-term care insurance through the use of federal tax deductions and

credits as well as by enacting long-term care partnership legislation. Finally, there are recommendations to address home- and community-based care and chronic care management.

STATE CONTRIBUTION TO THE MEDICARE DRUG BENEFIT

While Medicare beneficiaries have some guarantees, that on January 1, 2006 the Medicare program will begin in providing them with a drug benefit, states do not have the same guarantee that the fiscal burden will be lifted.

In some states, contrary to clear congressional intent, the phased down state contribution (clawback) provision will actually cause states to spend more in Medicaid. In addition to their mandatory clawback payment, some states will also face increased costs from the administrative burdens of the new law.

Mr. Chairman, let me again thank you for the opportunity to appear before you. The nation's Governors look forward to working with you closely to begin the process of reforming the Medicaid program. As currently structured it is unsustainable.

101

MEDICAID REFORM

A PRELIMINARY REPORT

from the

NATIONAL GOVERNORS ASSOCIATION

June 15, 2005

Medicaid is the nation's largest health care program, providing health and long term care services to 53 million low-income pregnant women, children, individuals with disabilities and seniors. It is a vital health care safety net and provides important services to those who can get care from no other source. Medicaid coverage has also played a critical role in reducing the number of the uninsured, currently estimated at 45 million nationwide.

Medicaid spending, however, has increased dramatically over the last five years driven by a 40 percent increase in caseload and a 4.5 percent per year increase in the health care price index, strengthening the impetus for reform. Comprehensive Medicaid reform must focus both on reforming Medicaid and on slowing both the number of low-income individuals and elderly becoming eligible for Medicaid. Medicaid will always have an important role as the health care safety net, but other forms of health care coverage must be strengthened to ensure Medicaid's financial sustainability. Enhancing the quality of care and containing costs are also critically important. Governors believe that Medicaid reform must be driven by good public policy and not by the federal budget process.

The Vision

The policies that are outlined in this paper do not represent comprehensive health care reform. However, the scope is wider than the existing Medicaid program as it focuses both on populations that may become Medicaid eligible, as well as some of the underlying cost drivers in the overall health care system. In this sense it can be viewed as Medicaid plus health care reform. The various policies that are recommended are linked by a number of themes that underline this reform package. First, there are a number of incentives and penalties for individuals to take more responsibility for their health care. Second, moving to a more flexible benefit package for non elderly, non disabled Medicaid populations as well as for individuals who gain access through the individual health care tax credit will reduce costs while increasing total access. Third, the creation of state purchasing pools, that would use the combined leverage of public programs (offering a common S-CHIP-type benefit package) and individuals using the health care tax credit should strengthen the ability of small purchasers to gain more competitive rates in the health care marketplace. Fourth, technology and other state innovations are focused on reducing the long-run costs. Fifth, there are a number of policies designed to reduce reliance on Medicaid coverage. Finally, the paper includes a number of potential short-run policy changes as well as long-run structural changes that will improve the US health care system.

Specific health care policies are organized around these five objectives:

1. Reforming Medicaid
2. Enhancing Quality and Reducing Costs in the Overall Health Care System
3. Strengthening Employer-Based and Other Forms of Private Health Care Coverage
4. Slowing the Growth of Medicaid Long-Term Care
5. State Contribution to the Medicare Drug Benefit

1. Reforming Medicaid

Medicaid now covers 53 million Americans and the program is expected to spend a total of $329 billion in combined state and federal funds in 2005. While the Medicaid program is extremely cost effective compared to private sector health care, the existing program structure is inflexible and the benefits are not necessarily consistent with the needs of the various populations. This

paper focuses on both short-run flexibilities that could help states realize incremental savings and a major restructuring that would be necessary to make the program sustainable over the long-run.

Long Term Restructuring

Although Medicaid is the largest health care program in the nation, generalizations about the program are difficult to make, because it operates so differently in each of the states and territories. In addition, Medicaid is even more complicated than 56 different programs, because within each state, Medicaid plays a number of very distinct roles while serving a number of very distinct populations.

Medicaid essentially has three major functions:

- It provides comprehensive primary and acute care coverage for everyone who is eligible for the program (low income children, parents, seniors, and people with disabilities);
- Some Medicaid beneficiaries also qualify for comprehensive long term care services, depending on their needs; and
- Medicaid also helps finance services for people with chronic and disabling conditions such as HIV/AIDS, severe mental illness, and MR/DD. Each of these populations relies on Medicaid for support that they cannot receive elsewhere, and Medicaid restructuring must consider their unique needs and circumstances.

Although Medicaid does serve these three major roles, it also serves other functions such as a source of funding for uncompensated care in hospitals, and as a supplement to Medicare for low-income beneficiaries for whom it pays cost sharing and wraps around for various services in addition to long-term care.

Medicaid is serving many roles in the health care system. All of these roles could be improved upon by a greater focus on wellness and health promotion as opposed to simply "sick-care" treatment. These goals can be achieved by relying more heavily on care management and coordination.

- For low-income, but relatively healthy individuals who rely on Medicaid as a health insurance product, Medicaid should be transformed into a more mainstreamed, S-CHIP type program that could be coordinated with state and federal tax credits.
- For individuals with disabilities who have no other recourse than to rely on Medicaid, reforms should encourage more consumer choice and benefit packages that improve the quality of their care where possible, but not jeopardize their stability of care.
- A new national dialogue is needed to confront the issues of an aging population and the potential sources of funding for end-of-life care. The easiest solution may be to incorporate long-term care services into Medicare, but an alternative approach could be to link long-term care funding to Social Security, or broader pension reforms or other changes to solidify the link between personal responsibility and end-of-life care.

What is clear is that Medicaid can no longer be the financing mechanism for the nation's long-term care costs and other costs for the dual eligibles. Approximately six million Americans are dually eligible for full Medicare and Medicaid benefits, and another one million receive financial assistance to cover out-of-pocket costs, such as co-payments and deductibles. These individuals represent a small portion of Medicaid's 53 million person caseload, and despite the fact that they are fully insured by Medicare, they still consume 42 percent of all Medicaid expenditures.

Compared to other Medicare beneficiaries, dual eligibles are sicker, poorer, more likely to have chronic health conditions, and at higher risk for institutional care.

The details of this restructuring, however, are beyond the scope of this paper. The nation's Governors will continue to work on this issue and will be providing further detail.

Short-Run Flexibilities

A. Prescription Drug Improvements – States and the federal government have long suspected that Medicaid overpays for prescription drugs. The President's budget proposes to set federal ceilings on the prices that states pay for prescription drugs. The proposal would change the current system, whereby states purchase drugs based on the Average Wholesale Price (AWP). States have long been concerned that manufacturers have been inflating this number and that Medicaid has therefore been overpaying for drugs for many years. The President's proposal would establish a new price target for states, the Average Sales Price (ASP) that would be defined by law, subject to Federal audit, and lower than AWP. States would be allowed to reimburse pharmacies no more than ASP plus six percent (to account for dispensing fees and other costs) for all generic and brand name drugs.

Governors believe that the burden of reducing Medicaid expenditures for prescription drugs will require a multi-prong approach and should include savings proposals that affect both drug manufacturers and retail pharmacists, as well as increase state utilization management tools that decrease inappropriate prescribing and utilization. It is critical that states maintain and enhance their ability to negotiate the best possible prices with the industry.

There may be benefits of using ASP or other calculations as a reference price, because increased transparency of drug costs can serve to decrease total costs, especially if there is more flexibility with respect to dispensing fees (they should not be tied to a percentage of the cost of the drug dispensed, for example.)

This proposal should be modified in several ways:

- *Increasing the minimum rebates that states collect on brand name and generic prescription drugs to ensure lower total costs that would not solely impact pharmacists nor create disincentives to provide generic drugs where appropriate. Medicaid's "Best Price" provision should not be eliminated in exchange for this;*
- *Requiring that "authorized generics" be included in the Medicaid rebate calculations. An authorized generic is a brand product in different packaging that some manufacturers distribute through a subsidiary or third party at the same time that a true generic is launched by a generic manufacturer. This product is essentially a brand product at a cheaper price, but it violates the Hatch-Waxman 180 day exclusivity protection for generic manufacturers, and because CMS does not include these products in the Medicaid rebate calculations, it results in hundreds of millions of dollars in lost revenue for state Medicaid programs.;*
- *Forcing discounts on the front end of drug purchases rather than waiting an average of six months (not including dispute time) to receive rebates;*
- *Using closed formularies to drive beneficiary utilization and decrease costs similar to those that will be used by Medicare Part D plans;*
- *Giving states additional tools such as tiered co-pay structures to encourage greater utilization of generic drugs;*

- *Enacting stronger sanctions (including criminal penalties) for companies and individuals that fail to accurately report ASP (or whatever new methodology is adopted);*
- *Allowing states to join multi-state purchasing pools and to combine Medicaid with other state-funded health care programs to improve leverage; and*
- *Allowing managed care organizations to access Medicaid rebates directly for the Medicaid populations that they serve.*

B. Asset Policy –
Asset Transfers. There is concern that many individuals are utilizing Medicaid estate planners in order to shelter assets and therefore qualify for Medicaid funded long term care services. Examples of such estate planning approaches include:

- Sheltering assets in trusts, annuities and other financial instruments that are then deemed as "not available to the Medicaid beneficiary;"
- Converting "countable assets" under the law into "exempt assets"; and
- Transferring assets through joint bank accounts or other means to close relatives.

Under current law, when an individual applying for Medicaid has transferred assets within the three year "look-back" period, the amount of those transfers are used to calculate a period of ineligibility for Medicaid. This period of ineligibility is determined by dividing the total amount of the assets transferred by the average monthly cost of nursing home care in a given service area. For example, if an asset worth $40,000 is transferred during the look-back period and the average costs of nursing home care is $5,000 per month, then the individual would be subject to an eight-month waiting period to receive Medicaid eligibility. This period of ineligibility, however, begins on the date of the actual transfer of the asset, and by the time the person actually applies for Medicaid, that period has often expired.

The President's budget proposes to change the rules regarding penalties for individuals who transfer assets in order to become eligible for Medicaid long term care. The proposal would begin that penalty period on the date that the individual enters the nursing home or becomes eligible for Medicaid, whichever is later.

This approach should be encouraged and a number of other similar approaches should be explored around assets transfers to prevent estate planners from simply moving to alternate schemes. Other approaches to address inappropriate transfers could include:

- *Increasing the look-back period from three years to five years (or longer);*
- *Limiting the amount and types of funds that can be sheltered in an annuity, trust or promissory note*

In all cases, these changes should be federal requirements, although there should be ability to "opt-out" of the federal guidelines if the state can prove that existing policies would meet the intent of the law. Furthermore, there should be some resource threshold, e.g., $50,000 and indexed in future years, below which assets transfers would be exempted, as well as policies in place to protect individuals with dementia or others at risk of being exploited.

While this approach should provide some savings by preventing inappropriate transfers, state officials will need many more tools in order to fully address the growing long-term care crisis in

the Medicaid program. Many of these other approaches are addressed in the long-term care section below.

Reverse Mortgages. This is another tool that could help prevent individuals with considerable assets from depending upon Medicaid. According to the U.S. Census Bureau, 81 percent of seniors own their homes and 73 percent own them free and clear. This represents $1.9 trillion in untapped home equity that is currently exempted from Medicaid's eligibility calculations. According to the National Council on Aging, 48 percent of America's 13.2 million households age 62 and older could get $72,128 on average from reverse mortgages, and "in total, an estimated $953 billion could be available from reverse mortgages for immediate long term care needs and to promote aging in place."

This proposal would create an incentive and a new allowance for individuals to pursue reverse mortgages in order to pay for long-term care services (in addition to private long term care insurance, which is currently allowed). Any person who obtained a reverse mortgage under this proposal would be able to shelter $50,000 (or some other appropriate amount that would be indexed to inflation) in equity from their house without incurring penalties. Other incentives to encourage reverse mortgages should be contemplated. Broader use of reverse mortgages would be both an effective way to reserve Medicaid funding for those who have truly exhausted all of their other means, and a way to provide more consumer-directed options for seniors to choose from in developing their own long-term plan of care. The number of individuals currently on Medicaid who own their own homes is relatively small and this proposal would not likely affect them, so immediate savings would be limited. However, the major impact of this proposal would come from restraining the future growth of the program and in fostering a greater sense of personal responsibility with respect to end of life financial planning.

Other similar approaches could include requiring some form of family contribution to the costs of long-term care. Similar methods of "deeming" family income are utilized by states in their child support systems and might not be difficult to implement for Medicaid. In any case, provisions should be made to allow individuals to pass along some portion of their assets/resources to family members without incurring penalties. This would allow the balancing of both the needs of an ownership society with the responsibility of family to provide for the care of their loved ones.

C. Cost Sharing – Current law prohibits co-payments for some populations; for some services like family planning and emergency care; restricts co-pays, where allowed, to a maximum of $3; and ultimately treats cost sharing as unenforceable if the beneficiary cannot or will not pay. These rules, which have not been updated since 1982, prevent Medicaid from utilizing market forces and personal responsibility to improve health care delivery.

A new vision for cost-sharing should make Medicaid look more like S-CHIP, where states have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services, and could make them enforceable. As in S-CHIP, financial protections to ensure that beneficiaries would not be required to pay more than 5% of total family income (no matter how many family members are in Medicaid) are a critical balance to this proposal. For higher-income households (for example, those above 150 % FPL) a 7.5% cap could be applied, as under the current HIFA waivers.

States would have broad latitude to waive these types of cost-sharing for any populations or services that it determines would be negatively impacted by such policies. The purpose of increased cost sharing is not to restrict access to necessary medical care, but to allow individuals

to contribute to the costs of their own health care as much as possible. These new policies would be monitored and evaluated heavily and if the evidence shows that increased cost-sharing harms appropriate access, the policies should be revised.

D. Benefits Package Flexibility – The Medicaid program is viewed as the health care program for the poor, but it neither serves all poor people, nor are all of the beneficiaries below the federal poverty level. Medicaid's populations are very diverse, ranging from relatively healthy families and children to the frail elderly, to individuals with serious physical and developmental disabilities. The types of services and supports needed by these populations are quite different, yet the Medicaid benefits package remains "one-size-fits-all."

Many states have found that the flexibility built into the SCHIP program allows for greater efficiencies without compromising quality of care. Extension of this flexibility to services for appropriate Medicaid populations would allow states to provide more targeted services while managing the program in a way that prevents sweeping cuts in the future.

Medicaid reform should include the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as those for whom Medicaid serves as a traditional health insurance program. This discussion extends beyond the traditional distinction between "mandatory" and "optional" populations, which are arbitrary distinctions when it comes to the need for health care services. This would include an improved ability to set benefit limits and cost sharing amounts, do employer buy-in programs, eliminate retroactive eligibility periods, and establish different benefit packages for different populations or in different parts of the state. Medicaid can be improved by focusing more on improving health outcomes rather than adhering to a sometimes-arbitrary list of benefits mandates (that are often the result of effective lobbying by provider interest groups).

Many relatively healthy kids and families are technically mandatory, and many of the optional populations, such as the Medically Needy, are among the frailest in the program. Reform must therefore acknowledge that there are people served by Medicaid that need a comprehensive package of benefits. For more medically fragile populations, changes in the benefit package should be made to encourage more chronic care management and other services that can improve health outcomes and reduce costs.

E. Comprehensive Waiver Reforms – Waiving various portions of the federal Medicaid statute has become the norm, rather than the exception for states. HHS officials routinely describe that they consider thousands of state waivers every year. Yet, despite all this action, states must still jump through significant hoops in order to make relatively minor changes to their Medicaid programs, and often, major changes are simply outside the scope of the current waiver authority. *Reforms are needed to increase the ease with which states get current waivers, expand the ability to seek new types of changes, and change the federal statute to eliminate the need for many waivers altogether.*

The most commonly waived portions of the Medicaid statute are those requiring that beneficiaries have "freedom of choice" of provider, and that services be comparable, statewide, and consistent with respect to amount, duration, and scope.

- *The federal statute should change to reflect these commonly waived and antiquated provisions by allowing states to innovate in these areas through the state plan amendment process.*

- *Similarly, 1915(b), 1915(c) and PACE waivers should be administered through the state plan process, not waivers. It is critical in this scenario that these waivers retain the basic protections of the waiver, such as the ability to control costs and utilization common to the 1915(c) waivers. The state plan amendment process should include check boxes for typical waived items so that States could continue to target these services on the issues of comparability, statewideness, and amount, duration, and scope. States would realize cost savings because services would be implemented sooner and States would reduce administrative costs associated with waiver development, cost effectiveness/budget neutrality, reporting, and the waiver amendment/renewal process.*
- *In addition, streamlining the waiver process for all states that choose to pursue larger reforms and innovative programs would be a helpful improvement.*
- *Allowing states to easily receive approval to try an approach already tested successfully in other states would be one improvement.*
- *Automatically converting a waiver to a state plan after the first renewal would be another, as would a consistent 5 year approval/renewal period.*
- *Many promising innovations in Medicare/Medicaid integration or care coordination are never implemented because of outdated notions of siloed budget neutrality requirements. The requirement for budget neutrality should be waivable at state option and the statute should also allow for states to consider savings to the Medicare and other federal programs when considering the impact of Medicaid changes.*
- *States that wish to make substantial improvements to their Medicaid programs may find that some portions of the statute are not waivable at all. States should be allowed to apply for "superwaivers" that envision much broader changes than can be achieved under the current 1115 waiver structure. Such waivers should allow states to develop effective programs that meet the unique needs of their citizens.*

The State of Arizona has operated its Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), through a Section 1115 waiver, since the inception of Arizona's participation in Medicaid in 1982. There are many lessons to be learned to reduce costs from Arizona's experience. All Medicaid eligible persons are enrolled into managed care plans that AHCCCS contracts with using competitive bidding to maximize market forces. Market forces drive quality while holding down costs. Several states have demonstrated success with this model, and others should look to it to contain costs.

F. Judicial Reforms – The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers that impede this fundamental management tool. To that end, Congress and HHS should authorize states to rightfully make basic operating decisions about optional categories of the program.

Federal judicial actions have sometimes become a means by which the judicial branch makes decisions about Medicaid programs that should be left in the hands of state elected officials and competent program managers. If the management of the Medicaid program is being handled in a manner that is consistent with legislative and congressional intent, the court system should not become involved.

These court actions sometimes conflict with the policy positions of state and local officials and go beyond addressing the specific problem that was the basis of the initial lawsuit. These court actions fit into two broad categories:

- Consent decree cases
- Court decisions based on a specific case that have an adverse affect on the state Medicaid program as a whole

These court decisions can remain in place for decades and institutionalize the policies of elected officials who have long since left office. For example: Arkansas cannot make any change in fees paid to physicians without going back to court to remain in compliance with a consent decree entered into between the state and the Arkansas Medical Society in 1993. These court actions also create an environment where state time and resources that could be spent on the greater good of the whole program go toward reducing the impact of the specific court decision.

Federal reforms are needed to constrain the broad ability of judicial decrees in Medicaid cases that clearly impede state innovation and reform. In a time of shrinking resources and growing demand it is not realistic to ask states to manage these complex programs with court decrees overriding sound management decisions.

These court decisions and the subsequent legal actions that follow, increase administrative costs and divert valuable resources that could be far better spent on services to clients.

G. Commonwealths and Territories – The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years, to the extent that some of the jurisdictions are financing over 80 percent of their Medicaid costs, and many of the Medicaid expansions such as transitional medical assistance are not available. The imbalance affects quality of care issues and creates increased financial stress. Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.

2. Enhancing Quality and Controlling Costs in the Overall Health Care System

America's current health care system is ripe for improvement and states are ready to take the lead in helping drive change. States are small enough to tailor solutions unique to their cultures, institutions and health care markets, but large enough to experiment with systemwide reform. States can also partner effectively with health care providers, insurers, and purchasers to lead large scale pilot projects.

We must increase the efficiency, productivity, and quality of our entire health care system, which will increase the opportunities for reasonable coverage expansions. Like welfare reform a decade ago, states can play a lead role in driving this transformation through demonstration projects in partnership with the private sector.

Accordingly, Congress should establish a National Health Care Innovations Program to support the implementation of 10 to 15 state-led large-scale demonstrations in health care reform over a 3-to-5-year period. Using information technology to control costs and raise quality would be a core objective of these demonstrations. States would serve as the lead entity for these demonstrations, but they would have to partner with the private sector. Some of these would be for statewide provider networks while others would be for networks in major metropolitan areas. They would focus on:

- deploying information and communications technology, including interoperable electronic health records (EHRs) accessible to all participating providers and patients, to improve services;
- improving quality of care, including disease prevention and management, through establishment of evidence-based practices, measuring outcomes, and pay-for-performance programs;
- using innovative strategies to cover many of the Americans who currently lack health benefits;
- empowering consumer choice through price transparency, quality reporting, and financial incentives; or
- reducing malpractice incidents and improving adjudication of malpractice claims.

Each demonstration project would be selected through competition and encouraged to demonstrate multiple innovations. All projects would need to emphasize the goal of increasing cost-effectiveness and, to the extent possible, improving health care quality.

For a more comprehensive discussion on this issue, see the NGA white paper on health care reform demonstration programs.

The financing of any of these solutions should not come at the expense of Medicaid funding.

3. Strengthening Employer-Based and Other Forms of Private Health Care Coverage

Between 2001 and 2003, the proportion of Americans under the age of 65 covered by employer-sponsored health care dropped from 67 percent to 63 percent. While some of this reduction could be cyclical due to the economic downturn, many argue that the increase is more structural, as the U.S. economy is becoming more service and small business oriented and more competitive in the ever more global marketplace. Several policies could assist in reducing the number of individuals losing health care coverage. The financing of any of these solutions should not come at the expense of Medicaid funding.

A. Individual Health Care Tax Credit – A refundable tax credit could be developed that would be available to all low-income individuals below some income threshold, e.g., $3,000 for a family of four with incomes below $25,000, which is phased-out at income levels of $60,000. This credit would be a premium subsidy that could be paid directly to a health care plan by the U.S. Department of the Treasury. Unlike the trade assistance program that targets unemployed workers, eligible workers that could receive tax credits could have their employers deduct payments from wages and send them directly to the U.S. Treasury who would combine those funds with the tax credit, confirm eligibility, and forward the payment directly to the health plans.

To increase the use of the tax credit, the federal government could also mandate presumptive eligibility so that individuals would have to opt out as opposed to opting into the system. It is critical that this subsidy be set at the appropriate level. If it is too low, there will be few individuals who could use it; and if it is too high, then it would be an incentive for businesses to stop providing employer-paid health care. It is also critical that the level have the appropriate relationship with any credit for small employers. The credit would be available for all individuals who meet the income criteria and are not participating in an employer-paid or public program. Individuals who qualify for both Medicaid and the tax credit would be able to choose between the

two. States should also be allowed to enhance the tax credit. One option would be to allow states to use disproportionate share funds for the enhancement.

Because this is a refundable tax credit it is reflected in the federal budget as an outlay as opposed to a reduction in revenues. This opens up the potential option for the states to apply for a waiver that would allow the funds to come directly to the states based on a plan that would maximize health care access. For example, the Michigan Third Share program, which has equal amounts paid by employers, employee, and government, could utilize these funds for the government share. Such a waiver option would allow individual states to tailor the funds to their unique labor force and health care marketplace. Such a tax credit also equalizes tax treatment of all individuals with regard to health care. This tax credit can also be designed to allow individuals to buy into the S-CHIP benefit or to otherwise require that the credit only be viable when used to purchase some basic, threshold benefit, as defined by the state. It is difficult to determine how many individuals would use a tax credit of this nature.

B. Employer Tax Credit – A new employer tax credit would be developed for small firms, i.e., up to 100 workers. The employer tax credit would be about $200 per individual or the amount necessary to make the federal contribution necessary to enact this policy the same as that necessary to enact the individual tax credit. The policy rationale is to equalize the tax treatment between the individual tax credit and the employer-based tax credit. Unlike the Administration's proposal, it would not be restricted to employer contributions to Health Savings Accounts. The employer tax credit would be restricted to only workers below a given wage rate. The amount of the credit, the targeting, and the relationship to the individual tax credit are key in order to support the employer-based system, as opposed to providing incentives for employers to reduce coverage. Also, the state should be able to designate the minimum benefit package to be eligible for the tax credit. This credit would be reflected as a reduction in revenues to the federal government.

C. State Purchasing Pools – The federal government would make grants to states to create state purchasing pools. In the past, states have experimented with purchasing pools, but most have failed because they were never large enough to avoid risk-selection and ended up becoming high risk pools that were subsidized. Specifically, there was a financial incentive for healthy individuals to obtain their insurance outside the pool. Currently, the Federal Employees Health Benefit Program (FEHBP) and the small firm purchasing alliance in California (now called Pac Advantage) are existing purchasing pools. Permitting states to develop an SCHIP benefit package for their non-disabled, non-elderly Medicaid population, and including the same benefit package for the individual health care tax credit, should allow them to create a large enough pool (mostly in metropolitan areas) to negotiate effective rates.

To avoid adverse risk, states should be allowed to mandate that both populations be part of the purchasing pool. States will need the discretions to design their purchasing pools. This will include health plan qualifications, underwriting, rating rules, and enrollment rules. The pool could be the mechanism for Medicaid women and children, SCHIP, state employees, COBRA options, and the tax credit as well as any private firm, particularly small business that purchases health care in the state. This could have the added benefit of stabilizing the individual and small group market. Such a large pool could also maximize consumer choice. The President's budget includes this proposal.

D. Catastrophic Care/Reinsurance Model to Address Unsustainable "Legacy Costs" – Numerous employers in the U.S. have been consistent, reliable partners with their employees on

health insurance coverage, yet their ability to continue providing this coverage to retirees ("legacy costs"), current employees, and their families--amidst rising national health care costs--is becoming a distinct competitive disadvantage. Catastrophic care, chronic diseases, and serious illnesses contribute significantly to the overall cost of health care and should be addressed. While more attention and resources must be focused on wellness and disease management programs as well as best practices to ensure quality care, some bold options that offer uniquely American solutions for our American legacy cost challenges are needed. The following are two concepts to consider—one that is employer pools and another that is insurance pools. A hybrid could also be considered.

One option is to create a reinsurance pool whereby employers and other payers would be reimbursed by the federal government for part of the cost of catastrophic medical bills of their employees. To be involved in this program, employers could be required to provide health care coverage equivalent to a benchmark plan to all of their employees and/or provide preventive and disease management programs to better manage care and improve quality and care.

Another option to explore more fully is a national "Healthy Mae," as Senator Frist refers to it. The senator believes that a "Healthy Mae" model, fashioned after Fannie Mae, would help insurers more broadly share risk, reduce administrative costs, and create a vibrant secondary market for health insurance just as the U.S. has done for home mortgages. Potentially a publicly-chartered private insurer, "Healthy Mae" could help create a big secondary market for health insurance and would reduce the financial burden on employers when their workers' medical bills rise above a certain threshold. "Healthy Mae" would be designed to give buyers access to a more stable insurance market—which presumably would feature lower rates that could keep more people covered.

4. Slowing the Growth of Medicaid Long-Term Care

Medicaid has quietly over the years become the nation's largest payer of long-term care services, funding approximately 50 percent of all long-term care spending and nearly two-thirds of all nursing home residents. With the anticipated demographic changes, the potential liability for future long-term care costs can only grow. While Medicaid reforms over the past twenty years have focused on improving the long-term care benefit (eliminating the institutional bias, encouraging consumer-directed care, etc), new efforts need to focus on how to encourage personal responsibility and discourage the reliance on Medicaid financed long-term care. Ultimately, a new national dialogue is needed to confront the issues of an aging population and the potential sources of funding for end-of-life care.

The following two policies could help slow the growth of elderly enrollment in Medicaid.

A. Tax Credits and Deductions for Long-Term Care Insurance – Currently, about 28 states provide deductions or tax credits for long-term care insurance. The federal government currently allows tax deductions for the purchase of insurance, but only if the premium amounts exceed 7.5 percent of an individual's adjusted gross income. Only 11 percent of the population age 65 and older and 8 percent of those between ages 55 and 64 have a long-term care policy in effect.

The potential impact of deductions and tax credits is very different, since they impact quite different income groups. The deduction is more effective in stimulating the purchase of long-term care insurance since it is more valuable to younger, higher-income individuals in higher tax brackets. Because these individuals may allow policies to lapse and because they are less likely to

enroll in Medicaid, they do not provide the maximum possible relief to Medicaid per lost dollar in federal tax revenues. On the other hand, tax credits can be better targeted to lower-income individuals who have a higher probability of becoming Medicaid eligible. This will lead to more relief in Medicaid spending. A December 31, 2001 report by ABT Associates indicated that Medicaid saves $1.16 and $2.67 respectively in 2025 and 2050 for every dollar lost due to federal tax credits. Tax deductions do not break even. A combination of a significant tax credits, e.g., $2,000, and a small deduction, e.g., $200, might be the most effective in lowering Medicaid costs. States, through their capacity as regulators of insurance, set minimum standards and other guidelines for any such policy that could be obtained through the tax credit.

The Treasury should also develop some mechanism so that individuals can receive the credit when they pay the premium to avoid the long delay between payment and reimbursement via annual tax submissions. Tax credits are particularly effective to the federal government as well as states due to the potential Medicaid savings. Because this credit focuses on the very expensive population in long-term care, potential Medicaid savings are significant. The federal government may also want to mandate that all firms who provide 401(k) and other pensions provide an option to convert a portion of an annuity into long-term care insurance. This tax credit would be reflected as a revenue reduction in the federal budget. As of 1998, there were $9.5 trillion in qualified retirement plans, some portion of which could ultimately be used for long term care financing.

B. Long Term Care Partnerships – Four states (California, Connecticut, Indiana, and New York) have been operating promising partnerships between Medicaid and the long-term care insurance industry. Although their approaches differ, the basic concept is that individuals who purchase private insurance and exhaust its coverage would be allowed to access Medicaid and still protect some of their assets. There are two basic approaches that the four states utilize—the dollar-for-dollar model and the total asset protection model. In the dollar-for-dollar model, beneficiaries are able to keep personal assets equal to the benefits paid by the private policy. In the total asset model, all assets are protected after a threshold for years of coverage has been crossed, typically three or four years. In both cases, Medicaid becomes the payer when the partnership policy benefits are exhausted. States are projected to realize savings because Medicaid becomes the payer of last resort, not the first.

Federal law prohibits the expansion of these partnerships beyond those four states, but 17 states have passed enabling legislation allowing them to begin such a program should the federal prohibition be repealed, and several others are currently exploring that option. While long-term care partnerships do not promise a silver bullet for Medicaid's long-term care crisis, they can be a key part of the solution, and therefore all states should be allowed to participate.

In addition to tax treatment and other incentives for the purchase of long term care insurance, there are ways to improve the delivery of long term care services for individuals who remain covered by Medicaid. Those include both increasing the focus on home and community-based alternatives to institutional care as well as strengthening the chronic care management components of both Medicare and Medicaid.

C. Improving Access to Home and Community-Based Care. The long-term care policies advocated by NGA should also include reforms to the Medicaid program that produce better health outcomes for beneficiaries and result in greater efficiencies for both the federal government and states. Such reforms should give states more tools to encourage home and community-based care and could include the elimination of the requirement for a waiver for

home and community based care as discussed in the section on waiver reforms and in the current NGA policy on Long Term Care (HHS-28).

D. Improving Chronic Care Management. The long-term care policies advocated for by the Governors should include reforms that encourage better care for the chronically ill populations in Medicaid. Although this is a small population, they demand a large portion of the available resources. States should be rewarded for program improvements that produce savings for both Medicaid and Medicare, particularly through improved chronic care management, by sharing savings evenly with states in the form of enhanced FMAP on a year-to-year basis. States should have the authority to provide financial incentives for care management methods that save money and improve outcomes outside of the targeted case management benefit.

5. State Contribution to the Medicare Drug Benefit

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) was designed to deliver a federal pharmacy benefit to Medicare beneficiaries. It was also designed to ease state Medicaid programs of their responsibility for providing pharmacy benefits to those eligible for both the Medicare and Medicaid programs—the dual eligibles.

While Medicare beneficiaries have some guarantees that on January 1, 2006, the Medicare program will begin providing them with a drug benefit, states do not have the same guarantee that their fiscal burden will be lifted. In some states, contrary to clear congressional intent, the Phased-Down State Contribution (clawback) provision will actually cause states to spend more in Medicaid in fact, a handful of states are projecting that they will never see any financial relief in prescription drug costs from the MMA than they would have in the absence of the law. In addition to their monthly clawback payments, states will also face increased costs from the administrative burdens of the new law. While state Medicaid programs operate with administrative costs far below those of private insurers, states have been forced to trim their program overhead even further in order to protect scarce resources for the care that their beneficiaries need. Tracking, calculating, and reporting clawback payments, as well as the other duties that resulted from the MMA, present substantial new administrative tasks [as well as potential costs] for Medicaid programs.

Integrating Medicaid's coverage with the drug coverage provided by the separate prescription drug providers will be a difficult undertaking for states. The clawback provisions should not be a further financial burden on states as they work to focus on the coordination of care that is central to the spirit of the Medicare Modernization Act.

Questions Submitted to Governor Warner and Governor Huckabee
Senate Committee on Finance's Hearing
"The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net"
6/20/05

On behalf of the National Governors Association, we appreciate the opportunity to testify before your committee and to more fully respond to the many important follow-up questions raised by committee members. The Medicaid reform policy adopted by the nation's Governors represents bipartisan consensus positions. While the consensus nature of our work sometimes does not allow detailed responses to some of the enclosed questions, we hope that we may work together with members of the committee and other interested stakeholders in developing legislation that can be enacted this year, as well as in the years to come.

Chairman Grassley

1. In your testimony, you talk about the importance of changing the rules for how seniors can qualify for Medicaid faster by transferring assets. Specifically, you state that Medicaid should restrict the type of assets that can be transferred. Would you elaborate on what type of assets someone can transfer so that they Medicaid will pay for their long term care costs sooner, and how you would propose closing these loopholes?

   A) An issue for most states is not only shielding assets, but also the mechanisms and increasingly complex legal maneuvers used by people and their estate planners to transfer and/or shield cash. The "Estate Planning Industry" is becoming bold in its advice to people on how to use trusts, promissory notes, and other legal devices to transfer assets to heirs and, more recently, even to shield income that might otherwise prevent a beneficiary or spouse from qualifying for Medicaid. A major issue for states in recovering money for Medicaid beneficiaries long-term care costs is that the estate planning industry has been adept in finding legal loopholes and other means to transfer assets and shield resources making it easier for clients to quality for Medicaid. Aided by television and other advertising, states believe that estate planners encourage people to create trusts and other financial schemes that enable people to transfer assets to their heirs. Thus, when their health deteriorates and long-term or institutional care is required, they have few accessible assets enabling them to qualify for Medicaid and receive long-term care services at taxpayers' expense, even though these individuals' and their families have substantial assets and in some cases income and other resources.

   There are several problems for states in developing and enforcing fair asset transfer and other resource shielding mechanisms policies. One, in many cases, estate planners use legitimate loopholes and other legal methods to assist people in showing few or no assets (other than housing, a vehicle, and personal property

which are permitted). Two, the estate planning industry has been adept at keeping ahead of and adapting to changes states implement to better control or reduce asset transfers. Some examples of the estate planning industry's maneuvers cited by states include the use of people using promissory notes to relatives and annuities to reduce liquid assets thereby qualifying for medical assistance.

Policy options to reduce the use of transfers and other asset shielding maneuvers include expansion of the look back period for Medicaid eligibility. Estate and trust lawyers will continue to find new methods to place assets and income into uncountable categories for the purposes of establishing Medicaid eligibility. Due to the state-by-state variation, it is unlikely that estate and trust law alone can be reformed to prevent these practices. Nevertheless, Medicaid could contain the asset transfer practices by extending look back periods on a state-by-state basis and ensuring federal statutes support states' flexibility. In addition, states could consider revising countable asset definitions the purpose of establishing Medicaid eligibility. Such changes would likely require federal Medicaid law modifications under applicable provisions of Section 1902 of the Social Security Act.

2. The Medicaid statute requires states to seek recovery from the estate of someone who had non-countable assets and then goes on Medicaid. Do you believe that states do enough currently with estate recovery?

   A). States are increasing their efforts with respect to the current rules around estate recovery. States have found, however, that the principles around Third Party Liability generally hold true in this area as well. The retroactive nature of estate recovery's "pay and chase" model is less effective than the preventive nature of the "cost avoidance" model.

   For the purposes of estate recovery analysis, one must look at the probate estate versus the non-probate estate. OBRA '93 specifically defines the term "estate" as all real and personal property and other assets included within an individual's estate, as defined for purposes of state probate law. Generally, if a deceased person is the sole owner of an asset and title is vested completely in the person's name, the asset is subject to probate. There is wide variation among states with regard to probate law. Moreover, according to recent data, 33 states go beyond the probate estate of deceased individuals when pursuing estate recovery. Some have suggested that the federal law should be more prescriptive in the area of defining probate versus non-probate assets. An expansion of the definition of assets that are eligible for estate recovery efforts would likely aid in the process of estate recovery. States historically have been unable to recoup a substantial percentage of Medicaid long-term care expenses through the estate recovery process.

3. We know that seniors have hundreds of billions if not trillions of dollars of equity in their homes. Medicaid allows seniors to shield their home equity from being counted. Reverse mortgages has been discussed as a way of getting seniors to use

that home equity to pay for their own care and not to go on Medicaid. What is your policy to increase the use of reverse mortgages?

A). Several things could be done to increase the use of reverse mortgages. Reverse mortgages involve upfront costs (similar to any home purchase/sale/refinancing) and if those costs could be waived, partially funded by Medicaid, or assumed into the annual payout of the mortgage, there would be more incentive for individuals to pursue this strategy. Similarly, if an individual's home were to be considered a "countable asset" with respect to Medicaid eligibility, the use of reverse mortgages would also increase. This should be combined with restrictions on how such funds might be sheltered.

Many policymakers have raised the potential benefit of reverse mortgages as a source of funding for long-term care. The National Council on the Aging estimated that seniors have approximately $2 trillion in home equity. Policymakers cite the appeal of people being able to stay in the community in their homes and still receive the social, physical, mental, and other support services they need to age gracefully. However, there are important issues that will need to be considered before the use of home equity loans to fund long-term care expenses becomes widespread. First, under current laws, states have no authority to require people to use home equity to offset long-term and other medical care expenses. Second, Medicaid permits people to exclude their homes from Medicaid eligibility determination, so there is little financial incentive for people to use their home equity to pay for long-term care expenses.

By way of background, a reverse mortgage is a loan that allows homeowners age 62 and older to convert home equity into cash while living at home for as long as they are able. Individuals can receive payments as a lump sum, line of credit, monthly payments. The funds can be used for any purpose. The reverse mortgage loan comes due when the (last) borrower moves out, dies, or sells the home. The homeowner could never owe more than the value of the house at the time of sale or repayment of the loan. This would protect from excessive appraisals at the commencement of the reverse mortgage. Finally, borrowers would continue to own the home.

4. One of the asset transfer proposals would increase the lookback period from 3 years to 5 years. Yet we know that it is extremely difficult for seniors to document transfers of assets over a three-year period and for states to administer a three year process already. Do you believe states are adequately prepared to properly review documentation if the lookback period were increased?

A) States should have the option of increasing the lookback period to longer than three years. Those states that may not find it politically feasible, logistically manageable, or appropriate from a policy perspective would not be forced to do so. States indicate they would be ready to adapt to a longer look back period almost immediately. Expanding the look back period would not be a conceptual

change, so that states would only have to collect more of the same information they already collect to verify asset transfers back to three years. The five-year look back period also levels the playing field between trusts and other types of asset vehicles. For example, in some states, the look back period on trusts is currently five years, although for other types of assets it is three years.

5. In your testimony, you argue that states need the flexibility to better tailor benefit packages for the specific Medicaid recipients who need them. Could you please elaborate with specific examples of what you think states could do with more flexibility?

   A) Recognizing that there are many chronically ill, disabled, aged, or other special needs populations in Medicaid that need access to a broad array of improved services, there are many relatively healthy populations that would not suffer from receiving a benefits package similar to that provided by SCHIP. Allowing many of these current Medicaid beneficiaries access to this benefit could allow some states to expand coverage to the currently uninsured, could allow other states to avoid eligibility reductions, and with the added leverage of SCHIP, the state's employee health plan, and individuals accessing a refundable health care tax credit could allow some states to help stabilize the small group and individual markets and prevent the steady growth in the uninsured.

6. In your testimony you say that states need additional tools to manage the Medicaid prescription drug benefit. Could you elaborate on what tools you believe states need that they don't currently have in law and why these tools are needed? In your testimony you say that states need additional tools to manage the Medicaid prescription drug benefit including greater utilization of generic drugs. How would you create greater incentives for the use of generic drugs and what policy changes do we need from CMS or Congress to assist you?

   A) States are not allowed to operate a truly closed formulary in Medicaid. Although the ability to use preferred drug lists and prior authorization is useful in controlling inappropriate drug prescribing and utilization, without the ability to close formularies for drugs such as Viagra, hundreds of millions of dollars will continue to be spent on non-life saving drugs. Another tool would be the ability to develop effective tiered co-pay structures to encourage generic drug utilization where appropriate. Although states may currently operate tiered co-pays, Medicaid's current cost sharing rules, with a maximum co-pay of $3 per drug is not conducive to encouraging cost effective utilization.

7. In your testimony, you advocate for a streamlined waiver process. You also argue that there are certain policies that need not require a waiver. Could you please elaborate on the policies that you think should no longer require a waiver and explain why you do not think they should require a waiver to be implemented?

A) In seeking "flexibility" states believe they can be more adaptable and creative in filling gaps and experimenting with specialized services, programs, and approaches through experiments or demonstrations. With the ability to bypass some federal Medicaid requirements without triggering lengthy waiver applications, states could save time, money, and better tailor programs to meet specific needs. For instance, some states believe that they would have a better idea of how to propose a new program if they could first try it on a limited basis with a smaller population before implementing it statewide. States believe they and their federal partners too would benefit from states' increased flexibility to create programs that target special populations or limited geographic areas before expansion to entire states. Similarly, requirements for waivers to be cost-neutral can be an unrealistic burden on new or experimental programs. In many situations, smaller pilots or experiments could iron out problems and keep research investment to a minimum before decisions on whether or not a program works are made. With freedom to create smaller experiments states could test new care delivery and other concepts as well as assess demand and beneficiary/provider satisfaction before committing to an expensive and potentially risky new program.

This could be accomplished through the state plan amendment process in the absence of the amount, duration, scope and "statewideness" provisions of sections 1902 (a)(1) and 1902 (a)(10)(b) of the Social Security Act. The revised state plan amendment also would include a checkbox indicating limited geographic service area or other limitations.

States also believe there would be substantial benefit in permitting states to replicate waivers that have been implemented and sustained in other states, in some cases for years. Some of these waivers are so commonplace and have been in existence for so long that they have become the standard of practice. Yet any new state that wanted to implement a similar program would be forced to submit and defend a lengthy waiver application and wait for a time consuming review. This process is time consuming and tends to discourage innovation by forcing states to make a substantial investment in any new programs without much benefit to anyone.

States would also like to see more waiver flexibility in provider contracting. Although states now may contract selectively for some services without waivers, there are many more services where the ability to contract with, say preferred providers, might enable states to cut costs while improving quality. Contracting flexibility could be important under some pay-for-performance (P4P) approaches. Additional at-risk contracts that share savings with provider groups that can lower care costs while improving quality could be important in stretching increasingly scarce resources. State purchasing pools have been successfully utilized for pharmaceutical products, but the same concepts might be applied to other services and products if requirements can be adequately addressed under current regulations or waivers.

Senator Baucus

1. Medicaid is paying too much for prescription drugs – I agree we need to look at reforms. I have a few questions about your proposals for reform in this area:

    - Today, state Medicaid programs pay an extra fee when a drug is dispensed. But the President's proposal would NOT allow dispensing fees. I have heard that cutting out the dispensing fee would hurt independent pharmacists, especially those in rural areas. Is that true? Would you support allowing a separate dispensing fee?

    - On generic drugs, what should the payment formula be? How would your proposal affect the incentives for pharmacies to dispense generic versus brand-name drugs?

    - What standard would you propose to replace AWP – ASP? AMP? Another basis?

    A) The Governors are not endorsing the proposal to model Medicaid's reimbursement policy after that utilized under Medicare Part B. In fact, Governors have long maintained that prescription drug savings should not come entirely at the expense of independent and rural pharmacists. There is value to establishing a new benchmark price, such as ASP, if it increases transparency and leads to overall reduced prices. It is important to recognize that prescription drug costs are a factor of both the price paid for the drug and the dispensing fee paid to the pharmacist. Dispensing fees should remain a separate but important issue and should neither create incentives to dispense expensive drugs, nor disincentives to provide patient counseling. Governors believe that while prescription drug savings should come equally from stakeholders in the system, changes should not provide disincentives for generic drug utilization. We do not currently have enough information on alternate reference pricing to know what AWP should be replaced with. ASP appears to be a more accurate (and lower) reference, but the Governors are open to considering other alternatives that would have the same effect.

2. Federal law now ensures that all Medicaid beneficiaries have access to medically needed basic care like hospital and specialty services. It also requires medically necessary screening and treatment services for children and long term care services for the elderly and disabled. But the NGA proposal would give states "flexibility" to change these required benefits. Would that mean changing the guarantee of medically necessary services for children or access to long term care? How would you protect elderly and disabled individuals and ensure access to care? Are there certain populations to whom you would consider such benefit package flexibilities not to apply? Would your proposal support the elimination of hospital and specialty care for certain populations? To the extent that you are

looking at these cuts, are you concerned that this might actually increase health costs by increasing need for acute services or emergency room care?

A) Governors believe that Medicaid reform should include the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as those for whom Medicaid serves as a traditional health insurance program. Many states have found that the flexibility built into the SCHIP program allows for greater efficiencies without compromising care. The Governors do however acknowledge that that there are people served by Medicaid that need a comprehensive package of benefits. For more medically fragile populations, Governors are proposing changes in the benefit package in order to encourage more chronic care management and other services that can improve health outcomes and reduce costs. The goal of this flexibility is to allow states to design their programs to reflect the very diverse Medicaid populations that range from relatively healthy families and children to the frail elderly, to individuals with serious physical and developmental disabilities. The types of services and supports needed by these populations are quite different.

3. Your proposal cites CHIP as a model for benefit package flexibility and cost-sharing, but isn't CHIP the wrong model for the Medicaid population? Children eligible for CHIP are healthier than Medicaid-eligible children and they have higher income and so can afford greater cost-sharing for the services provided. And, even CHIP includes Medicaid's cost-sharing protections for individuals below 150% of poverty and limits on the amount of cost-sharing that can be imposed per service for higher-income individuals. I am concerned that your proposal, allowing no limits on the cost-sharing amount except that the aggregate cannot be greater than a percentage of income, may go too far. Is it your intent that the proposal would allow cost-sharing to be imposed at any amount, up to the aggregate limits suggested? Does the proposal adopt CHIP's current limits on cost-sharing for individuals between 100 and 150% of poverty? Do you intend to include limits for those under 100% of poverty?

A) The Governors propose making the federal rules governing cost-sharing look more like S-CHIP, where states would have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services. The proposal recognizes that Medicaid beneficiaries should have financial protection from burdensome cost-sharing requirements. As in S-CHIP, the Governors propose financial protections to ensure that beneficiaries would not be required to pay more than 5% of total family income. These limits are being proposed for all individuals in the Medicaid program with suggestion of a higher percentage of income limits (e.g. 7.5% limit) for beneficiaries with higher incomes (for example, those above 150% FPL). It is important to note that these cost-sharing changes are not being proposed as a requirement, but merely a framework for states to develop policies that meet the unique needs of their citizens. States would have broad latitude to waive these types of cost-sharing for any populations

or services that it determines would be negatively impacted by such policies. The intent behind the proposal is to allow states to better manage health care by encouraging necessary health care in the most appropriate setting.

4. Oregon's recent experience with cost-sharing indicates that even a relatively small increase in cost-sharing requirements could have dramatic consequences. In 2003, Oregon began enforcing a monthly premium ($6-20) for some of their enrollees and nearly half of those who were subjected to the premium increase (50,000 individuals) dropped off Medicaid within 10 months. There was also an increase in emergency room use of 17% during that period. What protections would you recommend to ensure that your proposal wouldn't result in a similar outcome?

   A) The Governors' proposal recognizes that financial protections are a critical balance to the increased flexibility governing cost-sharing in the Medicaid program and propose that beneficiaries not be required to pay more than 5% of total family income (or 7.5% for higher-income households). Furthermore, states would have broad latitude to waive cost-sharing for any population or service that it determines would be negatively impacted by a cost-sharing policy. The purpose of cost-sharing is not to restrict access to necessary medical care. The Governors propose that new cost-sharing policies would be monitored and evaluated heavily to evaluate the impact on beneficiaries, and if the evidence shows that increased cost-sharing harms appropriate access, the policies should be revised.

5. Your proposal supports judicial reforms that would "remove legal barriers that impede" a state's ability to manage and make basic operating decisions for its Medicaid program. What specific proposals are being endorsed by the Governors in this area? Would your proposal extend to enforcement of federal requirements by federal agencies, as well as other private parties? Would local governments also be affected by this proposal? If you propose to limit judicial enforcement of federal requirements, what means of redress would Medicaid beneficiaries and providers have if they felt a state had not complied with federal requirements? Under your proposed changes, wouldn't that limit the federal government's ability to enforce federal requirements, except through withholding of federal funding?

   A) U.S. Department of Health and Human Services officials should have to stand by states when one of their waivers is questioned in the judicial system and should work with states to define for the judiciary system that any state has a fundamental right to make basic operating decisions about optional categories of the program.

6. With respect to the Long Term Care Partnerships program, some have raised concerns that there is a need for greater consumer protections in place to ensure that consumers get the benefits promised. What consumer protections would you support in an expansion of the program? Please provide any further details on changes to the existing program that you would support

A) The Governors believe that consumer protections are a critical component of the expansion of the Partnerships to other states. Inflation protection is one of the most important protections. In order for people to enter the long term care insurance market, they must be assured that the value of their policy will not erode significantly over time. Governors also believe that current protections such as suitability, ratings standards, and non-forfeiture clauses are important components of a sustainable long term care insurance market. While simply lifting the current restrictions on the number of participating states may not ultimately be the response, great caution should be exercised to ensure that states still have incentives to enter into such partnerships and that the constantly evolving market isn't unnecessarily restricted. For example, there should be incentives for states to enter into reciprocal agreements with other Partnership states, not mandates that they do so. Similarly, while the current Partnership states are moving away from a total asset protection model and toward a dollar for dollar protection model, new Partnership policies should not be prescriptively mandated into a single model that may become obsolete over time.

7. With respect to your proposal on changes to the asset transfer rules, it is my understanding that the current rules ensure that individuals who transfer funds within the lookback period are held accountable for the value of services that could have been purchased with those funds by making them ineligible until the funds are spent down as they would have been for long term care services. For example, a mother that helps her adult daughter with health care costs or a granddaughter with school tuition could be ineligible for nursing home care for a period, but then eligible once the funds were spent down. However, the proposal appears to create a situation where this woman would be ineligible for care for a significant period, even if she had no resources to spend on her own long term care services. What do you envision would happen to a woman in this situation? Wouldn't imposing the penalty at the time of eligibility leave our nation with a great problem in meeting the needs of individuals who didn't have the resources to pay for their care when they needed it?

A) The Governors believe that Medicaid's most important role is as a safety net program, providing health care and long term care services to people who have no other options. However, Medicaid now provides half of all long term care spending in the country and covers two thirds of all people in nursing homes. Medicaid is no longer just a safety net and policies must be enacted to encourage those with resources to self-finance their care and to support families who can provide care to their frail family members. It is understandable for seniors to want to pass along something to the next generation, but it is equally as important for

public policy to encourage the next generation to similarly respect and care for seniors in return. The national debate on long term care must confront the growing need for long-term care services and the ability/willingness of people to plan ahead for that inevitability.

8. Some have raised concerns that extending the look-back period for asset transfers would be infeasible because many elderly individuals suffer from Alzheimer's disease or other forms of dementia and would be less likely to keep the needed records to document their expenses during the five year period. How do you respond to this claim?

A) It is regrettable, but Alzheimer's disease is primarily a disease of the elderly. However, in general, beneficiaries' impairments would not be a major issue in extending the look back period for asset recovery, although in a few cases, beneficiaries' abilities to provide accurate records might affect the speed and completeness of states' asset searches. States have developed financial verification procedures that are not completely dependent on records from individuals. Bank and other records would be available for many beneficiaries prior to onset of Alzheimer's disease and other impairments that would enable the state to recover assets, where appropriate. Look back periods of any length present documentation issues for seniors who do not keep comprehensive financial records regardless of mental capacity. Most financial information reviewed by states in look back periods is likely to involve banks and other financial institutions created by transactions and accompanied by a verifiable paper trail. Other resources such as court documents and federal and state income tax records also could be used to conduct such reviews.

9. Chairman Grassley and I have raised a number of concerns about CMS' use of the Secretary's waiver authority to waive fundamental federal Medicaid requirements, including the Early and Periodic Screening, Diagnosis and Treatment Benefit (EPSDT). Do you support our view that EPSDT requirements should not be waived? Do you believe the law should be changed to permit waiver of EPSDT?

A) The Governors proposal recommends a number of reforms to increase the ease with which states get current waivers, expand the ability to seek new types of changes, and change the federal statute to eliminate the need for many waivers altogether. Regarding benefits for children, the Governors proposal includes the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as those for whom Medicaid serves as a traditional health insurance program. The proposal recognizes that there are people served by Medicaid that need a comprehensive package of benefits.

Senator Kyl

Governor, I have read thru the National Governors Association "Medicaid Reform Policy Document" which lists the 7 policy reforms the NGA suggests. It mentions "Medicaid spending ... has increased dramatically over the last five years, driven by a 40 percent increase in caseload and a 4.5 percent per year increase in the health care price index, strengthening the impetus for reform." In some states, the increase in Medicaid spending has been for things like intergovernmental transfers (IGTs).

There is a list of 15 states which have been identified as potentially misusing intergovernmental transfers – Are you aware of this list? Have you seen this list? Why isn't the elimination of improper IGTs on the list of the NGA's reforms? How do you explain the behavior of some states which have used IGTs to fund other state projects by 'double billing' the federal government for Medicaid reimbursement?

A) The Medicaid program is administered by the states and jointly financed by the states and the federal government. The percentage of the state's share varies depending on several factors, but averages about 57% federal and 43% state. The "state" share can be financed entirely through state funds, but states also have the option to require local governments to share the costs. Of the "state" share, up to 60% can be financed by local contributions. These contributions, or intergovernmental transfers (IGTs), are perfectly legal, and are a legitimate mechanism that many states rely on to finance the Medicaid program. By definition, IGTs that are in existence now are those that have been approved and sanctioned at one time by HHS. The development of a list of "improper IGTs" causes confusion and consternation amongst state staff that are not kept apprised of the changing rules and standards by which their programs are being judged. The Governors, however, feel very strongly that Medicaid reforms must provide savings for both the states and the federal government. Restricting the use of IGTs or other financing mechanisms will only serve to reduce the resources available to fund the nation's health care safety net without reducing any of the need, or of the state's obligation to pay for the services.

2. The first reform cited in the NGA policy paper is for prescription drug improvements. You are exploring increasing the rebates, switching from average wholesale price (AWP) to some other pricing scheme and using tiered co-payments.

While it is feasible that the Committee could legislate to increase the rebate percentages, how does that reform the system as oppose to shifting the burden onto another player – in this case, the pharmaceutical industry? What is the policy rationale for increasing the rebate percentage?

Patients in Medicaid cannot be refused treatment for not paying a co-payment, so how does your suggestion of enforcing tiered co-payments lead to real savings to the program?

A) It has long been understood at the state level, and increasingly accepted at the federal level, that the state Medicaid programs have been paying too much for prescription drugs. The base price upon which many staets reimburse, the Average Wholesale Price, is understood to be an inflated number that does not truly represent actual costs, and yet this has formed the basis of state reimbursements for 15 years. Reforms to this are needed and are the avenues of federal and state savings least likely to negatively impact beneficiary access to health care. The statute generally requires that Medicaid receives the "Best Price" with respect to what other health care entities pay. In practice, this has not been the case; increasing the minimum rebate percentage would help ensure lower Medicaid costs.

3. While I appreciate the willingness of both of you to participate in this hearing, can you briefly speak of the decision by the NGA to not participate in the Medicaid Commission, which the NGA originally supported? If Medicaid reform is so important to you and the states, why not participate in a meaningful discussion?

   Would you not agree that states and the federal government cannot afford to put off enacting some meaningful reforms to the Medicaid system (like IGT reform, co-payments) to prevent even greater debts to both systems?

   A) The nation's governors are supportive of the commission and look forward to working with it to reform the Medicaid program. Given that the NGA Medicaid Working Group has completed much of its work, the members thought it would be most effective to continue their work as an independent bipartisan group. NGA has provided its recommendations to Congress and will do so for commission as opposed to being part of the commission.

   The NGA Center for Best Practices would also be pleased to assist the commission by providing staff for outreach, research and other information as appropriate to the Medicaid Commission, which would provide an important link between the commission and NGA's ongoing work on Medicaid.

   Governors believe that while some Medicaid reforms (those highlighted in our recommendations) can and should be enacted this year, the most meaningful reforms that must be made are those actually outside of the Medicaid program itself. Addressing the issues of health care costs and quality, the erosion of the employer-sponsored market, and the nation's lack of a long term care strategy must be accomplished in the near future.

Senator Crapo

1. We often hear talk that we do not yet know enough about Medicaid to formulate sensible policy to reform its structure in order to more efficiently and effectively deliver healthcare.

Do you both agree? Should we shelve any serious policy reform until we have a few more years of 'understanding' under our belts? Are the states financially capable of waiting a while longer? Or do we collectively know enough that we can rationally make clear and convincing reform policy judgments?

A) There is no one closer to the every day challenges and opportunities of the Medicaid program than those entrusted with its administration. State Medicaid Directors and the Governors they work for have focused enough attention on Medicaid reform to provide a framework for the short term and long term changes that are needed. Medicaid reform need not wait, because the answers are readily available; nor can it wait, as the pressure it is placing on state budgets becomes more unbearable every day.

Senator Rockefeller

MEDICARE

1. Governor Warner and Governor Huckabee, at a time when Medicare is overpaying HMOs by billions of dollars and growing at rates that exceed Medicaid, do you not agree with me and Senator Baucus that Medicare savings should be on the table in the context of the budget reconciliation debate? Wouldn't that help reduce the burden on states and contribute to a more realistic savings number?

   A) The Governors believe that Medicaid reform is not only possible but also necessary in the short term. The NGA Medicaid reforms reflect consensus reforms that are driven by policy reasons, and not the need to save an arbitrary amount of federal dollars. If the sum total of Medicaid reforms that Congress can achieve this year results in an overall savings total less than the number on the table, then Governors believe that no more savings should be sought from the program. The Governors do not wish to recommend other programs that could provide additional federal savings.

BLOCK GRANTS AND CAPS

2. As you know, there is widespread concern and opposition to Medicaid block-grants and arbitrary spending caps that limit federal support for Medicaid. Recognizing this, NGA made clear in a letter in December that the Governors, on a bi-partisan basis, oppose arbitrary spending caps and block grants given the potential impact on state financing, Medicaid providers and Medicaid

beneficiaries. Is it still the position of the NGA that the Governors oppose Medicaid block-grants and caps in any form? What about block-granting federal Medicaid payments for optional beneficiaries? Can you share with the Members of this Committee the implications and consequences of the federal government capping or block-granting the Medicaid program?

A) Governors are still opposed to arbitrary caps or limitations on federal funds in the Medicaid program.

IMPACT OF MEDICAID COST-SHARING

3. The NGA proposal states that if these new cost-sharing rules were implemented, if evidence shows that the increased cost sharing hurts access, policies could be revised. Yet, we already have ample evidence that increasing cost sharing makes it hard for low-income to access the care that they need, reduces use of essential care, and can trigger the subsequent use of more expensive care such as emergency room care or hospitalization. In reaching its cost-sharing recommendations, did the NGA consider the cost-sharing experiences of Oregon, Vermont, Maryland, and Virginia and the drawbacks of causing beneficiaries to forego necessary medical care? How much more evidence do we need before we recognize that increasing cost sharing keeps low-income people from getting the care they need?

Oregon: After Oregon raised Medicaid premiums to $6 to $20 per month and instituted tougher premium collection policies in 2003, enrollment among the group of beneficiaries subject to the premiums *dropped by half, or 50,000 people.* The greatest fall-off in enrollment occurred among very low-income groups of beneficiaries, those with incomes well below the poverty line.

Vermont: In 2003, Vermont raised premiums in its Health Access Plan, which covers adults between 50 and 185 percent of poverty, from $10-$50 every six months to $10-$65 every six months. The state also increased premiums for families with children covered under CHIP from $20-$50 every three months to $25-$70 every three months and imposed new premiums for adults in state run prescription drug programs. Of the 40,000 individuals who were assessed the new premiums in December 2003, 4,500 (over 10%) lost coverage by January 2004 because of increased cost-sharing.

Maryland: Approximately 6,400 children in families with incomes between 185 and 200 percent of poverty were subject to a new premium of $37 per month in the state's CHIP program. As a result of this new premium and state enforcement rules, 28 percent of children (over 1 in 4) subject to the premium were disenrolled in CHIP. The state ultimately eliminated the premium costs because of this loss of coverage.

Virginia: The state imposed premiums of $15 per child up to a limit of $45 per month per family on SCHIP recipients under Governor Gilmore. In a very short time, inability to pay the premiums was about to cause 3,000 people to lose coverage. Governor Gilmore ultimately suspended the looming terminations. And, Governor Warner, it is my understanding that you then eliminated the premiums entirely when you took office.

A) The Governors recommendations are the product of input from the experiences of Governors across the country. The proposal recognizes that financial protections are a critical balance to increased flexibility governing cost-sharing in the Medicaid program and propose that beneficiaries not be required to pay more than 5% of total family income (or 7.5% for higher-income households). Furthermore, states would have broad latitude to waive cost-sharing for any population or service that it determines would be negatively impacted by a cost-sharing policy. The purpose of cost-sharing is not to restrict access to necessary medical care. The Governors propose that new cost-sharing policies would be monitored and evaluated heavily to evaluate the impact on beneficiaries, and if the evidence shows that increased cost-sharing harms appropriate access, the policies should be revised.

4. Medicaid has a strong history of making sure pregnant women can get early prenatal care, which helps ensure healthy babies. And babies born without good prenatal care may need high levels of health care over many years. Doesn't it make sense that we should do everything we can to encourage early and comprehensive prenatal care, including requiring no co-pays for these services?

   A) The goal behind the increased flexibility being sought in the Governors' proposal is not to decrease use of appropriate services, but to be able to better manage state Medicaid programs in order to improve health care delivery. Governors recognize the importance of providing access to certain services, including preventive services such as prenatal care.

5. Some are concerned that increasing cost-sharing requirements may reduce already-low provider payments. Have you estimated what impact co-pays will have on providers who serve a large portion of low-income individuals?

   A) Included in the Governors' proposal related to cost-sharing is that states would be able to make them enforceable. Furthermore, these new policies would be monitored and evaluated heavily and if the evidence shows that increased cost-sharing harms appropriate access, the policies should be revised.

6. The NGA policy on increasing cost-sharing requirements mentions the idea of "personal responsibility." Are you aware that recent research has shown that out-of-pocket medical expenses for poor adult Medicaid beneficiaries have grown

twice as fast as their incomes in recent years? These individuals spend more than three times as much of their income on health care as middle-class adults with private insurance.

Is it really NGA's intention to ask Medicaid patients below the poverty line – making less than $800 per month – to pay more for their health care when they are already paying three times as much of their income as middle-class patients are paying?

A) The intention of the Governors' proposal is not to pose barriers to beneficiaries' access of appropriate health care services. The proposal recognizes that Medicaid beneficiaries should have financial protection from cost-sharing requirements. States would have broad latitude to waive cost-sharing for any population or service that it determines would be negatively impacted by a cost-sharing policy. New cost-sharing policies would be monitored and evaluated heavily to evaluate the impact on beneficiaries, and if the evidence shows that increased cost-sharing harms appropriate access in a particular state, the policies should be revised.

USING CHIP AS A MODEL

7. NGA describes its cost-sharing proposal for Medicaid as being similar to that of the Children's Health Insurance Program (CHIP). First, I think it is important to point out that CHIP, by definition, is for children in families with higher incomes than those on Medicaid. So, the Medicaid and CHIP populations are not the same. Moreover, the NGA proposal appears to provide even less beneficiary protection than CHIP. Given that Medicaid serves the poorest and sickest in our society, wouldn't having less cost-sharing protections than those that exist under current law risk serious harm to the people who most depend on the program?

A) Medicaid currently covers 53 million Americans. Many of them are the poorest and sickest in our society, but as the program has grown, many of the populations covered are the working poor and other individuals who have the same health care needs as mainstream America. The Governors' proposal recognizes that Medicaid beneficiaries should have financial protection from cost-sharing requirements. These cost-sharing limits that are proposed are an aggregate limit to protect beneficiaries, but are not being put forth as a requirement for all beneficiaries. States would have latitude to waive these types of cost-sharing for any populations or services that it determines would be negatively impacted by such policies. As stated above, these new policies would be monitored and evaluated heavily and if the evidence shows that increased cost-sharing harms appropriate access, the policies should be revised.

8. Governors have suggested that moving healthy, non-elderly and non-disabled populations to a program like CHIP warrants attention in federal efforts to reform Medicaid. It has been estimated that up 30% of Medicaid patients seen at health centers fall under the "optional" service category in Medicaid.

   It strikes me that one potential problem in moving some people into a CHIP-type program is the likely profound negative impact it will have on our nation's community health centers and the optional Medicaid patients they serve. What are your thoughts on the viability of providing services like those offered by CHIP to optional Medicaid patients seen at health centers? And could you comment on the potential elimination of EPSDT services for these patients if such a policy was carried out as part of federal Medicaid reform?

   A) The Governors' believe that Medicaid reform should include the ability to offer a different level of benefits to appropriate Medicaid populations. The goal of this flexibility is to allow states to better target services to the very diverse Medicaid populations for whom the types of services and supports needed are quite different. This is true of beneficiaries regardless of where they seek care. We would certainly anticipate the ability of health centers to adapt and even thrive in such a new environment.

FLEXIBLE BENEFITS AND EPSDT

9. The Governors' proposal would permit state Medicaid programs to target benefits, which suggests that current Medicaid benefit requirements would no longer necessarily apply. This seems to imply that the basic benefit protection for children, known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, would be eliminated. This benefit can make the difference between diagnosing and treating an illness that would otherwise go untreated, thus leaving many children unable to learn in school and develop in life. Is the NGA in fact proposing to eliminate EPSDT for children?

   What benefits would be lost? How many children would be affected? What will children do who lose this benefit (since it does not exist in the private sector)?

   A) Governors believe that Medicaid reform should include the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as those for whom Medicaid serves as a traditional health insurance program. Many states have found that the flexibility built into the SCHIP program allows for greater efficiencies without compromising care. The Governors do however acknowledge that that there are people served by Medicaid that need a comprehensive package of benefits. For more medically fragile populations, Governors are proposing changes in the benefit package in order to encourage more chronic care management and other services that can improve health outcomes. The goal of this flexibility is to allow states to design their programs to reflect the very diverse Medicaid populations that range from

relatively healthy children to those with serious physical and developmental disabilities. The types of services and supports needed by these populations are quite different.

ASSET TRANSFERS

10. The vast majority of people who receive Medicaid coverage for nursing home care have extremely low incomes and have had to deplete whatever assets they once had in order to qualify for Medicaid; these people have little or nothing to pass on to their children. Extremely wealthy people, in contrast, will be able to shield all their assets and income from taxation if the estate tax is permanently repealed, and will be able to pass these large sums on to their children.

    At a time when Congress is considering making it easier for very wealthy people to pass large sums on to their heirs by repealing the estate tax, can you tell me why the Governors believe it is fair to make it even harder for people with limited means to pass far more modest sums to their heirs?

    A) The Governors believe that Medicaid's most important role is as a safety net program, providing health care and long term care services to people who have no other options. However, Medicaid now provides half of all long term care spending in the country and covers two thirds of all people in nursing homes. Medicaid is no longer just a safety net and policies must be enacted to encourage those with resources to self-finance their care and to support families who can provide care to their frail family members. It is understandable for seniors to want to pass along something to the next generation, but it is equally as important for public policy to encourage the next generation to similarly respect and care for seniors in return. The national debate on long term care must confront the growing need for long-term care services and the ability/willingness of people to plan ahead for that inevitability.

    This question raises political considerations about the appropriate allocation of societal resources among taxpayers. However, the discussion about long-term care strategies sometimes touches on whether people should be permitted to pass on some small legacy for their heirs. On one hand of this discussion, it is a recognizably worthy goal to permit people to shelter a small estate from Medicaid spend-down provisions. On the other hand, the current Medicaid statute does not have provisions for passing on an inheritance no matter how small it may be. The idea of permitting people to maintain a small inheritance before qualifying for Medicaid goes against some of the programs' founding principles that it was created as a medical program to help poor people who had no other resources; not as the Nation's *de facto* long-term care insurance plan.

11. Some have charged that older people with substantial assets are taking advantage of the Medicaid nursing home benefit, and that we consequently need to make our

assets transfer policy far more restrictive. But research indicates that most people over the age of 65 have very modest resources: the typical older person has a net worth of under $25,000 (apart from their home, which no one should have to sell to qualify for health care). Older people who are in poor health have even more limited resources. Furthermore, most people in nursing homes help pay for their care using their own funds. Given these facts, don't we need to make sure that in cracking down on abusive asset transfers, we don't end up hurting the many seniors who have only limited means?

A) The Governors believe that Medicaid's most important role is as a safety net program, providing health care and long term care services to people who have no other options. However, Medicaid now provides half of all long term care spending in the country and covers two thirds of all people in nursing homes. Medicaid is no longer just a safety net and policies must be enacted to encourage those with resources to self-finance their care and to support families who can provide care to their frail family members. It is understandable for seniors to want to pass along something to the next generation, but it is equally as important for public policy to encourage the next generation to similarly respect and care for seniors in return. The national debate on long term care must confront the growing need for long-term care services and the ability/willingness of people to plan ahead for that inevitability.

12. I am concerned that the governors' proposals could make it harder for elderly people to qualify for Medicaid long-term care if they previously transferred assets to a family member. Many older people provide modest assistance to help their children and grandchildren pay for college, purchase a first home, and the like, and some of these people could suddenly find themselves needing long-term care just a few years later — especially if they suffer a stroke or a fall. Would the governors' proposal allow states to go after grandparents who assist their children or grandchildren but then, after an unforeseen major health episode, find themselves needing long-term care through Medicaid? Would the state really try to recover funds the grandparent had given a grandchild years earlier to help pay for college or a home?

A) The Governors believe that Medicaid's most important role is as a safety net program, providing health care and long term care services to people who have no other options. However, Medicaid now provides half of all long term care spending in the country and covers two thirds of all people in nursing homes. Medicaid is no longer just a safety net and policies must be enacted to encourage those with resources to self-finance their care and to support families who can provide care to their frail family members. It is understandable for seniors to want to pass along something to the next generation, but it is equally as important for public policy to encourage the next generation to similarly respect and care for seniors in return. The national debate on long term care must confront the growing need for long-term care services and the ability/willingness of people to plan ahead for that inevitability.

GENERIC DRUGS

13. First, I would like to say that I am happy to see that the NGA proposal includes recognition that authorized generics should be included in the calculation of Medicaid Best Price. As you know, I have been working on this issue for some time and hope that we can enact legislation to make this change.

    However, I am concerned that your proposal indicates that the Medicaid rebate should be increased on both brand name drugs and generics. As you know, increasing rebates on generic drugs could lead to generic manufacturers pulling out of the Medicaid program because their profit margins are already so slim. By seeking to increase Medicaid rebates for generic manufacturers, aren't you increasing financial burdens on the very industry that provides the greatest cost savings to the Medicaid pharmaceutical program? Don't you agree that we should be doing all we can to increase generic utilization, and not seeking to increase the financial burden on the generic industry?

    A) Governors believe strongly that the states and the federal government can realize significant savings in the area of prescription drug costs. Some of these savings should come from increased rebates from drug companies and some through increased utilization of generic drugs. Preserving Medicaid will require efforts from all stakeholders in the system and Governors do not believe that there are segments of the prescription drug market that are sacrosanct and cannot be asked to help contribute in some way to overall cost savings. Increasing generic drug utilization will increase the financial benefit to the generic industry.

14. According to a recent HHS report, U.S. consumers could save an additional $17 billion a year by purchasing FDA approved generic drugs rather than brand drugs (Source: HHS Report on Prescription Drug Importation, December 2004). When we explored Medicare Part D in the last session of Congress, it was clear that we could not make the program work without maximum use of generic drugs. As I read through your White Paper, I note only one suggestion for increasing generic drug utilization (tiered co-pays). Do you have other ideas that would increase the use of generic drugs in Medicaid programs?

    A) Many of the most effective methods for increasing generic drug utilization come from addressing physician prescribing patterns and other behaviors that are difficult to legislate. Moving to a tiered co-pay structure was the only legislative recommendation that the Governors could agree upon.

15. It is my understanding that generic drugs make up about 47% of Medicaid prescriptions but only 15% of Medicaid expenditures on prescription drugs. Clearly, then, increasing rebates on generics will not provide a substantial income for states. I am concerned that there could be several negative consequences as a

result of increasing rebates on generic drugs. I understand that due to the commodity type pricing on many of generic products, some manufacturers currently, with an 11% rebate, lose money on more than 50% of their products that are purchased by Medicaid. Raising the rebate could disinsentivize generic companies from manufacturing some products and as competition declines, prices will increase for not only Medicaid but for all consumers. Have you considered these potential consequences? Have you done any type of economic analysis of the impact your recommendations will have on Medicaid and other state programs?

A) It is not the intention of the Governors to provide disincentives to generic drug utilization, and our policy recommendations include several provisions that should help provide greater incentives for generic drug utilization. Governors did feel that if minimum rebates were increased for brand name drugs, then it might be possible to also consider increases for generic drugs that would be small enough not to skew the current market incentives for generic manufacturers.

MEDICAID INVESTMENTS

16. Don't you agree that Medicaid reform should include investments in the program that strengthen it over the long-term? Would you agree that some of the high priority investments the Congress should be looking are:

    - Stopping the FMAP reduction that 29 states, including many on this Committee, will see next year without Federal intervention?

    - Guaranteeing that the $1 billion in unspent CHIP funds that were originally allocated to the states are not returned to the federal government?

    - Preventing the Medicare drug law from having a negative impact on Medicaid beneficiaries and state budgets?

    A) The Governors believe that Medicaid reform should be driven by good public policy and not by an arbitrary budget number. If however, Medicaid reforms are enacted that provide greater than expected savings in Medicaid, it would be appropriate to also consider reinvestments that could help states further improve their programs. These reinvestments should consider the impacts on state budgets.

Senator Bingaman

Question to Governors Warner and Huckabee: Position on Block Grants

1. Just last year when the Finance Committee met we were discussing a proposal by the Administration to cap or block grant federal Medicaid matching funds to the states. As leaders of the National Governors Association this past December, you both issued a letter arguing that "reform...should not be part of a 2006 budget

reduction and reconciliation process, especially if it does nothing more than shift additional costs to states."

What is the position of the National Governors Association on block grants or the imposition of arbitrary caps on federal Medicaid spending to states?

A) Governors are opposed to arbitrary caps or limitations on federal funds in the Medicaid program.

Question to Governors Warner and Huckabee: Two-Year Medicare Disability Waiting Period

2. It is also been NGA policy that the federal government should bear a greater share of the financial burden for those who are dually eligible for both the Medicare and the Medicaid programs. As you note, 42 percent of total Medicaid spending is currently for "dual eligibles," who are low-income seniors or disabled citizens.

   Senator DeWine and I have recently introduced legislation entitled "Ending the Medicare Disability Waiting Period Act." Currently, people who are severely disabled and qualify for Social Security Disability Insurance, or SSI, must wait two years after receiving their first disability check to receive Medicare coverage. An estimated 40 percent of those people stuck in the waiting period, who by definition are severely disabled, receive Medicaid coverage at a cost of several billion dollars a year to the Medicaid program until Medicare finally kicks in.

   House Ways and Means Chairman Bill Thomas recently questioned this policy as well. Would the states support eliminating the two-year Medicare disability waiting period, as it would save the Medicaid program billions of dollars while also improving care and treatment for some of nation's most vulnerable citizens?

   A) If Medicaid reforms are enacted that provide more savings than expected, it would be appropriate to consider reinvestments into the program.

Question to Governors Warner and Huckabee: Pregnant Women Coverage

3. Medicaid has a strong history of making sure pregnant women can get early prenatal care, which helps ensure healthy babies. And babies born without good prenatal care may need high levels of health care over many years. Doesn't it make sense that we should do everything we can to encourage early and comprehensive prenatal care, including requiring no copays for these services?

   A) The goal behind the increased flexibility being sought in the Governors' proposal is not to decrease use of appropriate services, but to be able to better manage state Medicaid programs in order to improve health care delivery. Governors recognize the importance of providing access to certain services, including preventive services such as prenatal care.

Questions to Governors Warner and Huckabee: Grandparents as Primary Caregivers

4. With respect to your policy on long-term care, I am concerned about the impact on grandparents as caregivers. For example, Mr. and Mrs. Brown are the primary caregivers for their 16-year-old grandchild. Over the last three years they have paid $20,000 for support of their grandchild. Mr. Brown suffers a stroke and needs long term care. Mrs. Brown has total liquid assets of $50,000. Mr. Brown is *otherwise eligible* but will not be approved for Medicaid because of the $20,000 expenditure for his grandchild. Instead, Mrs. Brown will be placed in the precarious position of paying privately for six months that will, at today's costs, totally exhaust her $50,000 nest egg.

   It is my understanding that grandparents that help their grandchildren as primary caregivers may some day be turned away from nursing home care because they helped financially support their grandchildren. How would your policy prevent that from occurring?

   A) The scenario outlined in the question would probably be handled by states' existing Medicaid practices. For example, in reviewing asset transfers as part of determining Medicaid eligibility many states use a "rebuttable presumption" standard. Under a rebuttable presumption standard, the law makes a presumption that can be rebutted with the presentation of specific evidence. In the case of asset transfers, the rebuttable presumption device might work as follows: In the scenario presented above, it is clear that Mr. and Mrs. Brown have not been providing the $20,000 as a means to become eligible for Medicaid. They would be able to present evidence to the Medicaid program that the transfers were for the legitimate purpose of supporting a grandchild. However, if another set of grandparents transferred assets with the clear intent to use estate planning to later qualify for Medicaid; applicable look back periods would apply.

Question to Governors Warner and Huckabee: Dental Care

5. I think we can agree that prevention should be a core precept of the Medicaid program, since it results in overall savings to the health care system. We know for instance that when low income children receive preventative dental care their costs are almost 40% lower than those who do not. Furthermore, when you compare the cost of managing symptoms related to tooth decay, it costs approximately 10 times more to treat Medicaid patients in the emergency room than these same patients in a dental office. Further we know that failure to prevent dental problems has long term adverse consequences that are not only costly but affect overall health.

   Does the National Governors Association believe that a comprehensive dental benefit equivalent to what is provided under current law should be maintained in the federal Medicaid program?

   A) The goal behind the increased flexibility being sought in the Governors' proposal is not to decrease use of appropriate services, but to be able to better manage state

Medicaid programs in order to improve health care delivery. Governors recognize the importance of providing access to certain services, including preventive services for children such as dental care.

Question to Governors Warner and Huckabee: T-2 Disability Workload Problem

6. The Social Security Administration (SSA) has discovered a computer processing glitch that resulted in a failure to identify Supplemental Security Income (SSI) recipients who had become eligible to receive Social Security Disability Insurance (SSDI).

   According to the American Public Human Services Association, "The SSA system checks earnings records against the SSI records to identify individuals who should be receiving SSDI. If the system finds an SSI recipient who is eligible for SSDI, it places a diary on the SSI record. This diary alerts the SSA field office to send a notice to the recipient, asking them to apply for SSDI. As a result of the SSA processing glitch, the diary was never posted to the SSI record of numerous beneficiaries and they were not notified that they needed to apply for SSDI. SSA is still working to determine the full scope of the problem, but it is estimated that 500,000 individuals eligible to receive SSDI did not receive benefits due to this system error."

   The effect would appear to a fairly dramatic cost-shift from Medicare to the Medicaid program. What is the latest status of this issue and how does the National Governors Association think it should be addressed?

   A) Governors have not addressed this issue. However, if Medicaid reforms are enacted that provide more savings than expected, it would be appropriate to consider reinvestments into the program.

Question to Governors Warner and Huckabee: State Flexibility in Prescription Drug Coverage

7. According to the HIV Medicine Association in Mississippi, the Mississippi Medicaid program has implemented a "policy beginning July 1 that will limit prescription drug coverage for adult Medicaid beneficiaries to just two brand-name drugs per month with absolutely no exceptions." If the standard of care for HIV disease calls for a combination of at least three antiretroviral drugs to effectively suppress HIV, this clearly is not effective treatment for people with HIV and yet states already have such flexibility.

   In Florida, there have apparently enacted legislation that would require, each year, that a patient must first fail on the cheapest mandated medications before a patient is given access to the medication their physician believes is necessary. While this might work with some diseases or illnesses, evidence indicates this could be devastating to patients with mental illness or HIV, for example.

   In your statement, you cite examples of how states have not done negative things with flexibility. However, as these examples indicate, that is certainly not always the case. Therefore, how can we provide states with added flexibility and yet

ensure there are not negative consequences to vulnerable populations, such as this case?

A) Governors are actively seeking ways to stretch finite health care dollars to provide coverage for as many people as possible. There must be a balance between the needs of the current Medicaid population, the needs of the 45 million Americans with no health insurance at all, and the stark realities of the limitations of state budgets. Knowing that shortsighted fixes can result in decreased Medicaid costs but greater increases in uncompensated hospital care, Governors have every incentive to ensure that medically necessary services are delivered appropriately and efficiently to those in need.

Question to Governors Warner and Huckabee: State Flexibility and Prescription Drug Coverage

9. According to the HIV Medicine Association in Mississippi, the Mississippi Medicaid program has implemented a "policy beginning July 1 that will limit prescription drug coverage for adult Medicaid beneficiaries to just two brand-name drugs per month with absolutely no exceptions." If the standard of care for HIV disease calls for a combination of at least three antiretroviral drugs to effectively suppress HIV, this clearly is not effective treatment for people with HIV and yet states already have such flexibility.

In Florida, there have apparently enacted legislation that would require, each year, that a patient must first fail on the cheapest mandated medications before a patient is given access to the medication their physician believes is necessary. While this might work with some diseases or illnesses, evidence indicates this could be devastating to patients with mental illness or HIV, for example.

Therefore, how can we provide states with added flexibility and yet ensure there are not negative consequences to vulnerable populations, such as in these cases?

A) Governors are actively seeking ways to stretch finite health care dollars to provide coverage for as many people as possible. There must be a balance between the needs of the current Medicaid population, the needs of the 45 million Americans with no health insurance at all, and the stark realities of the limitations of state budgets. Knowing that shortsighted fixes can result in decreased Medicaid costs but greater increases in uncompensated hospital care, Governors have every incentive to ensure that medically necessary services are delivered appropriately and efficiently to those in need.

NATIONAL ACADEMY
for STATE HEALTH POLICY

Washington, DC Office
NASHP
2021 K Street, NW, Ste 800
Washington, DC 20006
Tel [202] 416-0414
Fax [202] 296-0025

EXECUTIVE DIRECTOR
Alan R. Weil

TESTIMONY BY ALAN R. WEIL
Executive Director
National Academy for State Health Policy

Before the
Committee on Finance
United States Senate

Hearing on
The Future of Medicaid: Strategies for Strengthening America's Vital Safety Net

June 15, 2005

The views presented are those of the author and do not necessarily represent those of NASHP trustees or sponsors.

Chairman Grassley, Ranking Member Baucus, and members of the committee, I appreciate the opportunity to appear before you today to discuss the Medicaid program. My name is Alan Weil and I am Executive Director and President of the National Academy for State Health Policy (NASHP). NASHP is a non-profit, non-partisan organization based in Portland, Maine, dedicated to helping states achieve excellence in health policy and practice. Before taking my current position I was a center director at the Urban Institute and, before that, executive director of the Colorado Department of Health Care Policy and Financing, which is the state Medicaid agency.

As members of this committee, you are aware of the important role Medicaid plays in financing health care services for an incredibly broad array of Americans including children, parents, people with disabilities, and the elderly. Medicaid provides financial support for our safety net institutions which provide needed care to 45 million Americans without health insurance. And Medicaid fills in many gaps in the Medicare program, especially in the areas of cost sharing, long-term care, and, for another 6 months, prescription drugs. There are many sources you can turn to for information on the Medicaid program; I have attached [only for members of the committee] an article I wrote a couple of years ago that provides my perspective.

Yet, as you also know, Medicaid costs are putting pressure on state and federal budgets. Indeed, it is cost pressure that is the primary driving force behind efforts to reform the program. The challenge is to address these fiscal challenges without harming the health and functional status of the vulnerable populations the program currently serves. This is no simple task.

A Bipartisan Framework for Medicaid Reform

Before describing the work we have done in this area, I want to offer a brief framework for thinking about change in the Medicaid program. If you want to reduce the cost of the program, there are only three types of options available. First, you can shift costs to another payer, second you can shift costs to the program's enrollees, and third you can make the program more efficient.

Medicaid has a long tradition of taking the first approach—freezing or reducing provider payment rates to achieve short-term savings. Indeed, this is often the only option states feel they have when confronting an immediate fiscal crisis. And there is a long tradition of cost-shifting between the states and the federal government—a tradition that does nothing to improve the overall functioning of the program.

As states have faced protracted budget difficulties, more have turned to the second approach—eliminating certain services, capping others, increasing administrative burdens on applicants, and in some instances reducing eligibility levels. These have generally been considered options of last resort, but some Medicaid reform proposals seek to enshrine them as preferred policy. This is a very risky proposition given the extremely low income of most Medicaid enrollees.

A truly bipartisan approach to improving Medicaid needs to emphasize the third approach: making the program more efficient. On a risk-adjusted basis, Medicaid is actually less expensive than private health insurance. This is primarily due to low payment rates for services. Despite these low costs, Medicaid administrators and enrollees have many ideas for how to make the program more efficient. For the sake of the long-term stability of the program we should use tight budgets as an opportunity to design a more efficient program.

It is important to note that flexible is not the same as efficient. Those who propose flexibility should bear the burden of presenting evidence to support concrete steps they would take with their newfound flexibility to make the program more efficient. You may decide that cuts are necessary to achieve fiscal goals, but cuts should not hide behind vague language like flexibility.

There is one important additional factor when considering changes to Medicaid. For good or ill, Medicaid has become the foundation on which much of our health care system is built. Medicaid is now intertwined with state mental health systems, services for people with developmental disabilities, school-based health, child protective services, juvenile justice, public health, and welfare reform. Medicaid serves as a source of catastrophic coverage that helps make private health insurance more affordable. And Medicaid provides coverage for low-income families who would otherwise be uninsured. Changes to Medicaid can have ripple effects through all of these systems, and can make it more or less likely that your other efforts to reduce the number of Americans without health insurance will succeed. Thus, it is important that you consider changes to Medicaid in context.

Making Medicaid Work for the 21st Century

I am pleased today to be able to present to you the results of an 18-month project undertaken by NASHP with major funding from the David and Lucile Packard Foundation and additional support from the Robert Wood Johnson Foundation, AARP, and the Agency for Health Care Research and Quality within the U.S. Department of Health and Human Services. The project was called Making Medicaid Work for the 21st Century and began in 2003 when NASHP convened a group of state officials and national experts with a broad range of experience in the Medicaid program to develop recommendations that would make the program more effective and successful. (A list of the workgroup's members is included as Attachment A.)

The workgroup approached its topic in a spirit of compromise, understanding the need to balance meaningful federal standards with state flexibility in program design and implementation. Before making recommendations, the workgroup stated the importance of viewing its recommendations as a total package because the recommendations are interrelated and reflect a complex balancing of interests. The report is the result of a

consensus process, so no individual member should be viewed as having adopted the recommendations as his or her preferred position.

The final report of the workgroup identified many opportunities for strengthening the Medicaid program and enabling it to continue to play a critical role in the country's health care system. The report's detailed recommendations identify opportunities for improvement in all areas of the Medicaid program and include calls for simplifying and expanding eligibility, increasing program flexibility for optional populations, improving coordination and integration with the Medicare program and private insurance, adjusting current financing mechanisms, and providing states with tools to manage the long-term care system and, in the process, rebalance the institutional and home and community-based care systems.

Key recommendations were developed for Medicaid eligibility, benefits, and financing and include the following.

Eligibility

The workgroup regarded as its most significant recommendation that Medicaid should provide comprehensive health care coverage for the poorest Americans—all people with incomes at or below the federal poverty level—without regard to age, family structure, or health status. This new national minimum eligibility level would apply in all states and would replace the current system of categorical eligibility which ties Medicaid eligibility to other matters such as age, family structure, and health status.

In addition:

- The workgroup recommended continuing the existing option for states to extend Medicaid coverage to eligibility groups with income above minimum federal requirements.

- Current requirements to cover children and pregnant women with incomes above the poverty level should be preserved.

- States should be offered more flexibility in determining eligibility, including the ability to simplify eligibility requirements by basing eligibility just on income.

- States should be given new options for setting financial and functional criteria to qualify for long-term care services. States should be permitted to modify income and assets tests to allow those applicants seeking community care who are most likely to use up their resources within a short time of entering a nursing home to qualify for Medicaid financed acute and community care (but not institutional services) while they are still in the community. States should also be permitted to set different functional criteria for institutional and community long-term care services.

Benefits

The workgroup recommended that all individuals covered up to the new national minimum eligibility level be entitled to the same set of acute, primary care, and long-term care benefits provided under current Medicaid law.

For individuals with income above the mandatory level, states should be allowed to offer the current Medicaid benefit package or a lesser, but still comprehensive, set of benefits that meets certain benchmark standards. If a state chose to offer benefits to an optional group, it would be required to offer acute and preventive care, but could choose whether or not to offer long-term care. States could also choose to offer a different long-term care benefit package to optional eligibles than they do to the mandatory group.

The workgroup recommended continuing current rules that limit cost sharing to nominal levels for mandatory eligibility groups. The group recommended that states have the option to set higher levels of cost sharing for optional eligibility groups.

In addition:

- The workgroup gave special attention to waiver recommendations for long-term care and home and community-based services (HCBS). Given that HCBS waivers now exist in every state, the workgroup recommended that states have the option of converting these waivers into an ongoing program within Medicaid. These services would no longer be subject to the waiver requirements of cost neutrality and periodic renewal, and states could retain certain features of their waivers such as the ability to limit the number of participants.

- Parents of Medicaid-eligible children should be able to choose to enroll their children in the SCHIP program so long as certain enrollee-protection standards are met.

Financing

The workgroup evaluated the current financing structure in which the federal government matches qualifying state Medicaid expenditures, and it rejected the need for radical restructuring of this approach. Specifically, the workgroup recommended against converting Medicaid financing into a block grant to states.

The workgroup recommended that revisions be made in the formula and process for establishing the federal matching percentage (FMAP). The FMAP needs to be set in a way that more quickly and accurately reflects changes in the economy and in the fiscal capacity of states.

The federal government should provide more support to states for the Medicaid costs associated with low-income persons enrolled in Medicare. This increased level of

support should be provided in conjunction with efforts to improve care coordination and program management between the two programs.

In addition:

- The federal government should provide states with an enhanced match (at the SCHIP rate) for the new costs associated with simplifying and expanding eligibility to include all Americans with income at or below the federal poverty level.

- States should be given new opportunities to coordinate Medicaid coverage with private, employer-sponsored insurance through premium assistance programs. States should be allowed to implement premium assistance programs under a state plan amendment with certain features that now require a waiver, such as policies related to wrap-around benefit coverage, wrap-around cost sharing, and crowd-out prevention. Further, states should be allowed to require employers to enroll their Medicaid-eligible employees in the employer's health plan at times other than the open enrollment period.

Other Recommendations

The workgroup made additional recommendations related to needed changes in Medicaid, including the following.

- Allowing states to extend eligibility for Medicaid financed home and community-based (but not institutional) long-term care services to applicants whose incomes are low enough, but whose assets are too high, for them to qualify for Medicaid—if the cost of institutional care would soon deplete their assets enough to qualify for Medicaid.

- Extending the federal policy of reimbursing states 100 percent of the cost of services provided to American Indians/Alaskan Natives in Indian Health Service or tribal facilities to include all services provided to this group regardless of where the service is delivered.

Concluding Remarks

We learned two important lessons as we carried out the Making Medicaid Work for the 21st Century project. First, there are many opportunities to strengthen and improve the Medicaid program. These opportunities fall largely into the third category of change I described earlier: making the program more efficient and effective. People who work with the program are skeptical of grand claims for large savings, and they know how hard it can be to put good ideas into practice. Still, there are concrete steps that the federal government and states can take to improve the program without simply shifting costs to others or increasing costs for the most vulnerable Americans.

Second, while NASHP serves state officials who have a great deal of experience with the Medicaid program, the state perspective must be balanced against other critical perspectives, including those of more than 50 million Americans who are enrolled in the program. States bring a wealth of experience and expertise to discussions of Medicaid's future. The program has certainly been strengthened by the lessons learned from state experimentation. While states have a tremendous stake in Medicaid's success, we are not the only ones with such a stake. Our deliberations benefited greatly from the inclusion of multiple perspectives to assure that in looking out for the interests of the states we did not fail to consider the interests of others.

On behalf of NASHP and those who helped us with our work, I am pleased to share with you the results of our deliberations and to let you know that we stand ready to assist you in any way possible to strengthen and improve the Medicaid program.

Attachment A

The Making Medicaid Work for the 21st Century Workgroup

Neil Bergsman
Executive Director
Maryland Department of Budget & Management
Past President
National Association of State Budget Officers

Steve Berman, Director, MD, FAAP
Professor of Pediatrics and Director
Children's Outcomes Research Program
Univ. of Colorado School of Medicine
The Children's Hospital Denver
Past President
American Academy of Pediatrics

Lyn Bodiford
State Affairs Coordinator
AARP
Tallahassee, FL

Barbara Coulter Edwards
Medicaid Director
Ohio Department of Job and Family Services

Mary Dewane
Consultant
Schaller Anderson, Inc.
Pheonix, AZ
Formerly:
Chief Executive Officer, CalOptima

Anne Dunkelberg
Senior Policy Analyst
Center for Public Policy Priorities
Austin, TX

Christine Ferguson
Commissioner
Massachusetts Department of Public Health

Len Fishman
President and CEO
Hebrew Rehabilitation Center for Aged
Boston, MA

Catherine Halverson
Senior Vice-President
Business Development and Government Relations
Centene Corporation
Washington, DC

Mary Kennedy
Vice President
Business Development
Evercare
Minnetonka, MN
Formerly:
Medicaid Director
Minnesota Department of Human Services

David Lehman
Policy Advisor
Office of the Governor
Boise, ID

Kathy Leitch
Assistant Secretary
Aging and Disability Services Administration
Washington Department of Social and Health Services

Deborah Lisi-Baker
Executive Director
Vermont Center for Independent Living

Cindy Mann
Research Professor
Institute for Health Care Policy and Research
Georgetown University
Washington, DC

Donna McDowell
Director
Bureau of Aging & Long Term Care Resources
Wisconsin Health and Family Services Department

Jack Meyer
President
Economic Social Research Institute
Washington, DC

Angela Monson
State Senator
Oklahoma State Senate

Janet Olszewski
Director
Michigan Department of Community Health

Robert Rubin
Clinical Professor of Medicine
Georgetown University
Washington, DC

Ree Sailors
Executive Policy Advisor
Governor's Executive Policy Office
Olympia, WA

Dennis Smith
Director
Centers for Medicaid & State Operations
Washington, DC*

Vernon Smith
Principal
Health Management Associates
Lansing, MI

Maggie Tinsman
Senator
Iowa State Senate

Alan Weil
Executive Director
National Academy for State Health Policy
Portland, ME
Formerly:
Director, Assessing the New Federalism
The Urban Institute
Washington, DC

**Although Mr. Smith and CMS staff participated in various workgroup discussions and provided technical assistance, CMS does not endorse, nor does it necessarily concur in any of the specific recommendations contained in this final report.*

There's Something About Medicaid

Medicaid suffers from a chronic mismatch between what we ask it to do and what we are willing to pay.

by Alan Weil

PROLOGUE: In the realm of political rhetoric, Medicaid has never been able to shake its metaphorical status as a stepchild—"fundamentally a welfare program for the poor," as one powerful congressional committee chairman dismissively described the program last year. In reality, however, it is much more than that. Medicaid has now overtaken Medicare in both enrollment and spending to become the largest health insurance program in the United States. It insures one-fifth of the nation's children and pays for one-third of all childbirths. It finances nearly 40 percent of all long-term care expenses, more than one-sixth of all drug costs, and half of states' mental health services. It is, in a much-improved metaphor coined in the following essay, the "workhorse" of the U.S. health system.

In this overview of Medicaid's indispensible role, Alan Weil of the Urban Institute explains how and why the program has been "called upon to solve all manner of health-related problems that no other institution or sector of the economy is willing to address." Services for pregnant women and children are the best-known example, but Medicaid is also the largest payer for services for AIDS patients, supports coverage under the "ticket to work" program for people with disabilities, covers treatment for breast and cervical cancer in forty-four states, and pays for drugs and cost sharing for lower-income Medicare beneficiaries.

Weil explains that the flexible state-federal structure and funding of the Medicaid program has been the key to its utility in filling out the infrastructure of the health system. But in the periodic fiscal crises that put the program in the crosshairs of state budget overseers, it becomes a victim of its own success. Medicaid is inevitably subject to daunting cost increases, and the people it serves are much less able than Medicare beneficiaries are to make their voices heard when the pressure to rein in public spending is greatest.

Weil is director of the Urban Institute's Assessing the New Federalism project, designed to track and evaluate changes in state and federal health, welfare, and social service programs. He formerly held a Cabinet-level position as director of Colorado's Medicaid agency, among other responsibilities, and was a member of the Clinton administration's health care task force. He holds a master's degree in public policy from the Kennedy School of Government and a juris doctor from Harvard Law School.

ABSTRACT: In the thirty-seven years since its creation, Medicaid has grown in terms of whom it covers and what it costs. Current rates of Medicaid enrollment and cost growth are high relative to state budget capacity, but not by historical standards. The current Medicaid fiscal crisis is a result of weak state fiscal conditions and the gradual accretion of populations and services covered by Medicaid. States view Medicaid as an essential part of their current strategies to provide insurance to their low-income populations, cover the chronic care needs of people with disabilities and the elderly, and finance the health care safety net. Medicaid has accomplished much, and it can continue to do so if the underlying fiscal pressures and tensions built into it are addressed.

AFTER A GOOD RUN OF FIVE YEARS, Medicaid is back in the crosshairs. In 1995 Congress passed legislation to repeal the program and replace it with "Medigrants," which would have provided states with a fixed sum of money and tremendous flexibility regarding which populations and services to cover. With President Clinton's veto of the legislation, efforts to convert Medicaid into a block grant came to an end. Total expenditures on the program then grew at their lowest rate in history—an average of 3.6 percent between 1995 and 1999.[1] After years of growth, Medicaid declined slightly as a portion of state budgets during this period.[2] In 1997 strong federal revenue projections created room in the budget for the new State Children's Health Insurance Program (SCHIP). For the last half of the 1990s Medicaid was out of the spotlight, while states and the federal government focused their attention on implementing welfare reform and SCHIP.

Those days have come to an end. In 2001 and 2002 Medicaid spending growth rates broke back into double digits.[3] The Congressional Budget Office (CBO) now projects a federal growth rate of 12 percent in 2002 and an average of 9 percent a year for the next ten years.[4] States reported an 11 percent increase in their Medicaid spending in 2002.[5] This news comes at a time when state budgets are under unprecedented pressure. The Rockefeller Institute reports the sharpest decline in state tax revenues since it began tracking them in 1991. The second quarter 2002 decline of 10.4 percent from the same period one year earlier follows on the heels of three previous quarters of year-on declines, and September 2002 data suggest that the third quarter 2002 will continue this downward trend.[6] Thirty-one states reported fiscal year 2001 Medicaid spending in excess of budget appropriations, and as of May 2002 twenty-eight states reported this for FY 2002.[7] The federal budget is in deficit in FY 2002 after four years of surpluses.

In 1995 the need to cut growth in the program to balance the federal budget kicked off debates over major Medicaid reforms. Now states are taking the lead, proposing fundamental changes in the fiscal relationship between states and the federal government.[8] States are not asking for block grants, but the word "unsustainable" appears in most descriptions of trends in Medicaid spending.

If money is at the heart of debates over Medicaid, the millions of indigent people whose varied and complex medical needs are met by the program are its soul.

"The fiscal pressure Medicaid now faces is more an indication of the program's success than of its failure."

The amount of human suffering the program alleviates is immense. In the absence of a comprehensive health care system that meets the acute and chronic care needs of the nation, Medicaid perfectly fits the metaphor of the "safety net."

Medicaid is a program loved by few, denigrated by many, and misunderstood by most. It is at least three different programs in one: a source of traditional insurance coverage for poor children and some of their parents; a payer for a complex range of acute and long-term care services for the frail elderly and people with physical disabilities and mental illness, many of whom were once middle class; and a source of wraparound coverage for low-income elders on Medicare. Eligibility criteria, services used, and costs vary greatly across these populations, challenging those who would make generalizations about Medicaid.

Medicaid is often criticized, and often for contradictory reasons. Medicaid is costly, its budget is difficult to control, and governors argue that rising Medicaid costs get in the way of other priorities such as education and public safety.[9] Yet providers are routinely paid less by Medicaid than they are by other payers, enrollees often learn that finding a provider who will accept Medicaid is not easy, and concerns periodically emerge about quality, especially in nursing homes and managed care—problems that could be ameliorated by spending more money.[10]

Medicaid is criticized for its rigid rules—with multipage application forms, extensive documentation requirements, dozens of federally defined eligibility categories, and court-imposed benefits. Yet states establish eligibility levels, determine which services are covered, set payment rates for providers, and define licensing and quality standards for providers and health plans, leading to tremendous variety in who has and what it means to have a Medicaid card. States vary in the percentage of the population they cover with public programs and in how much they spend on them.[11] Waivers—the federal government's process for granting states flexibility within constraints—have freed the program from some of its rigidity but have also opened the program to criticism for undermining the basic rights of the eligible population and contravening congressional intent.[12]

In this paper I argue that the fiscal pressure Medicaid now faces is more an indication of the program's success than of its failure. Medicaid has become the workhorse of the U.S. health care system. When the nation has identified a new problem—from a population that needs health coverage to a provider or health system in need of financial support—Medicaid has gotten the call. These decisions, initiated at times by the federal government and at times by states, have yielded the large and rapidly growing Medicaid program we have today. Medicaid's crises are an indication of the mismatch between our ambitions for the program and the resources we commit to it.

What Is Medicaid?

■ **Eligibility.** Medicaid eligibility has expanded steadily since the program's enactment in 1965.[13] The program began as an adjunct to cash welfare, meaning that it primarily covered very-low-income single parents and their children, and the aged, blind, and disabled. Expansions beyond this base have been most notable for children and pregnant women. As of 30 September 2002 the phase-in of a 1989 federal law is complete, making all poor children under age nineteen eligible for Medicaid. States must also cover children under age six and pregnant women with incomes up to 133 percent of the federal poverty level. States can set more generous eligibility standards, and thirty-eight have done so for infants and pregnant women, while twenty-two have done so for children ages 1–5.[14] Most states have extended eligibility to children up to 200 percent of poverty through SCHIP.[15] Medicaid covers 55 percent of all poor children and about 20 percent of children overall.[16]

Coverage of nondisabled adults is far more limited. While children are eligible based upon family income, adult eligibility is limited to pregnant women and parents in families eligible for cash welfare under historical rules.[17] Since the income threshold for welfare in the median state is only 45 percent of poverty, most low-income parents are ineligible for Medicaid.[18] Thirty-nine states have medically needy programs for adults who fall into an eligibility category but whose incomes exceed formal program standards.[19] Notably absent from the list of eligible adults are those without children in the home, who make up 62 percent of the adult uninsured population.[20] These adults can be covered only through waivers. In 1999 Medicaid covered 5 percent of nonelderly adults and 15 percent of those with incomes below 200 percent of poverty.[21]

People of all ages with disabilities are eligible for Medicaid if they meet the stringent income, asset, and disability standards of the federal Supplemental Security Income (SSI) program or if they are receiving similar state supplements and the state chooses to extend eligibility to this group. States have a variety of additional federal options available to them to extend eligibility to people requiring long-term care services even though their income exceeds SSI eligibility limits.[22] Certain low-income elders on Medicare are eligible for assistance with Medicare cost sharing. Qualified Medicare Beneficiaries (QMBs), with incomes below poverty, have all Medicare cost sharing covered, while Specified Low-Income Medicare Beneficiaries (SLIMBs), with incomes up to 120 percent of poverty, have their Medicare Part B premiums covered.

■ **Covered benefits.** Medicaid provides a comprehensive benefit package for those who enroll. The federal government mandates coverage of thirteen services, including inpatient and outpatient hospital services; physician services; laboratory testing and x-rays; nursing home and home health care; family planning; and for children under age twenty-one, a broad supplementary package known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). There are also more than a dozen optional benefit categories, including prescription drugs, which all states

cover; intermediate care facilities for the mentally retarded (ICF-MR), which twenty-two states cover; and optometric services (twenty-eight states), dental services (twenty-six states), and prosthetic devices (thirty-one states).[23]

Medicaid benefits must be provided at no cost to children and pregnant women and with only "nominal" copayments for adults, which the federal government has interpreted to mean generally no more than $3, with coinsurance rates up to half the cost of the first day of institutional care.[24] No premiums can be charged, and there are no deductibles to meet before coverage begins.[25] States have latitude to define the "amount, duration, and scope" of the services they provide, and some states have chosen to limit the number of prescriptions, inpatient hospital days, and various therapies a recipient can receive each month.

The comprehensive nature of Medicaid benefits is often misunderstood. The breadth of covered services reflects the complex needs of the disabled population the program serves. The strict limitations on cost sharing reflect the recipients' absence of disposable income; median annual household income of children enrolled in Medicaid was $11,300 in 1997, and for nonelderly adults it was only $10,000.[26] These aspects of Medicaid have led some to refer to it as a Cadillac and to object to the provision of very-low-cost health services to some when other low-income people without health insurance receive no government assistance at all. These critics raise legitimate questions about the fair allocation of limited resources, especially as Medicaid expands beyond the poorest population. Still, the program design reflects the needs and resources of the population it serves.

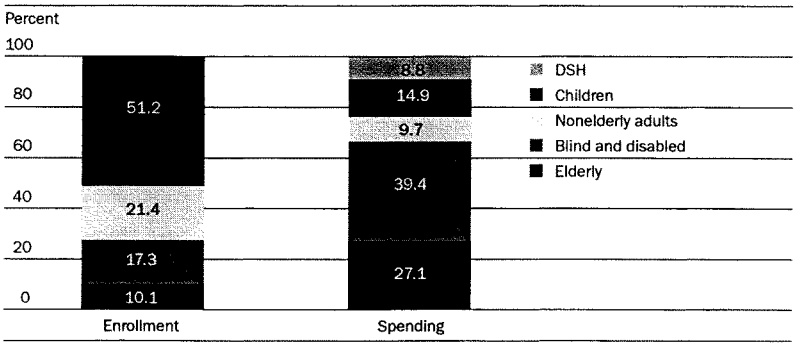
■ **Enrollment and spending.** Enrollment in Medicaid has climbed from four million in 1966 to forty-seven million in 2002.[27] During the same period expenditures have grown from $0.4 billion to $257 billion.[28] Although children and nondisabled adults account for the majority of Medicaid enrollment, two-thirds of spending goes toward services for the elderly and disabled (Exhibit 1).

Not everyone who is eligible for Medicaid enrolls. Enrollment is free, but it is not always easy or convenient. Seventy-two percent of eligible children and 51 percent of eligible nonelderly adults are estimated to actually enroll.[29] Participation among eligible QMBs is estimated at 78 percent, while it is only 16 percent for SLIMBs.[30]

Exhibit 2 breaks down Medicaid spending by service. Nursing home care, managed care (which covers hospital, physician, and other services), and inpatient hospital care dominate the program, although home care and prescription drugs also represent substantial shares.

A common misperception is that the elderly and disabled primarily use long-term care services, while spending on acute care services is primarily for other adults and children. In fact, while almost all nursing facility, ICF-MR, and home health spending is on behalf of elderly and disabled enrollees, this group also accounts for 85 percent of prescription drug costs, more than half of inpatient and outpatient hospital spending, and nearly half of physician services.[31]

EXHIBIT 1
Medicaid Enrollment And Spending, By Eligibility Group, 1998

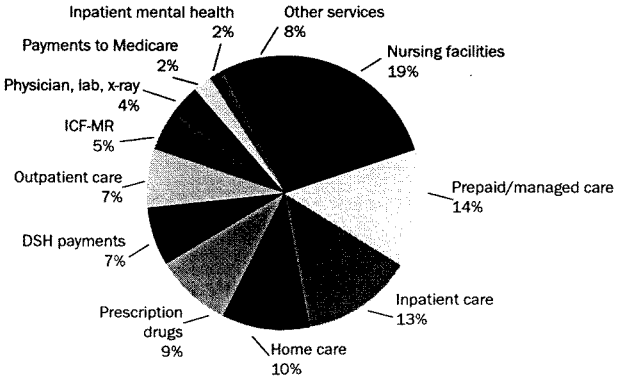


SOURCE: Urban Institute estimates prepared for Henry J. Kaiser Family Foundation, "The Medicaid Program at a Glance" (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2001).
NOTES: DSH is disproportionate-share hospital. Administrative expenses are excluded.

The Perfect Storm?

The preferred metaphor for Medicaid and state budgets today is "The Perfect Storm," recalling the movie of that name in which a powerful and unusual confluence of events led to disaster. According to this story, the three winds of today's Medicaid storm—growing enrollment, high medical inflation, and plummeting

EXHIBIT 2
Medicaid Spending By Service, 2001



SOURCE: B. Bruen, Urban Institute, unpublished data.
NOTES: ICF-MR is intermediate care facilities for the mentally retarded. DSH is disproportionate-share hospital.

state revenues—are combining to place extreme pressure on the program.

Medicaid costs are certainly rising through a combination of enrollment growth and medical inflation. According to the National Association of State Budget Officers (NASBO), state-funded Medicaid spending increased by 11 percent from FY 2000 to FY 2001 and is expected to increase by another 13.4 percent in 2002.[32] Two recent analyses have examined the components of this growth. Brian Bruen and John Holahan use administrative and case-study data to examine Medicaid's challenges in 1999 and 2000. They find that a number of factors are at play: rebounding enrollment after declines in the wake of welfare reform, continued steady increases in enrollment of the elderly and people with disabilities, rapidly growing drug costs, and the demise of managed care as a source of cost control.[33] Vernon Smith and colleagues interviewed Medicaid officials in all fifty states. They identify four factors most commonly cited by state officials to explain increasing Medicaid spending in 2002: prescription drug costs, enrollment increases, increased cost and use of medical services, and long-term care.[34]

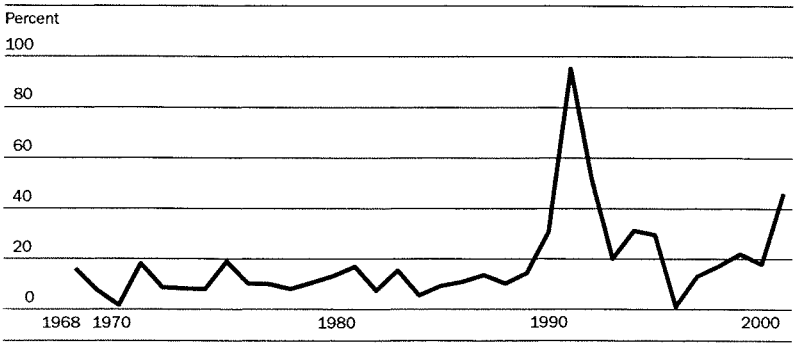
Yet these two winds in today's storm, while strong, are generally consistent with past experience. Medicaid enrollment has picked up, but if it is largely the result of SCHIP outreach and a rebound after welfare reform, it is concentrated among the least costly populations. In fact, enrollment growth among people with disabilities, the most expensive Medicaid population, averaged 5.3 percent per year over the past twenty-five years—a rate higher than in recent years.[35] Similarly, recent annual increases in national health spending of 8–9 percent are high compared with the mid- and late 1990s, but they are quite consistent with growth rates experienced in much of the 1970s and 1980s.[36]

It turns out that states have a remarkable ability to absorb even high rates of Medicaid cost growth. Exhibit 3 shows the percentage of new state tax revenues generated each year that have been devoted to Medicaid. With the exception of a spike during the fiscal crisis of the early 1990s, states have had many new revenues to spend each year even after paying for Medicaid cost increases.

Today's storm is almost entirely attributable to the tremendous stress on state budgets. As noted above, state revenue collections have fallen for the past few quarters. The scale of these revenue declines was largely unanticipated: States' collections from their major tax sources are running 5.6 percent below the estimates that were used when FY 2002 budgets were enacted.[37] When data for 2002 are available, the line in Exhibit 3 will go off the top of the chart, since the ratio is infinite in today's unique circumstance of declining nominal state tax revenue.

■ **The underlying fiscal problem.** The danger in dissecting each Medicaid fiscal crisis is that it makes them appear to be anomalies, each with its own etiology that if diagnosed and treated will resolve the crisis until an entirely new problem emerges. Unfortunately, a more appropriate view is to recognize that Medicaid operates from a high base of growth that is easily susceptible to shocks. Medicaid pays for health care services, which exhibit long-term growth rates in excess of general inflation

EXHIBIT 3
Percentage Of Increase In State Tax Revenues Consumed By State Medicaid Spending, By Year, 1968–2001



SOURCES: Centers for Medicare and Medicaid Services (CMS) Form 64 data; and U.S. Census Bureau, Annual Survey of State and Local Government Finances and Census of Governments, various years.
NOTE: Revenue is reported for state fiscal years; spending is reported for federal fiscal years.

and in excess of prevailing economic growth. The most expensive populations Medicaid serves—elders and people with disabilities—are growing steadily. These two characteristics assure that on average, Medicaid will experience cost trends that outpace overall economic growth (Exhibit 4). The Medicaid cost crises of the early 1990s and early 2000s represent extremes, but Medicaid cost growth is substantial even in normal times.

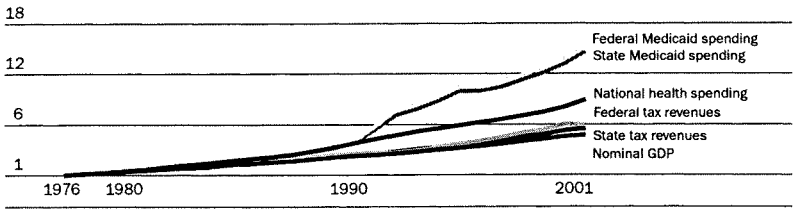
Thus, it turns out that the appellation "The Perfect Storm" is somewhat misplaced. A better characterization would be to view the late 1990s as "The Perfect Calm." A period of low medical inflation, stable or declining Medicaid rolls, and booming state revenues represents the true anomaly. In the longer view, it is the late 1990s, not the early 2000s, that stand out as different.

The Curse Of Success

Another important part of the Medicaid cost story is that the program is called upon to solve all manner of health-related problems that no other institution or sector of the economy is willing to address. The Medicaid platform has been built upon to cover new populations, support critical health care providers, compensate for the limitations in public and private insurance programs, and support other institutions facing fiscal difficulties.

■ **Covering populations.** Medicaid coverage has expanded well beyond the original cash-assistance populations of single mothers with children and people receiving payment under state Aged, Blind, and Disabled programs. In fact, the majority of Medicaid recipients do not receive any cash benefits.[38] Over the years Medicaid eligibility has expanded to meet the needs of various new populations.

EXHIBIT 4
Growth In Various Indicators, 1976–2001, Indexed To 1976 Values (1976 = 1)



SOURCES: For federal and state Medicaid spending, Centers for Medicare and Medicaid Services (CMS) Form 64 data; for national health spending, CMS Office of the Actuary; for federal tax revenues, Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years, An Update* (Washington: CBO, August 2002); for state tax revenues, U.S. Census Bureau, Annual Survey of State and Local Government Finances and Census of Governments, and U.S. Census Bureau, Governments Division, July 2002; and for nominal gross domestic product (GDP), U.S. Department of Commerce, Bureau of Economic Analysis.
NOTE: National health spending and GDP are reported for calendar years, state tax revenues for state fiscal years, and Medicaid spending and federal tax revenues for federal fiscal years.

Pregnant women. In 1989 the federal government required states to cover low-income pregnant women who were not receiving cash welfare. This coverage was designed to improve access to prenatal care, thereby improving birth outcomes. Medicaid now pays for one-third of all childbirths. Many low-income pregnant women had been receiving prenatal care in hospitals and clinics funded by states and counties.[39] Thus, as is the case with many Medicaid expansions, this one had three effects: to increase access to care, to shift part of a historically state and local funding responsibility to the federal government, and to reduce the uncompensated care burden on some providers.

Children. As discussed above, coverage for children has expanded well beyond the base of those in families receiving cash welfare payments. While children are the least expensive eligibility group per capita, costs for infants can be substantial.

HIV/AIDS. Medicaid is the largest payer of medical services for people with AIDS. The program serves more than half of all people with AIDS and as many as 90 percent of children with AIDS.[40] However, because SSI is only available to people who are disabled, people who are HIV-positive but asymptomatic or with limited symptoms cannot obtain Medicaid under traditional eligibility rules. California recently decided to apply for a waiver to cover people in this circumstance.[41]

Undocumented immigrants. Undocumented immigrants are prohibited from receiving most public social service benefits, including cash welfare. While Medicaid does not cover the routine medical needs of this group, it does pay for emergency services, including childbirth. This policy reflects recognition that these services must be provided under the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 and therefore will be provided as uncompensated care if there is no other payment source.

Ticket to Work. In 1999 Congress enacted the Ticket to Work and Work Incen-

tives Improvement Act, which allows states to expand Medicaid coverage to certain people with disabilities whose incomes are too high to qualify for SSI. This new source of coverage is designed to address the fact that many people with disabilities are able to work but by choosing to do so earn too much income to qualify for Medicaid. These workers may work in firms that do not offer health insurance, may work too few hours to qualify for that coverage, or, if they do have coverage, are likely to find that the benefits do not include certain therapies, home care, durable medical equipment, or expensive pharmaceuticals.

■ **Supporting systems.** Medicaid coverage benefits providers as well as patients, and some Medicaid policies reflect the goal of supporting specific providers.

Safety-net hospitals. Medicaid is the source of 41 percent of revenues for safety-net hospitals.[42] Most of these revenues are earned through traditional payments for services delivered to Medicaid-enrolled patients. Some safety-net hospitals also receive funds through the disproportionate-share hospital (DSH) program. Enacted in 1981, DSH requires states to consider the burden of serving a large number of Medicaid recipients or other low-income people when setting hospital payment rates. Many states have also sought to protect funding streams to safety-net hospitals as they have entered into managed care contracts.[43]

Community and migrant health centers. Medicaid is the source of 34 percent of revenues for community health centers (CHCs).[44] Included in the list of services that must be covered under Medicaid are those provided by federally qualified health centers (FQHCs). Of course, FQHCs are not a service at all—rather, they are a group of providers. Many FQHCs receive direct funding through Sections 320 and 330 of the Public Health Service Act, and until recently Medicaid law guaranteed that these providers would be paid 100 percent of their costs in providing services to Medicaid enrollees.[45] Thus, federal Medicaid policy assures an additional funding stream to support these critical-access providers.

Mental health systems. Medicaid is now the largest source of public funding for mental health services.[46] Medicaid's role here is complex. States ran and paid for mental health institutions when Medicaid was enacted. The federal government, attempting to ensure that federal funds would not simply supplant existing state funds, designed Medicaid eligibility standards in a manner that barred Medicaid from covering states' adult institutional populations. Yet in the 1990s some states designated their mental health institutions as DSH recipients, effectively circumventing the federal bar. The General Accounting Office (GAO) reported on six states that in 1996 were directing between 20 and 89 percent of their DSH funds to state psychiatric hospitals.[47] Medicaid is the primary source of funding for community-based mental health services, which also receive direct funding through other programs. In addition, Medicaid is a major payer of substance abuse treatment services.[48]

School health. School health systems are a recent addition to the list of providers funded partially by Medicaid. If they meet the appropriate legal standards, schools

can bill for services provided to Medicaid-enrolled children just as any other provider can. This represents a large potential revenue stream for children receiving special education. In the 1990s some states hired private consultants that used cost-allocation techniques to determine the share of school health services that could appropriately be considered Medicaid administrative costs.[49] Medicaid paid these costs, often simply replacing existing funding streams in schools.

■ **Patching holes.** Medicaid has been used to fill in holes in other public and private coverage.

Medicare. While Medicare is an essentially universal program for people over age sixty-five, it has substantial gaps in coverage: the near-absence of long-term care benefits, the limitation of drug coverage to hospital inpatient stays, and the existence of cost-sharing provisions that place burdens on low-income elders. Medicaid has received the call to fill in all three of these gaps. The "dually eligible" population (eligible for both Medicaid and Medicare) receives the full Medicaid package as a supplement to Medicare and thereby has coverage for long-term care services and prescription drugs. QMBs and SLIMBs receive assistance with Medicare's premiums and cost sharing. Medicaid spending for Medicare eligibles now accounts for about one-third of the program's costs.

Breast and cervical cancer treatment. The Centers for Disease Control and Prevention (CDC) provides free or low-cost screening for breast and cervical cancer. However, the CDC program does not include funding for treatment services. Recognizing the cruelty of providing screening without treatment, Congress enacted the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000, which gives states the option of providing Medicaid coverage to those who are found to have cancer through the CDC screening process. As of August 2002 plans for this type of coverage had been approved in forty-four states.[50]

State Fiscal Burden And Fiscal Relief

Medicaid imposes a substantial fiscal burden on states, and it provides a source of fiscal relief. The burden comes from growing costs associated with a program that has expanded dramatically in scope. The relief comes from three sources: states' ability to take what had been state, local, or private costs and obtain a federal matching payment to offset a portion of the costs; states' ability to meet new needs while bearing only a portion of the cost; and states' ability to manipulate the program to obtain federal matching funds for costs they did not actually bear.

State enrollment and spending reports do not contain sufficient detail to quantify the share of Medicaid cost growth that can be attributed to the program's many new responsibilities acquired over time. Nor do they offer a complete picture of how much fiscal relief the program has provided.

State-federal relations have been harmed by a series of efforts some states have made to maximize federal revenue, especially when states succeed in capturing new federal funds without contributing their own general funds. States have re-

"A primary reason to build upon Medicaid is that it offers the only infrastructure flexible enough to handle new challenges."

lied upon an alphabet soup of methods: DSH, intergovernmental transfers (IGT), and upper payment limit (UPL) strategies.[51] While these schemes appropriately gain a high profile, they obscure the facts that a substantial share of DSH funds go precisely to the purpose established in the program and that the overwhelming majority of increased Medicaid costs borne by states during the program's existence reflect actual costs associated with a growing eligible population requiring services whose costs grow at a rate that greatly exceeds general inflation.

Why Choose Medicaid?

If Medicaid is the subject of such political contention and is regularly criticized for crowding out other spending priorities, why do we so frequently build upon its base when we are confronted with a new health policy challenge? There are at least four reasons, which I discuss below.

■ **Infrastructure.** A primary reason to build upon Medicaid is that it offers the only existing infrastructure flexible enough to handle new challenges. The program has a track record of working with a heterogeneous mix of clients: young families, the frail elderly, people with serious physical impairments, and those with chronic mental illness. Medicaid has relationships with a diverse set of providers: generalist and specialist physicians, clinics, hospitals, pharmacists, medical equipment suppliers, nursing homes, home health agencies, therapists, and health plans.

Medicaid is flexible, adapting to changes in the health care market, such as the advent of managed care. Medicaid systems are public, assuring that they respond to political pressures whether coming from client advocates or from providers. Administrative costs of the program are low, accounting for less than 5 percent of total costs. None of this is to suggest that Medicaid is flawless, but rather that Medicaid provides a base from which almost any health matter can be addressed.

■ **Low-cost purchaser.** Medicaid payment rates are routinely lower than those paid by Medicare and the private sector.[52] The reason for this is simple: State Medicaid programs buy at the margin for populations that would otherwise be able to make only a small payment or none at all. Medicaid's low payments often offset what would otherwise be completely uncompensated care. This gives Medicaid overwhelming leverage: It sets low rates and generally finds providers willing to accept those rates. The downside of these low rates is limited access and financial strain on providers that may affect the quality of care.

■ **Financing structure.** Medicaid's matched financing structure is inherently expansionary. The federal government can offer or mandate an expansion in services or population, knowing that it will only pay somewhat more than half the cost, since states must pick up the balance. While the era of increasing federal mandates may have come to an end, the fiscal dynamic has not. Even today the federal government

can offer states options to expand, such as Ticket to Work or the BCCPTA, knowing that the federal government's cost will only be a share.

While states are on the receiving ends of mandates, when it comes to options they face a dynamic similar to that of the federal government. States can take advantage of federal options within Medicaid with cost to their own taxpayers of much less than the total program cost. This makes Medicaid an attractive vehicle for economic development, with modest state appropriations yielding total in-state spending of a far greater amount. It also offsets the natural political tendency to underinvest in spending on low-income populations.[53]

■ **Safety valve.** Ultimately, we turn to Medicaid because it provides a safety valve for the failure of other systems. The employer-based insurance system is voluntary. If we ask too much of it, employers will threaten to or actually drop coverage. Medicare is a highly politicized and ossified system, and proposed expansions inevitably become mired in broader debates about the structure of the program. Direct appropriations to solve social problems, such as the precarious financial health of safety-net providers, are hard to come by. It is not easy, but it is easier, to obtain funding as part of the much larger Medicaid budget.

Opportunities For Medicaid's Future

While Congress and the president debate Medicare prescription drugs and a patients' bill of rights for the umpteenth time, a quiet revolution has been under way in state health policy. States are constantly seeking to recalibrate their Medicaid programs to meet emerging needs. Before the current fiscal downturn began, two major models of innovation were emerging.

In acute care, the new state model is an effort to combine employer, individual, and sometimes community or philanthropic contributions with state and federal funds to provide an adequate health insurance package to those who are uninsured. The model takes many forms: premium subsidy or buy-in programs in which the state contributes to the cost of employer-sponsored health insurance coverage; expansions of public coverage, sometimes combined with scaled-down benefit packages; and individual buy-in programs that allow a person or family to purchase coverage through the state at a subsidized price.

In long-term care, states are gradually but steadily increasing their spending on home health care and waiver programs designed to offer alternatives to institutional care.[54] States are also experimenting with consumer-directed care programs that give clients far more control over the services they obtain and who provides those services.

What do these innovations have in common? All are trying to smooth out Medicaid's rough edges—to change it from an all-or-nothing program to one that meets a continuum of needs. Yet therein lies the rub. Medicaid costs have been lower than they would otherwise because of its rigid boundaries. If you do not offer people what they need, fewer will sign up. Blending funding streams and offer-

ing a continuum of services makes for a better—yet potentially more expensive—program.

How do we capture the power of this innovation and build upon the strong base Medicaid has already created? This paper can only take a small step in proposing a better direction for Medicaid. I recommend changes in three areas.

■ **Increased federal funding.** The federal government is in a better position than states are to respond to increases in health care costs and fluctuations associated with economic cycles. National health expenditures and Medicaid expenditures have been rising faster than either state or federal tax revenues (Exhibit 4). Thus, a shift in the cost burden from the states to the federal government does not eliminate the problem of Medicaid's consuming an increasing share of public resources. However, compared with the states, the federal government has a broader tax base, one that is not eroding because of shifts in consumption patterns, and is not constrained by balanced budget rules that assure that Medicaid spending spikes will coincide with tight fiscal conditions. There are many ways to structure an increased federal role in funding Medicaid. The details are less important than that a substantial shift occur.

■ **Constrained state options on spending.** While state "Medicaid maximization" strategies are legal, and federal payments are only made in accordance with federal rules, certain schemes undermine the integrity of the program and harm state-federal relationships. They also undercut states' legitimate claims that they are having difficulty bearing the financial burden of a growing Medicaid program.

With the exception of DSH and administrative payments (discussed in a moment), states receive federal matching payments only when an enrolled client receives a covered service and the state pays for the service. The definition of "enrolled client" is unambiguous, and "covered services" are also fairly clearly defined.

States legitimately bristle at the idea that the federal government will tell them how to generate their revenues. In general, whether a state wishes to rely upon broad-based taxes, local funds, tobacco settlement dollars, or other revenue sources to pay the state portion of Medicaid costs should be of little concern to the federal government.

An alternative intervention for the federal government to return the program to fiscal integrity is more active oversight of payment levels for providers along the lines of recent UPL limitations. Unfortunately, the track record of the federal government's intervening in payment rates is poor, with the Boren Amendment leading to federal courts' determining nursing home payment rates and FQHC payment rules impeding the development of managed care. Still, this is the only fix that is likely work. If the federal government knows that its matching payments are being used to pay a reasonable price for a covered service delivered to an eligible client, that should answer all critics and clarify the reasons for Medicaid cost increases.

Changes in federal policies that affect state revenues and provider payments

must also address DSH, another funding stream that provides critical support to some institutions but cannot be defended in its current form. These changes must be undertaken with great care, should not be made in the middle of a recession, and must be phased in. Yet, they are necessary if limited federal and state funds are to be directed to where the need is greatest, not to where state fiscal creativity has been employed.

■ **Revised waiver system.** States legitimately want to experiment with new approaches to Medicaid, and the nation gains from these activities. Yet "research and demonstration" waivers now seem less about research and demonstration and more about an opportunity to fundamentally modify the program. This view is nicely captured in policy of the National Governors' Association (NGA), which says that a state's waiver should become permanent after five years if the state meets the waiver's terms and conditions and that any state should be able to adopt another state's waiver without any review.[55] These are policies appropriate for plan amendments, not experiments.

The Bush administration's new Health Insurance Flexibility and Accountability (HIFA) demonstration initiative creates a streamlined template for states to submit waivers under Section 1115 of the Social Security Act. The new waiver policy raises a variety of risks, but key among them is the possibility that its primary function becomes to lock in SCHIP funds that states are on the verge of losing because of low spending on that program. If manipulating spending projections and financing streams becomes a major feature of the next round of waivers, this will further erode trust between states and the federal government.

What Medicaid needs is a bifurcation of the current waiver process. On one path are true experiments, which can teach us the answers to critical questions such as (1) What are the effects of cost sharing for very-low-income populations on enrollment, utilization, and health status? (2) Can employer subsidies be structured in a manner that encourages participation and guarantees an appropriate level of benefits? (3) Can individuals select and manage their providers with positive health, social, and financial results? For these experiments, the requirement of budget-neutrality should be eliminated. The nation has a tremendous stake in learning the answers to these questions. Surely the Medicaid program can afford to spend some money to learn if it is using its $257 billion effectively.

On another path should be a series of state plan options that can be adopted without waivers. States wishing to simplify eligibility standards, eliminate categorical boundaries to include adults in their programs, or adopt managed care should be able to do so without a waiver. The available options should be defined in statute, so that their consideration is public and their implications understood. In this regard, if states are to be given the option to scale back benefits, charge premiums, or increase cost sharing for some populations, then it should be Congress that establishes them.

MEDICAID IS ON A ROLLER-COASTER RIDE. Just a few years ago states were expanding their programs: aggressively pursuing outreach and enrollment and considering and adopting coverage for parents and prescription drug programs for elders. While states have largely protected Medicaid from budget cuts in 2002, if the economic and fiscal downturn continues, cuts in the program could be substantial.[56] Presumably the current Medicaid crisis will pass as state budgets recover, but at what cost to the low-income population?

Despite its detractors, Medicaid has shown itself to be the best among few options for addressing a multitude of health problems in the United States. The greatest risk for Medicaid is that we will continue to ask it to do more, while failing to provide the resources necessary to carry out its complex mission. It is amazing how much the program has accomplished under consistent fiscal stress punctuated by periodic crises and rare lulls. Imagine what it could do to address our remaining needs if it were not running so close to the edge. Failure to address Medicaid's underlying fiscal problems risks marginal care for our nation's most vulnerable populations and fitful progress toward our nation's health care goals.

This paper was prepared as part of the Assessing the New Federalism project, which has received major funding from the Annie E. Casey, W. K. Kellogg, Robert Wood Johnson, Henry J. Kaiser Family, Ford, David and Lucile Packard, John D. and Catherine T. MacArthur, and Charles Stewart Mott Foundations. The views expressed are those of the author and do not necessarily reflect those of the Urban Institute, its board, or its sponsors. Excellent research assistance was provided by Stephanie Schardin. Lisa Dubay, John Holahan, Genevieve Kenney, Cindy Mann, and three anonymous referees provided helpful comments on an earlier draft.

NOTES

1. B. Bruen and J. Holahan, "Acceleration of Medicaid Spending Reflects Mounting Pressures" (Washington: Kaiser Commission on Medicaid and the Uninsured, May 2002).
2. V. Smith and E. Ellis, *Medicaid Budgets under Stress: Survey Findings for State Fiscal Year 2000, 2001, and 2002* (Washington: Kaiser Commission, October 2001).
3. Centers for Medicare and Medicaid Services, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," 2001, State Reported Expenditures, Form CMS-64 and Predecessors.
4. Congressional Budget Office, "March 2002 Baseline, Medicaid and State Children's Health Insurance Program Fact Sheet" (Washington: CBO, March 2002).
5. V. Smith et al., *Medicaid Spending Growth: Results from a 2002 Survey* (Washington: Kaiser Commission, September 2002).
6. N.W. Jenny, *State Revenue Report: State Tax Revenue Decline Accelerates* (Albany: Nelson A. Rockefeller Institute of Government, September 2002).
7. National Association of State Budget Officers, *The Fiscal Survey of States*, May 2002, www.nasbo.org/Publications/fiscsurv/may2002fiscalsurvey.pdf (1 October 2002).
8. National Governors' Association, "Policy Positions: HR-32. Health Care Reform Policy" (Washington: NGA, 2001).
9. NGA, "Legislative Priorities, Medicaid," www.nga.org/nga/lobbyIssues/1,1169,D_1996,00.html (19 September 2002).
10. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Policy* (Washington: MedPAC, March 2002); S. Norton, "Recent Trends in Medicaid Physician Fees, 1993–1998," Assessing the New Federalism Discussion Paper no. 99-12 (Washington: Urban Institute, September 1999); U.S. General Accounting Office, *Nursing Homes: More Can Be Done to Protect Residents from Abuse*, Pub. no. GAO-02-312 (Washington: GAO, March 2002); and GAO, *Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area,*

Pub. no. GAO/HRD-90-81 (Washington: GAO, August 1990).

11. J. Holahan, "Variations among States in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?" Assessing the New Federalism Discussion Paper no. 02-07 (Washington: Urban Institute, June 2002).
12. E. Park and L. Ku, *Administration Medicaid and SCHIP Waiver Policy Encourages States to Scale Back Benefits Significantly and Increase Cost-Sharing for Low-Income Beneficiaries* (Washington: Center on Budget and Policy Priorities, 15 July 2001); and GAO, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, Pub. no. GAO-02-817 (Washington: GAO, July 2002).
13. A major exception to the trend of expansion is the elimination of eligibility for most noncitizens as part of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.
14. L. Ku, F. Ullman, and R. Almeida, "What Counts? Determining Medicaid and CHIP Eligibility for Children," Assessing the New Federalism Discussion Paper no. 99-05 (Washington: Urban Institute, 1999).
15. L. Dubay, I. Hill, and G. Kenney, *Five Things Everyone Should Know about SCHIP*, Assessing the New Federalism Brief no. A-55 (Washington: Urban Institute, October 2002).
16. Kaiser Commission, "Health Coverage for Low-Income Children" (Washington: Kaiser Commission, March 2000).
17. Eligibility is tied to the rules states had in place for the old Aid to Families with Dependent Children (AFDC) on the day PRWORA was passed, although states may make certain modifications.
18. U.S. House Committee on Ways and Means, *2000 Green Book*, 106th Cong., 2d sess. (Washington: U.S. Government Printing Office, 2000).
19. Ibid.
20. J. Holahan and N. Brennan, *Who Are the Adult Uninsured?* Assessing the New Federalism Brief no. B-14 (Washington: Urban Institute, March 2000).
21. Urban Institute, *Snapshots of America's Families II* (Washington: Urban Institute, October 2000).
22. B. Bruen et al., "State Usage of Medicaid Coverage Options for Aged, Blind, and Disabled People," Assessing the New Federalism Discussion Paper no. 99-09 (Washington: Urban Institute, August 1999).
23. Committee on Ways and Means, *2000 Green Book*. Counts of states include the District of Columbia and U.S. territories.
24. National Archives and Records Service, *Title 42: Public Health, 42 CFR 447.54* (Washington: U.S. GPO, Office of the Federal Register, 2001).
25. Some states, such as Tennessee, Massachusetts, and Delaware, have received waivers under Section 1115 of the Social Security Act to charge premiums to people made newly eligible when the state expands coverage beyond the base of mandatory eligibility groups. See M. Krebs-Carter and J. Holahan, "State Strategies to Cover Uninsured Adults," Assessing the New Federalism Discussion Paper no. 00-02 (Washington: Urban Institute, May 2000). New waiver guidance expands the possible uses of cost sharing.
26. Author's calculations from the 1997 National Survey of America's Families.
27. J. Klemm, "Medicaid Spending: A Brief History," *Health Care Financing Review* (Fall 2000): 105–112; and V.K. Smith, *Making Medicaid Better: Options to Allow States to Continue to Participate and to Bring the Program Up to Date in Today's Health Care Marketplace* (Washington: National Governors' Association, April 2002). These figures represent the number enrolled at any point during the year. The Urban Institute estimates that average monthly enrollment in 2002 was approximately thirty-seven million.
28. CMS, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program."
29. L. Dubay, G. Kenney, and J. Haley, *Children's Participation in Medicaid and SCHIP: Early in the SCHIP Era*, Assessing the New Federalism Brief no. B-40 (Washington: Urban Institute, March 2002); and A. Davidoff, B. Garrett, and A. Yemane, *Medicaid-Eligible Adults Who Are Not Enrolled: Who Are They and Do They Get the Care They Need?* Assessing the New Federalism Brief no. A-48 (Washington: Urban Institute, October 2001). Estimates for children exclude noncitizens and children with private insurance coverage.
30. M. Moon, N. Brennan, and M. Segall, "Options for Aiding Low-Income Medicare Beneficiaries," *Inquiry* (Fall 1998): 346–356.
31. Bruen and Holahan, *Acceleration of Medicaid Spending*.
32. NASBO, *Medicaid and Other State Healthcare Issues: The Current Situation*, May 2002, www.nasbo.org/Publications/PDFs/fsmedicaidmay2002.pdf (25 September 2002).
33. Bruen and Holahan, "Acceleration of Medicaid Spending."

34. Smith et al., *Medicaid Spending Growth.*
35. Author's calculations from data in Committee on Ways and Means, *2000 Green Book.*
36. CMS, "Health Accounts: Estimates, National Health Accounts," cms.hhs.gov/statistics/nhe/default.asp (10 October 2002).
37. NASBO, *Medicaid and Other State Healthcare Issues.*
38. L. Ku and B. Bruen, *The Continuing Decline in Medicaid Coverage,* Assessing the New Federalism Brief no. A-37 (Washington: Urban Institute, December 1999).
39. L.C. Dubay et al., "Local Responses to Expanded Medicaid Coverage for Pregnant Women," *Milbank Quarterly* (Winter 1995): 535–564.
40. CMS, "Medicaid and Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection," Fact Sheet, January 2002, www.cms.hhs.gov/hiv/hivfs.asp (10 July 2002).
41. J. Warren, "Davis Signs Bill to Help Patients with HIV," *Los Angeles Times,* 19 September 2002.
42. D. Rowland and R. Garfield, "Health Care for the Poor: Medicaid at Thirty-five," *Health Care Financing Review* (Fall 2000): 23–34.
43. R. Hurley and S. Wallin, "Adopting and Adapting Managed Care for Medicaid Beneficiaries: An Imperfect Translation," Assessing the New Federalism Occasional Paper no. 7 (Washington: Urban Institute, June 1998).
44. Kaiser Commission, "Health Centers' Role as Safety Net Providers for Medicaid Patients and the Uninsured" (Washington: Kaiser Commission, 2000).
45. As of 2002 FQHCs are paid on a prospective basis, as a result of provisions in the Benefits Improvement and Protection Act (BIPA) of 2000.
46. Lewin Group, "Results of the 1997 National Association of County Behavioral Health Directors Local Behavioral Health Care Survey" (Fairfax, Va.: County Behavioral Institute, 1997).
47. GAO, *Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals,* Pub. no. HEHS-98-52 (Washington: GAO, 23 January 1998).
48. R.M. Coffey et al., *National Estimates of Expenditures for Substance Abuse Treatment, 1997,* Pub. no. SMA-01-3511 (Rockville, Md.: Center for Substance Abuse Treatment and Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, February 2001), Table D.2(b).
49. GAO, *Medicaid: Questionable Practices Boost Federal Payments for School-Based Services,* Pub. no. T-HEHS-99-148 (Washington: GAO, 17 June 1999).
50. Department of Health and Human Services, "HHS Approves Nevada Plan to Insure Women with Breast or Cervical Cancer," Press Release, 14 August 2002, www.hhs.gov/news/press/2002pres/20020814.html (1 October 2002).
51. T.A. Coughlin and D. Liska, "Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals," *Health Affairs* (May/June 1998): 118–136; GAO, *Medicaid: State Financing Schemes Again Drive Up Federal Payments,* Pub. no. T-HEHS-00-193 (Washington: GAO, 6 September 2000); and T. Coughlin and S. Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences," Assessing the New Federalism Discussion Paper no. 02-09 (Washington: Urban Institute, June 2002).
52. MedPac, *Report to Congress;* and Norton, "Recent Trends in Medicaid Physician Fees."
53. J.K. Brueckner, "Welfare Reform and Interstate Welfare Competition: Theory and Evidence," Occasional Paper no. 21 (Washington: Urban Institute, December 1998).
54. Bruen and Holahan, "Acceleration of Medicaid Spending."
55. NGA, "Policy Positions: HR-32"; and "Policy Positions: HR-16. Medicaid Policy" (Washington: NGA, 2001).
56. J. Holahan, J. Wiener, and A.W. Lutzky, "Health Policy for Low-Income People: States' Responses to New Challenges," 22 May 2002, www.healthaffairs.org/WebExclusives/Holahan_Web_Excl_052202.htm (20 October 2002).

RESPONSE TO WRITTEN QUESTIONS SUBMITTED TO
ALAN R. WEIL

Senator Baucus

1. On Medicaid financing, the federal formula for Medicaid funding – the FMAP appears to be a problem for states. First, the FMAP formula isn't very responsive to economic change – states can see their federal share drop just as demand rises. The FMAP also can change a lot from year to year. Next year, 29 states including Montana will see a drop in federal funds. Montana stands to lose about 10 million dollars. How should we change the FMAP to fix these problems?

Response:

Our report includes a number of suggestions for modifying how the FMAP is updated, but participants in our Medicaid reform project did not agree on all of the details. There are two sorts of changes that warrant consideration. First are options that would use more current information in establishing the FMAP. These options are designed to make sure that FMAP adjustments occur quickly, providing more support to states when the economy turns down. Second are options that provide temporary increases in the rate on a formula basis when certain indicators deteriorate. Options like this emulate the policies for Unemployment Compensation, the duration of which is automatically extended at either the state or national level when employment indicators reach certain levels.

Regardless of the specific approach taken, it is important to note that increasing the FMAP when state fiscal conditions decline serves a critical function in guaranteeing that Medicaid coverage is available when people need it the most. A number of researchers have examined state behavior during the most recent economic downturn and concluded that the temporary increase in the FMAP adopted by Congress played a key role in averting more substantial cuts in the Medicaid program.

2. I have said that we should not balance the budget on the backs of the states. We also must be careful not do so on the backs of our nation's most vulnerable populations. We need to look at policy options that will not only save money but improve the quality of care delivered to beneficiaries. With proper care management, for example, some of the high costs of chronically ill beneficiaries could be avoided. I am interested your thoughts on improving quality. Based on your research, how would propose to create savings while improving quality and protecting access to care? What information is available about the experience with innovative state programs to support moving in this direction?

Response:

I share your view that savings obtained through improved health care quality are far preferable to savings that come from cuts in services. About half of the states

have indicated in recent surveys that they are experimenting with disease management and other similar programs targeted at Medicaid enrollees with chronic illnesses. These programs are mostly in their early days, so the evidence of their effectiveness with respect to quality and/or savings is limited.

While the concepts behind case management and disease management programs are sound, they face a number of barriers. Some programs are overlays on top of the existing delivery system. This approach can provide needed services, but can also increase, rather than decrease, the degree of fragmentation in how care is delivered. Low-cost interventions such as reminding people to take their medications may easily have a positive return on their small investment, but more comprehensive interventions are expensive and must show real health gains in order to offset their more significant costs. Most programs focus on a discrete population with a defined disease, such as diabetes. However, many of the highest cost Medicaid enrollees have multiple chronic conditions which must be managed jointly, not one-by-one.

From my review of the evidence, it is too early to identify specific states or specific models as the ones that are most likely to be effective. Indeed, because the models vary, it is important that the federal government continue to encourage state experimentation but not step in and direct all states to a single model.

Senator Rockefeller

1. Mr. Weil, in your Medicaid paper you mention requiring mandatory eligibility for all individuals below 100 percent of poverty. This is an idea that I support. In Congress, we hear a lot of rhetoric about states needing greater flexibility so that they can cover beneficiaries who are "truly in need." The fact of the matter is that most states do not provide coverage now for individuals many would describe as desperately in need of access to meaningful health coverage – those living below the federal poverty level. There is no federal minimum, and allowing states to design flexible benefits packages means that individuals that states currently cover could lose access to some of their benefits. Can you talk a little bit about why creating a federal minimum is a sound and appropriate policy approach when considering Medicaid reform?

Response:

There are many reasons to support a solid federal minimum standard of coverage under the Medicaid program. First, the federal government pays more than half the cost of the program. As such, it has a legitimate interest in how the program is designed and administered. A floor of coverage is an appropriate expression of that interest. Second, Medicaid has long suffered from complex eligibility rules that are one of the reasons so many people who are eligible do not enroll. A clear, national statement that everyone with family income below the federal poverty level is eligible for Medicaid, without regard to age, family

structure, or health status, would simplify the program and aid efforts to explain to people who is eligible. Third, while the FMAP formula is designed to provide a stronger incentive to expand Medicaid to poorer states than wealthier states, wealthier states continue to have more expansive Medicaid programs than poorer states. A federal floor assures that the gap in eligibility between the most expansive and most limited states is not too large – retaining some aspects of Medicaid being a "national" program.

While you are correct in noting that our report calls for mandatory eligibility for everyone living in poverty, it also calls for increased flexibility for states in defining eligibility and benefits for people with incomes above the federal poverty level. These recommendations should be viewed as a pair, as there were members of our work group who not have supported the one provision if the other were not also there.

I should also note that state flexibility with respect to how health care is delivered has led to many positive innovations in the Medicaid program and a great deal of learning about how to best meet the needs of the population the program serves. Flexibility along appropriate dimensions does play a positive role in Medicaid.

Senator Bingaman

1. Senator DeWine and I have recently introduced legislation entitled "Ending the Medicare Disability Waiting Period Act." Currently, people who are severely disabled and qualify for Social Security Disability Insurance, or SSI, must wait two years after receiving their first disability check to receive Medicare coverage. An estimated 40 percent of those people stuck in the waiting period, who by definition are severely disabled, receive Medicaid coverage at a cost of several billion dollars a year to the Medicaid program until Medicare finally kicks in.

   House Ways and Means Chairman Bill Thomas recently questioned this policy as well. What do you all think about eliminating the two-year Medicare disability waiting period, as it would save the Medicaid program billions of dollars while also improving care and treatment for some of the nation's most vulnerable citizens?

Response:

Eliminating the waiting period would, as you note, assist a large number of people with disabilities while also relieving states of a financial burden that is an artifact of an outdated federal policy. I believe states would respond very positively to the change you propose.

2. According to the HIV Medicine Association in Mississippi, the Mississippi Medicaid program has implemented a "policy beginning July 1 that will limit prescription drug coverage for adult Medicaid beneficiaries to just two brand-name drugs per month with absolutely no exceptions." If the

standard of care for HIV disease calls for a combination of at least three antiretroviral drugs to effectively suppress HIV, how does this square with providing states with added flexibility?

Response:

States currently have the authority to define the amount, duration, and scope of covered benefits. However, limitations on amount, duration and scope cannot be so substantial as to render the benefit meaningless. When states establish such limits, they generally have in place some mechanism for granting exceptions. When states discuss their desire for additional flexibility, they generally refer to their intention to limit benefits or impose cost sharing on Medicaid beneficiaries with more resources than those currently covered by the program.

Given the large amount of federal funding devoted to the Medicaid program, it is appropriate for the federal government to establish minimum standards states must meet when they administer the program. In our work, we have attempted to set a balance between minimum standards and state flexibility. That is why we call for flexibility in conjunction with a higher floor of coverage.

3. Alan, first of all, congratulations are in order as I understand you have a baby just a few months old that is doing very well.

   In your testimony, you point out that you can only save money in Medicaid by: (1) shifting costs to another payer; (2) shifting costs to the program's enrollees; or, (3) making the program more efficient.

   Of all the recommendations made by the project Making Medicaid Work for the 21st Century, which do you think are the ones we should prioritize for this year?

Response:

I thank you for acknowledging the birth of my daughter, Rebecca Darcy Weil, on December 30, 2004. As you note, she is doing very well.

The Making Medicaid Work workgroup viewed all of the recommendations as a whole representing a balance of many interests. As such, the group would not endorse selecting a subset of the items and only adopting them. The greatest risk of considering Medicaid policy in the context of budget reconciliation is the likelihood that those items that potentially save money will be given higher priority than others that might have a cost associated with them.

With that understanding, there are some recommendations that do not cost money, or potentially save money through efficiencies rather than shifting costs to others, that I encourage you to consider. For example, a series of recommendations regarding better coordination between Medicaid and Medicare, if implemented, have the potential to improve care for the most costly populations

in each program, reduce fraud in both programs, and promote greater accountability. Our recommendations regarding rebalancing the long-term care system to encourage more services in the community and fewer provided in institutions could also improve care, provide new options for a vulnerable population, and create more efficient systems of care.

Thus, while I believe our entire report warrants review, I would encourage those who have an eye toward containing program costs to begin by looking at the options that control costs through efficiencies rather than through shifting costs to others.

4. The Social Security Administration (SSA) has discovered a computer processing glitch that resulted in a failure to identify Supplemental Security Income (SSI) recipients who had become eligible to receive Social Security Disability Insurance (SSDI).

   According to the American Public Human Services Association, "The SSA system checks earnings records against the SSI records to identify individuals who should be receiving SSDI. If the system finds an SSI recipient who is eligible for SSDI, it places a diary on the SSI record. This diary alerts the SSA field office to send a notice to the recipient, asking them to apply for SSDI. As a result of the SSA processing glitch, the diary was never posted to the SSI record of numerous beneficiaries and they were not notified that they needed to apply for SSDI. SSA is still working to determine the full scope of the problem, but it is estimated that 500,000 individuals eligible to receive SSDI did not receive benefits due to this system error."

   The effect would appear to a fairly dramatic cost-shift from Medicare to the Medicaid program. Do you know what the status of this is and how do you think it should be addressed?

Response:

This sounds like an important issue, but I do not have additional information on it.

5. Do you believe there should be a federal floor on benefits and cost-sharing requirements below which no state can deviate? If the federal government is putting in a majority of the dollars, shouldn't we have some federal minimum standards for all Medicaid beneficiaries?

Response:

As I mentioned in response to Senator Rockefeller's question, I do believe federal minimum standards in Medicaid are appropriate.

The Making Medicaid Work workgroup endorsed a vision for Medicaid that includes a combination of federal standards and state flexibility. Specifically, the

group recommended a floor of coverage for everyone with income below the federal poverty level. For people in that category, benefit requirements and cost-sharing limits that currently exist in the Medicaid program would be retained.

The workgroup recommended a greater degree of flexibility for people with incomes above that level. For this group, benefits could be limited, so long as they met a benchmark standard of comprehensive health insurance coverage. In addition, cost sharing could be greater. The group did not reach agreement on an upper limit on cost sharing.

While different people will certainly have different views about the appropriate minimum standards for coverage, the workgroup recommendation certainly embraced the notion that federal minimum standards are appropriate.

###

COMMUNICATIONS

STATEMENT OF THE AIDS INSTITUTE

Chairman Grassley and Members of the Committee:

Thank you for sponsoring a hearing to discuss strategies for strengthening the Medicaid program and for the opportunity to submit comments for the record regarding this program that is so vital to people with HIV/AIDS.

Medicaid finances more than 55 percent of all AIDS care and 90 percent of all AIDS care for children in the United States.[1] We strongly encourage the Committee to grant serious consideration to the medical needs of Medicaid beneficiaries with AIDS and other people who are disabled by chronic medical conditions as they evaluate proposed changes to the Medicaid program. We are writing to share with you how two policy proposals being promoted by the National Governor's Association would negatively affect access to medically necessary care for people with HIV/AIDS in the United States.

Remarkable advances in HIV treatment have resulted in an 80 percent reduction in mortality and morbidity due to AIDS and related complications. Without the Medicaid program, many low-income people with HIV disease in the United States would be unable to benefit from these treatment advances. We strongly urge the Committee to avoid cost saving measures that would compromise access to life-saving medical care and treatment for low-income people with HIV/AIDS in the United States.

Increased cost-sharing for Medicaid services will disproportionately burden people with intense medical needs such as Medicaid beneficiaries with AIDS. People with AIDS rely on eight to fourteen medications per month to manage HIV disease, accompanying side effects and comorbid conditions. Routine health care visits and laboratory testing also are critical components of successful HIV treatment. Attaching higher fees to each of these services and denying services for failure to meet cost sharing obligations will force people with HIV/AIDS to go without medically necessary care. None of these services are optional for people with AIDS. Without reliable, consistent access to medical care and treatment, people with HIV/AIDS become sicker and need more costly treatment interventions such as inpatient hospitalization.

The crux of HIV treatment is known as Highly Active Antiretroviral Therapy (HAART) and calls for a combination of at least three antiretroviral drugs to effectively suppress the HIV virus. HAART transformed HIV disease from a death sentence to a manageable, chronic condition. Almost all antiretroviral drugs are brand name drugs; generic substitutions are not available. Near perfect adherence to the daily regimen of at least antiretroviral medications is required for successful treatment. Missed medication doses result in the development of drug resistant virus that does not respond to treatment and leads to the development of serious and deadly disease complications.

---

[1] Kaiser Family Foundation. Financing HIV/AIDS Care: A Quilt with Many Holes. May 2004.

The toxicity of the medications required to suppress the HIV virus causes many people with AIDS to experience serious treatment side effects including neuropathy, metabolic abnormalities and acute gastrointestinal distress that require medical and pharmacologic management. Management of HIV disease is further complicated by co-morbid conditions such as hepatitis C and serious mental illnesses that are common among people with HIV disease. The Centers for Disease Control and Prevention has estimated that at least 25 percent of people with HIV are co-infected with hepatitis C.[2] More recent studies estimate that as many as 30 percent of people with HIV are co-infected with hepatitis C.[3] Studies estimate that the prevalence of mental illness among people with AIDS is as high as 50 percent.[4]

There is ample evidence from recent studies that cost-sharing is burdensome to individuals with low-incomes, and results in individuals rationing prescription drugs and other health services to preserve income for necessities like housing and food. This situation is compounded when low-income individuals are dependent upon myriad drugs and health services simply to maintain some reasonable level of functioning. The truth of the matter is that significant savings from cost-sharing result from people denying themselves the health care services they need.

Allowing states to offer different benefits to different populations will compromise care and treatment for many people with AIDS. The difference between a "mandatory" beneficiary with AIDS and an "optional" beneficiary with AIDS could be as little as $15 in monthly income. Both are equally disabled with the same medical needs and are living on monthly income well below the federal poverty level, which will not support paying for services not covered by Medicaid.

In 2005, the federal poverty level is around $800 a month for an individual. In many states, eligibility for Medicaid for people with disabilities is around $585 per month. Failure to maintain current beneficiary protections that ensure all Medicaid beneficiaries have access to the same level of services will lead to some people with AIDS receiving substandard care.

Many people with AIDS qualify for Medicaid because their medical expenses are so high that when subtracted from their income they are left with very low monthly incomes, e.g., $200. It is critical that states continue to cover these "medically needy" individuals and continue to provide the same coverage to all beneficiaries. The "optional" eligibility categories ensure that seniors and people with disabilities with very low incomes, e.g., $600 a month, that are just slightly above the federal Medicaid income eligibility standard have access to life-saving health care services. Furthermore, many services that are likely to be excluded from a leaner benefits package are vital to monitoring and adhering to drug therapies, e.g., case management, mental health counseling and transportation. The case of the medically needy Medicaid beneficiary with HIV/AIDS challenges the widely held belief that so-called optional Medicaid beneficiaries are not as financially strapped or as sick as mandatory beneficiaries. Rationing services among groups of Medicaid beneficiaries is bad policy, potentially leaving many with serious health conditions with access to limited services.

---

[2] CDC. Frequently Asked Questions and Answers About Coinfection with HIV and Hepatitis C virus. Accessed online at http://www.cdc.gov/hiv/pubs/facts/HIV-HCV_Coinfection.htm on June 22, 2005.
[3] Fleming CA, Christiansen D, Nunes D, et al. Health-related quality of life of patients with HIV disease: impact of hepatitis C coinfection. CID. 2004:38:572-578.
[4] Bing EG, Burnam A, Longshore D, et al. Psychiatric disorders and drug use among human immunodeficiency virus – infected adults in the Unites States. Arch Gen Psychiatry. 2001;58:721-728.

The Medicaid program exists as a shared federal and state commitment to ensuring that our nation's neediest residents have access to health care services. The judicial system plays an important role overseeing this commitment by ensuring that low-income families, people with disabilities and seniors throughout the country maintain equal rights to basic health care services as defined by the Medicaid statute. Any attempts to weaken the role of the judicial system will undermine the guarantee that Medicaid beneficiaries have that they will have access to fundamental health care services. These protections are especially critical to people with conditions like HIV disease since HIV medical care is costly and persons with HIV/AIDS still experience discrimination because of their health status.

The role of the courts is particularly relevant to people with AIDS. Without the intervention of the 8th U.S. Circuit Court of Appeals in 1989 in Weaver v Reagen, 886 F.2d 194**,** people with AIDS would not have had access to AZT – the only treatment available for HIV disease at the time. This case also serves as an important precedent that paved the way for all subsequent HIV drugs to be included on every Medicaid formulary in the nation. We urge you to protect these very basic rights without which the federal entitlement to services under the Medicaid program could be rendered virtually meaningless for the individual Medicaid beneficiary. **We are particularly troubled by efforts to minimize and undermine the enforcement of consent decrees – an important vehicle for avoiding lengthy and costly litigation and for achieving compromised resolutions to challenging cases.**

We strongly urge you to realize savings in federal Medicaid spending without jeopardizing access to life-saving health care and treatment services. Furthermore, we hope that in the near future there will be an opportunity for Medicaid beneficiaries with AIDS and their health care providers to share with you their valuable perspectives and experiences regarding the Medicaid program. The Senate Finance Committee should hear from those who will be most directly affected by reductions in Medicaid spending—Medicaid beneficiaries and their providers. Please contact Christine Lubinski, executive director of the HIV Medicine Association, if we can provide additional information on Medicaid and people with AIDS or with questions regarding this statement at (703) 299-1215.

Respectfully submitted,

The AIDS Institute, Washington, DC
American Academy of HIV Medicine, Washington, DC
Gay Men's Health Crisis, New York, NY
HIV Medicine Association, Alexandria, VA
Project Inform, San Francisco, CA

alzheimer's association

the compassion to care, the leadership to conquer

THE FUTURE OF MEDICAID: STRATEGIES FOR STRENGTHENING AMERICAN'S VITAL SAFETY NET
JUNE 15, 2005

Statement to the Senate Committee on Finance, presented for the Record by the:

Alzheimer's Association
Washington Public Policy Office
1319 F Street, NW, Suite 710
Washington, DC 20004-1106
Contact: Bonnie Duffy, 202-393-7737 ext. 238 or Bonnie.Duffy@alz.org.

Executive Summary

Medicaid is the Critical Long-Term Care Safety Net for 850,000 People 65 and over who have Alzheimer's Disease and Related Dementias (AD)

- AD requires 24 hour a day care and lasts on average 7 to 8 years from diagnosis. 70% of people with AD live at home where family and friends provide most of their care.
- When paid care is needed, it quickly exhausts most family budgets – a nursing home costs on average $62,000 a year; home care - $18 an hour; dementia day care - $65 a day.
- 446,000 Medicaid beneficiaries with AD live in nursing homes; the rest get help at home or in other community settings.

The Alzheimer's Association Endorses the National Governors Association's (NGA) Call for a New National Dialogue on Long-Term Care (LTC)

- Our current over reliance on families, with Medicaid as the long-term care safety net, cannot be sustained over time.
- We need a fair and comprehensive approach to long term care that clearly defines the role of public and private financing, spreads risk and shares costs.
- We have time. The long term care pressure on Medicaid comes in 15-20 years when baby boomers begin to need long term care; in the short term growth in demand for Medicaid long term care will be slow or negative.
- Chronic care management for beneficiaries with AD – 95% of whom have other costly chronic health conditions – can save Medicare and Medicaid money.
- The most effective way to reduce Medicaid spending on long-term care is to increase funding for Alzheimer research at the National Institutes of Health. By delaying the onset and progress of Alzheimer's, we can save $10 billion in annual Medicaid spending.

The Medicaid Long-Term Care Safety Net Can Be Improved. The Alzheimer's Association supports the following concepts in the NGA's preliminary Medicaid proposal:

- Eliminate 1915(b) and (c) waivers and let states implement home and community based services through state plan amendments – while maintaining entitlement and access to quality nursing home care for those for need that level of care.
- Encourage Medicare/Medicaid coordination and integration by considering savings to Medicare from Medicaid changes, and vice versa.
- Provide incentives to states to improve chronic care management for dual eligibles and establish a Medicare chronic care benefit.
- Allow states to implement long term care partnership programs and provide a targeted tax credit for purchase of long term care insurance that meet NAIC standards in effect at time of purchase.
- Provide incentives to encourage home owners to consider reverse mortgages to help meet their retirement needs including but not limited to their long term care needs.

Congress Should Not Force Families to Bear an Even Heavier Burden of LTC

- Current asset transfer rules already impose a heavy burden on an older person applying for Medicaid, especially when that person has dementia. Proposals to "look-back" even further or to change the start date of the penalty period are most likely to harm those who truly do not have the resources to pay for long term care.
- We agree with NGA that a person should be able to pass on a certain amount of assets without penalty, and that protections should be in place for vulnerable persons including those with dementia.
- Congress should proceed cautiously and consult with those who work most closely with older people who are trying to manage their finances to meet their needs within the rules that Congress has already established.
- The Alzheimer's Association opposes any additional requirements for family contributions as a precondition of Medicaid eligibility.

Mr. Chairman and Members of the Committee:

The Alzheimer's Association appreciates this opportunity to present written testimony on behalf of the 4.5 million women and men in the United States who have Alzheimer's disease and the more than 19 million family members who care for them. Specifically, we offer our comments on the long term care recommendations in the bipartisan preliminary report on Medicaid Reform which the National Governors Association submitted to the Subcommittee on June 15.

We commend the Governors for the thoughtful effort that went into development of their long term care recommendations. The states have long been the leaders in developing innovative approaches to long term care that reflect the desire of frail elderly and people with disabilities to remain in their homes, if they can, and to direct their own care. Once again, they are taking leadership. While the Association does have some concerns about several of the specific recommendations, there is much in these long term care proposals that we support. We look forward to working with the Governors and the Congress as these proposals are further refined and legislation to implement them is considered.

Medicaid Is Important to People with Alzheimer's Disease and Related Dementias

Medicaid is the critical long term care safety net for people with Alzheimer's disease whose families can no longer care for them and who have spent down their income and assets on health and long term care services. While almost all people with Alzheimer's disease are covered by Medicare for their basic health care needs, that program does not pay for long term care.

Alzheimer's is the most expensive uninsured illness older Americans are likely to face. It requires 24 hour a day care and lasts, on average 7 to 8 years from the time of diagnosis. At any one time, at least 70% of people with Alzheimer's disease are living at home, where family and friends are providing most if not all of their care. Eventually though, the needs of the person with dementia are too much for families to manage on their own. And that is when costs begin to mount rapidly. The average annual cost of nursing home care in urban areas in 2004 was nearly $62,000, for a shared room.[1] Paid care for a person with dementia is also expensive. Home care provided through an agency averages $18 an hour.[2] Specialized dementia care at an adult day center costs from $45 to $65 a day. At those costs, retirement savings are quickly exhausted.

That is why 850,000 Medicare beneficiaries with Alzheimer's disease or similar levels of cognitive impairment, age 65 or older, rely on Medicaid for help paying for their long term care. Slightly over half, 446,000, are long term nursing home residents. The rest receive help at home or in other community settings.[3]

Long Term Care Is Much Bigger than Medicaid and Requires a Larger Policy Response

The Alzheimer's Association strongly endorses the Governors' call for a new national dialogue on long term care. We agree that Medicaid cannot continue as the primary default

mechanism for long term care when families can no longer pay for it on their own. We believe that many of the ideas that the Governors have put on the table merit immediate and serious attention as components of a fairer and more comprehensive system for spreading the risk and sharing the cost of long term care. These include:

- Expansion of home and community based long term care services and supports,
- Incentives for the purchase of private long term care insurance and other alternative funding mechanisms,
- Attention to long term care in policy discussions around Social Security, pension reform, and retirement savings, and
- Consideration of the appropriate role of Medicare in long-term care and chronic care management.

It is particularly significant that the Governors have linked the issues of long term care and chronic care. Alzheimer's disease presents perhaps the best example of how our failure to create such linkages may be adding substantially to both Medicare and Medicaid costs. Medicare expenditures for people with Alzheimer's are nearly 3 times higher than the average for all beneficiaries, even though Medicare is not paying for their long term care. That is because 95% of Medicare beneficiaries with Alzheimer's have one or more other costly chronic conditions that are common in the elderly.[4] Because of their dementia, they cannot manage those other chronic diseases, follow physician instructions, or communicate effectively about symptoms or pain. The result is acute care crises, excess disability, and premature functional decline which not only lead to potentially avoidable hospitalization but exacerbate long term care needs – adding costs for both Medicare and Medicaid.

The Governors are right that our current over reliance on Medicaid as the long term care safety net cannot be sustained over time. Fortunately, we have time to create a better system. The real pressure on Medicaid from long term care is still 15 to 20 years away, when the baby boomers begin to reach the age of risk of diseases like Alzheimer's and need long term care. In the short term, growth in demand for Medicaid long term care for the elderly is likely to be slow to negative.[5] Congress does not need to take drastic action that would undermine the Medicaid safety net for those who rely on it now.

Congress must also recognize that the most effective way to slow the growth in Medicaid spending is to reduce the need for long-term care. That can only happen by reducing the number of baby boomers who will face costly long-term illnesses like Alzheimer's disease. If medical research can find a way to slow the onset and progress of Alzheimer's as much as we can now slow Parkinson's and heart disease that could result in savings to Medicaid of $10 billion a year.[6] Scientists are on the verge of such discoveries, but they can only get there with an increased investment in Alzheimer research at the National Institutes of Health. If the answers are to come in time to save the baby boomers - and Medicaid, Congress must invest an additional $200 million in Alzheimer research now. It is one of the most effective ways to reach the goal that Congress, the states, and the Alzheimer's Association share – to preserve the Medicaid program without bankrupting the public purse.

The Medicaid Long Term Care Safety Net Can Be Improved

The Governors have put on the table a number of Medicaid reform proposals. While the Alzheimer's Association is concerned about changes in Medicaid that affect all age groups, we are limiting our comments to the long term care proposals because those are the ones that most directly impact the people with dementia whom the Association represents.

While some of these long term care proposals need additional detail before we can fully assess their impact on our constituents, we believe that the Association could support many of them. We look forward to working with the Governors and Congress to make sure that these ideas are developed and implemented in a manner that protects the interests of beneficiaries with dementia and other frail elderly. We do have concerns with several recommendations, which we identify in the final section of this testimony.

Specifically, the Alzheimer's Association supports the following concepts in the Governors' preliminary proposals:

1. Allow states to implement home and community based services (hcbs) through state plan amendments, thereby eliminating the need for 1915(b) or 1915(c) waivers. This would not affect the broader waiver requirements which are designed to assure that basic federal guarantees Congress has enacted over the years are not undermined. We have worked with many states as they have expanded services to allow more frail elderly people to stay at home and get the care they need. We have seen how the 1915(b) and (c) requirements have limited states' ability to innovate, particularly to provide services to people in the community who need help but do not yet meet nursing home eligibility standards. This is about creating long term care options, to tailor services to individual needs. It is not about restricting access to quality nursing home care for those individuals for which it is the most appropriate setting of care. While increasing states' flexibility to innovate in their long term care programs, Congress must maintain the entitlement to nursing home care and states must continue to make adequate investment to ensure the quality of that care.

2. Encourage innovations in Medicare/Medicaid integration and coordination by including potential costs and savings to Medicare in calculating the budgetary impact of changes in Medicaid, and vice versa. Beneficiaries with dementia make extensive use of both Medicare and Medicaid, as well as other public programs for the frail elderly – because they have extensive health and long term care needs. Changes that would yield costs or savings in one program will affect expenditures in the other program (for example, reduced spending on long term care could result in higher rates of hospitalization, while increased spending on community services could reduce acute care costs.)

3. Provide incentives to the states to improve chronic care management, especially for beneficiaries who are dually eligible for Medicare and Medicaid. In addition, provide a specific targeted chronic care management benefit as a basic feature of the Medicare program. Those chronic care initiatives must include particular attention to the

management of care for persons whose chronic health conditions are confounded by dementia.

4. Repeal the federal prohibition against additional state long term care partnership programs. These programs protect a specified amount of assets for persons who purchase qualified private long term care insurance policies. The Association supports this recommendation, provided that Congress specify that such policies meet the long term care insurance standards of the National Association of Insurance Commissioners (NAIC) that are in place at the time of purchase.

5. Provide a targeted federal tax incentive for the purchase of long term care insurance. We agree with the Governors that such an incentive should be in the form of a tax credit, rather than a tax deduction, to help target the incentive to lower income individuals who would be most likely to qualify for Medicaid. Like the Partnership policies, Congress should require that such policies meet the NAIC standards in effect at the time of purchase.

6. Provide incentives to encourage home owners with substantial home equity to consider reverse mortgages to meet their retirement needs including their needs for long term care. The high cost of reverse mortgages limits their utility for many older people. We urge Congress to consider the proposals set forth by the National Council on Aging to make reverse mortgages more attractive and affordable for lower income home owners, as well as marketing standards to protect prospective borrowers. Even with those incentives and protections, however, we do have concerns about imposing a reverse mortgage requirement as a condition of Medicaid eligibility and would not support a proposal that restricted the use of income from a reverse mortgage to long term care. For many older people, their home is their greatest if not their only significant asset. There are many essential needs toward which a home owner might seek a reverse mortgage including, for example, essential home improvements, payment of higher property taxes that come with increased home equity, Medicare prescription drug benefit cost-sharing and other uninsured health care needs, as well as long term care.

These long term care proposals offer the potential to improve existing Medicaid long term care services and supports for older people who rely on the program now or in the future. They also hold the potential for limiting somewhat the need for Medicaid assistance in the future. But they will not alleviate the urgency of the need for a more comprehensive consideration of long term care reform.

Families Should Not Be Forced to Bear an Even Heavier Burden of Long Term Care

While we are inclined to support most of the Governors' long term care recommendations, we raise concerns about two proposals that would have the effect of placing an even heavier burden on families who are already exhausting themselves, physically, emotionally, and financially, caring for loved ones with Alzheimer's disease and other serious disabilities. These proposals deal with rules regarding the transfer of assets and the "deeming" of family income for Medicaid eligibility.

Families are already bearing the heaviest burden of long term care for people with dementia. Seventy percent of people with Alzheimer's disease live at home, where family and friends provide 75% of their care. Over 70% of caregivers have been doing this for more than a year and nearly one-third have been caring for five or move years.[7] This is not easy work. Alzheimer caring is constant – described as "the 36-hour day." It includes the most intimate personal tasks – bathing, dressing, feeding, and toileting. But it also involves round-the-clock supervision, cueing and stand-by assistance to help the person with dementia retain their remaining functional abilities, and to protect them from harm from the challenging behaviors – including wandering and disinhibition -- that often accompany the disease.

Caregiving takes a heavy financial toll on families. A recent national survey found that two-thirds of working Alzheimer caregivers had missed work because of their caregiving responsibilities; 14% gave up work altogether or took early retirement; 13% cut back on work hours or took a less demanding job; 85 turned down a promotion; 7% lost job benefits. The same survey showed that nearly half of non-spouse caregivers were providing financial assistance, usually to a parent, averaging $218 a month.[8]

Nursing home costs place a particular burden on families. Even though Medicaid pays a substantial part of the nursing home bill, for elderly long-term nursing home residents, 48% of their bills is paid out-of-pocket.[9] Even when a person qualifies for Medicaid, he or she continues to pay all of their income (minus a token monthly needs allowance) to the nursing home; Medicaid only makes up the difference if they do not have enough income to pay the whole bill.

There is no free ride with Alzheimer's disease. In fact, for older Americans, Alzheimer's disease and the associated cost of long term care is the only estate tax they will face. That is why the Association has such concern about these two proposals included in the Governors' plan.

Family contributions. The Governors suggest that some form of family contribution to the costs of long-term care be required, presumably as a condition of Medicaid eligibility. It is hard to understand how families could be compelled to do more than they already do. Under current law, community spouses are allowed to keep only a modest amount of income and assets to meet their own needs – the rest must be used to pay the nursing home bill. It is not clear which other family members might be required to contribute to the cost of long term care for an older person, or how any such requirement could be equitably enforced. Family circumstances vary enormously. Some adult children provide unpaid care for years. Some provide a home for an ailing parent. Some provide emotional support long distance. Would adult children be "assessed" based on current income, family size, other obligations? Would a single adult child be asked to pay more than a married sibling with children? How would the caregiving contributions they have already made be valued? What about step-children?

This proposal seems a direct contradiction to the efforts that both the states and Congress have made in recent years to recognize, support, and reinforce the role of family caregivers – through respite and caregiver support services and tax credits. It should be rejected.

Transfer of assets. This is a complicated issue. We realize that Governors have struggled with these issues and are still trying to find a solution that protects those who need help and

acknowledges that older people should be able to pass on something to their children and other family members without undue penalty. That is reflected in the Governors' proposal to allow a disregard of a certain amount of transferred assets – they have suggested $50,000 adjusted for inflation. In addition, they have suggested that individuals with dementia or others at risk of being exploited be protected, although it is not clear how that can be done.

Older Americans, even those of relatively modest means, make decisions every day about the use of their resources – tithing to their churches, contributing to charity, assisting grandchildren with college education, helping adult children who face a financial crunch because of a job change or a health emergency. Those decisions are not made with an eye toward Medicaid but represent deeply held values about family and civic responsibility. Yet each of these gifts is considered an illegal transfer of assets if made within the so-called "look back" period for Medicaid eligibility. In addition, people with dementia and many other vulnerable elderly may be victims of fraudulent appeals or otherwise make ill-advised gifts that jeopardize their Medicaid eligibility.

We agree that persons with substantial resources should not attempt to shelter those resources to avoid paying for long term care. We work with hundreds of thousands of families who are caring for loved ones with dementia, including many who ultimately find themselves needing help from Medicaid. We do not see gross abuse of the current system. We find just the opposite – families struggle to do it all themselves and turn to Medicaid only as a last resort. Many find it necessary to consult lawyers, not because they want to hide assets or bend the rules, but because Medicaid is so complicated they cannot figure out the basic rules on their own, including the rules Congress established to protect spouses from impoverishment.

Current Medicaid financial eligibility rules, including those that govern transfer of assets, strike a reasonable balance between a state's interest in limiting Medicaid eligibility to those truly in need and the interests of the person applying for long term care assistance. If it is true that some people abuse those rules to qualify for Medicaid – and there is no evidence to indicate this is an extensive problem – such people are just as likely to find the means to get around more stringent rules that Congress or the states might impose. The people likely to be harmed are those who truly do not have the resources to pay for long term care.

The three year look back period already establishes a heavy burden on an older person applying for help with long term care. These are people who are already seriously disabled. Many have already moved to a nursing home, where at least half are suffering from dementia. Yet they are being asked to produce three years of financial records and to explain expenditures that they may not recall at all. In the case of people with dementia, their inability to handle their own financial affairs is often one of the first symptoms of their cognitive impairment. For them, reconstructing financial records may be impossible. Extending the look-back period to five years will place an even more unrealistic burden on these people, at a time when they are in need of immediate assistance. A five-year look back period would also pull into the net more gifts that were made for purposes totally unrelated to Medicaid.

We understand why states are proposing to change the start date of the penalty period for the transfer of assets, to the date a person enters the nursing home or becomes eligible for

Medicaid, whichever is later. In theory, it would allow the state to consider more asset transfers as disqualifying for Medicaid. In practice, it would disqualify persons who disposed of assets, regardless of the reason, and have nothing left to pay for their long term care.

Congress should proceed very cautiously in this area and consult carefully with those who work most closely with older people who are trying to manage their finances to meet their needs and the needs of their families within the rules that Congress has already established. In the end, the best solution lies in developing a clear national policy that delineates public and private responsibility for long term care, not in making Medicaid eligibility rules even more restrictive when no other options are available for people who need help now. The Alzheimer's Association joins the National Governors Association in its call for a national dialogue to confront the issues of an aging population and an increasing demand for affordable quality long term care.

---

[1] MetLife Mature Market Institute, *MetLife Market Survey on Nursing Home and Home Care Costs 2004.* Westport CT: MetLife Mature Market Institute (2004). Cited in AARP Public Policy Institute *Myths about the Medicaid Program and the People It Helps.* AARP Public Policy Institute (2005)

[2] Ibid.

[3] Urban Source Institute tabulations from the 2000 Medicare Current Beneficiary Survey. Note that these figures do not include dual eligibles who are enrolled in Medicare managed care plans.

[4] Bynum JPW, Rabins PV, Weller W, Niefeld M, Anderson GF, and Wu AW. The relationship between a dementia diagnosis, chronic illness, Medicare expenditures, and hospital use. *JAGS*, 52:187-194, 2004.

[5] AARP Public Policy Institute *Myths about the Medicaid Program and the People it Helps.* AARP Public Policy Institute (2005).

[6] The Lewin Group *Savings Lives, Saving Money: Dividends for Americans Investing in Alzheimer Research.* Alzheimer's Association, Washington DC (2004)

[7] Alzheimer's Association and the National Alliance for Caregiving *Families Care: Alzheimer's Caregiving in the United States 2004.* Washington, DC. Alzheimer's Association (2004)

[8] Ibid.

[9] Federal Interagency Forum on Aging Related Statistics *Older Americans 2004: Key Indicators of Well-Being.*

1705 DeSales Street NW, Suite 700
Washington, DC 20036
Toll-Free: 866.241.9601
T: 202.659.0699 F: 202.659.0976
www.aahivm.org

August 11, 2005

United States Senate
Finance Committee
"The Future of Medicaid" Finance Committee Hearing
Testimony for the Record

Securing the Future of Medicaid Benefits for the Neediest Patients Afflicted with HIV Disease

The American Academy of HIV Medicine (Academy) is an independent organization of HIV Specialists and others dedicated to promoting excellence for all patients in HIV/AIDS care. As the largest independent organization of HIV frontline providers, our 2,000 members provide direct care to more than 340,000 HIV patients—more than two thirds of the patients in active treatment for HIV disease.

All of our patients must receive the proper combination drug therapy to effectively treat their HIV disease. HIV/AIDS is a complicated medical condition that requires multiple therapies to treat not only the principle infection, but also co-morbid conditions, opportunistic infections, as well as the toxicities of the treatments themselves. The standard of care for the treatment of HIV calls for various combinations of three or more brand-name drugs, in addition to any medications that would be required to treat other common medical complications arising from the infection or from the drugs themselves.

Many of these patients currently being treated for HIV and AIDS – some 43% or more as estimated by the 2004 IOM report *The Public Financing and Delivery of HIV Care* – rely on Medicaid for access to health care. This makes Medicaid the single largest insurance mechanism, public or private through which patients obtain care.

We have reason to believe that the tenuous fiscal condition of many state Medicaid programs means that restrictions in federal spending will jeopardize and limit access to essential services such as prescription drugs and physician visits. Medicaid reforms presently being implemented on the state level are *already* failing our patients. Consequently, our membership of frontline clinical HIV providers is particularly concerned that severe changes to the Medicaid program on the federal level will only further disrupt access to desperately needed care and treatment.

We are already seeing this happen, for example, in Tennessee, where some 2,000 HIV-positive patients are being excised from Medicaid rolls, patients who likely cannot otherwise afford expensive care and treatment. Similarly in Mississippi, funding scarcity for the program has led to dangerous restrictions limiting the number of prescriptions Medicaid patients may fill on a monthly basis to five total and *only two brand-name medications*. As mentioned above, the clinical standard of care for suppression of HIV disease calls for three or more brand-names, so any reforms that restrict access to these drugs are directly harming patient lives and public health.

We recognize that a $10 billion cut to Medicaid is but a fraction of the total outlay going towards the program. But as increasingly more people depend on Medicaid as their life-line to care, any cuts to the program – already burdened by surging health care costs – clearly represent a journey

in the wrong direction. Tennessee, Mississippi, Florida, among others, while understandably looking at innovative ways to restructure the program and contain costs, are woefully compromising life-saving clinical care.

Medicaid, in fact, must be made *stronger* and more vibrant, which in turn would offer the *true* flexibility that the program needs. For example, under a reduced or otherwise limited federal funding arrangement, the Medicaid program may not have had the resources to cover antiretroviral therapies when they were rapidly developed in the 1990's. Altering or reducing federal support now would likely limit the ability of Medicaid programs to respond to medical advances – such as new, more effective and less toxic anti-HIV therapies – as they are developed.

Though people are fortunately living longer with HIV due to successful, if expensive, therapies, a growing number of economically disadvantaged HIV-positive individuals continue to turn to Medicaid. Though the costs to Medicaid may be increasing in the short term, the costs associated with caring for people without coverage certainly would be greater. Without routine access to treatment, people get sicker and require more intense interventions such as emergency hospitalization, resulting in even higher health care costs for beleaguered states to assume.

Clinical evidence demonstrates that beyond just these individual patients, keeping people on comprehensive therapy is important for *public health* reasons as well. Maintaining this high-risk population on the program rolls and keeping them in treatment and adherent to their drug regimens limits transmissions and reduces the likelihood that mutated and drug-resistant strains of HIV will circulate.

In summary, the Academy concludes that access to medical care for vulnerable HIV/AIDS patients should be expanded on the federal level, rather than restricted. Limiting federal support for Medicaid will make it virtually impossible for states to develop innovative programs such as the proposed Early Treatment for HIV Act (ETHA). ETHA, for its part, would allow states to offer Medicaid coverage to people with HIV before they develop AIDS and become disabled as is currently required. Earlier access to HIV therapies keeps people healthier and more productive, and reduces long-term health expenses. The Academy firmly holds that common-sense, innovative approaches such as these should be the appropriate direction in which Medicaid should evolve.

While we appreciate the Administration's thoughtful intent to counter waste, fraud and abuse, we fear that any attempts to further squeeze a burdened program will at some level trickle down to reduced medical services for highly vulnerable people, whether intended or not.

We concede that cuts to the Medicaid program are inevitable through Reconciliation. At this point, however, we ask you to negotiate those cuts this September with the utmost care, preserving patient services to the best extent possible. We further urge in the strongest possible terms that you truly approach Medicaid reform with a *genuine commitment to rebuilding and expanding* care-access through Medicaid later in this session of Congress, as that is where true reform shall be found.

Respectfully submitted,

Howard A. Grossman, M.D.
Executive Director
American Academy of HIV Medicine

American Academy of Pediatrics

STATEMENT FOR THE RECORD

FOR THE

SENATE COMMITTEE ON FINANCE HEARING

ON

"THE FUTURE OF MEDICAID: STRATEGIES FOR STRENGTHENING AMERICAN'S VITAL SAFETY NET"

OF THE

AMERICAN ACADEMY OF PEDIATRICS

ENDORSED BY:
Ambulatory Pediatric Association
American Pediatric Society
Association of Medical School Pediatric Department Chairs
Society for Adolescent Medicine
Society for Pediatric Research

June 15, 2005

American Academy of Pediatrics
Department of Federal Affairs
The Homer Building
601 Thirteenth Street, N.W.
Suite 400 North
Washington, D.C. 20005
202-347-8600 / 800-336-5475 / Fax 202-393-6137

The American Academy of Pediatrics (AAP) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, who are deeply committed to protecting the health of the 27.8 million children and adolescents who receive health care throughout the Medicaid program.[1] Children represent over 50% of all Medicaid enrollees, but they account for less than 25% of all Medicaid expenditures – including expenditures for children with special health care needs.[2] Without Medicaid, these children and adolescents would not have access to the care they need to live happy, healthy, functional lives.

The Academy and the pediatric societies would like to provide specific comments on a few select areas below raised by the National Governors Association (NGA). Additional AAP policy on Medicaid can be found in our Medicaid Policy Statement, which is also enclosed.

Benefit Package

Preventive care is the cornerstone of pediatrics. The value of preventive care in the Medicaid program has been sustained and promoted since its inception. Emphasizing preventive care for children and adolescents is a strong investment in our nation's future and must be maintained.

In Medicaid, preventive care is guaranteed though the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Maintaining EPSDT ensures that illnesses are identified early, immunizations are not delayed, and that there is appropriate monitoring of early childhood development. We know from recent data that adherence to well-child care recommended visits is effective at lowering the risk of emergency department (ED) use and the risk of avoidable hospitalization.[3] Identifying and treating conditions early prevents further complications and more serious illness in the future, which is more costly to treat.

The EPSDT protection is vitally important, however, not only in assuring that children and adolescents receive needed preventive services, but that they also receive the full range of medically necessary diagnostic and treatment services they need. Moreover, we strongly support policies that would encourage the availability of the services of primary care pediatricians, pediatric medical subspecialists, pediatric surgical specialists, developmental and behavioral service providers, care coordinators, and hospitals with appropriate pediatric expertise. Such services should be provided through the medical home, as defined by the AAP.

A medical home is not a building, but is defined as primary health care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. In a medical home, a pediatric clinician works in partnership with the family/patient to assure that all medical and non-medical needs of the patient are met. Through this partnership, the pediatric clinician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child/youth and family.

Cost Sharing

Access to affordable needed comprehensive health care benefits and services is vital to providing a safety net for low-income children and children with special health care needs. Existing cost

sharing protections ensure that children and pregnant women are not prevented from accessing needed health care services because of inability to pay. The pediatric community is highly concerned that changes to cost sharing policies would drastically and negatively affect the ability of children to obtain needed care.

We know from evidence – including two new reports from the Kaiser Family Foundation and the Center on Budget and Policy Priorities[4] – and past experience in states that have instituted cost sharing in other programs that it can prove to be a significant barrier to health care. While some nominal cost sharing requirements such as premiums or copayments may be appropriate for some populations, Medicaid must maintain the policy prohibiting cost sharing on all Medicaid benefits for children, particularly preventive services.

Adequate Medicaid Payment

The issue of low payment in Medicaid is one that has plagued the program for years. On average, Medicaid reimburses pediatricians at only 69% of the rate that would be paid under Medicare, and only 56% of commercial rates for an office visit.[5] In some states, Medicaid payment is even lower. Such low reimbursement impedes access to quality health care. Low Medicaid payments do not cover costs and increasingly force pediatricians to make difficult business decisions of continuing to treat patients at a financial loss, or limiting participation in the Medicaid program altogether. The lack of access for patients that is created then drives utilization to expensive sites such as emergency rooms. Moreover, low Medicaid reimbursement endangers the economic viability of "safety net" providers, fragmenting the care children in Medicaid receive.

While a number of states have taken steps to increase Medicaid reimbursement rates to match those of Medicare, most have not. Any discussion of restructuring Medicaid must include steps to appropriately reimburse physicians for the care they provide children under the Medicaid program.

Enhancing Quality and Controlling Costs in the Overall Health Care System

Pediatricians applaud efforts to enhance state Medicaid quality-improvement activities for children. Such quality improvement measures should include: quality-performance measures by states to address access to care, utilization, effectiveness, and satisfaction related to preventive, primary, acute and chronic care for children; appropriate incentives; uniform and consistent EPSDT reporting with minimal paperwork burden on providers; and use of the Consumer Assessment of Health Plan Survey (CAHPS) for a representative sample of children enrolled in state Medicaid programs, especially children with special health care needs.

There should also be programs to improve the quality of pediatric care as well as tools and measures to monitor changes, especially the provision of medical homes for children with special health care needs; updated meaningful provider-assessment and –certification activities; partnership with other state agencies such as Title V offices to support practice-level improvements in pediatric care; the monitoring of enrollment patterns and reasons for enrollment

changes; implementation of general administrative review processes to ensure managed care organizations and behavioral health organizations are qualified and available; and timely, linguistically appropriate, meaningful results of quality-related activities to beneficiaries to facilitate their participation in health care decision-making.

Improving Access to Home- and Community-Based Care

We strongly recommend that Medicaid maintain eligibility, coverage, and access for children with special health care needs through home- and community-based services waivers and Katie Beckett programs.

Improving Chronic Care Management

Children with special health care needs are a unique group of children in Medicaid, and require specific treatments and systems that address their exact needs. The pediatric community strongly recommends that care for children with special health care needs to be provided in a medical home. Moreover, states should develop policies that encourage care coordination with direct involvement by the primary care pediatrician within a medical home. Such care coordination links children with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and to provide them with optimal health care.

Care coordination is often complex and many barriers exist, but states, with federal support, should offer incentives to identify children with special health care needs and offer plan providers enhanced payments for providing a medical home, including family education, practice-based care coordination, and transition to adult care. States should also implement special planning and oversight of the use of managed care for children with special health care needs, including children in foster care and children with mental health conditions. This should cover benefit specifications for specialty or chronic care services, composition of pediatric provider networks, policies for flexible service authorization, care coordination, quality-performance measures for preventive care delivery for children with various types of chronic conditions, family participation, pediatric risk-adjustment mechanisms, and other financial incentives for high-quality care.

Comprehensive Waiver Reforms

The Academy understands the desire by states to streamline the process for obtaining waivers to federal Medicaid law, or for allowing changes to programs without the use of waivers. However, we are concerned with any proposal to allow for waivers or other changes to Medicaid without the appropriate input of all stakeholders in Medicaid, as well as safeguards to ensure that states do not unnecessarily deny care to children. In recent years with some state waiver proposals, we have seen a reluctance to provide full details of proposals initially. Moreover, in some instances, states have been hesitant to allow for the necessary feedback from all Medicaid stakeholders. It is therefore very important that any effort to allow for the streamlining of waivers or changes is

balanced with the need to provide minimum standards, adequate protections for health care for children, and appropriate input from all Medicaid constituents.

Judicial Reforms

Since the Medicaid program is a federal-state partnership, and states are the administrators of Medicaid, it is understandable that states require full operational authority over their Medicaid programs. However, it is critical that such programs meet the basic standards outlined by federal Medicaid law and that adequate protections for children are in place. Without the ability to seek enforcement of federal standards, federal Medicaid law in essence becomes a series of "suggestions." The legal system provides the only real recourse to seek enforcement when states drastically fall short of federal standards. This last safety net ensures that enrollees receive the care to which they are entitled under the program, and must not be compromised. While acknowledging the right of states to make operational changes, we do not feel that such changes should be allowed to break federal Medicaid law or fall short of federal standards set by Congress. The Academy therefore recommends that any proposal to restructure Medicaid does not impede in any way the ability of those involved in the program to seek assurances that children receive the care to which they are entitled, even through the courts when necessary.

Prescription Drug Improvements

While we understand the need to control the cost of prescription drugs in the Medicaid program, it is vital that efforts to control prescription drug spending are not simply placed on the backs of children. In federal fiscal year 2000, children represented 54.6% of all Medicaid enrollees, but accounted for only 22.9% of prescription drug expenditures in the program.[6] Children are not the drivers of prescription drug expenses in Medicaid. No prescription drug control should in any way limit the ability of a child to obtain the medication he or she needs, either through pharmacy benefit limitations, cost sharing, or any other means.

In closing, the American Academy of Pediatrics and the pediatric societies seek to ensure that any restructuring of Medicaid is done with the 27.8 million children the program serves foremost in mind. Together with the State Children's Health Insurance Program (SCHIP), Medicaid is this country's only and vital safety net for children. Medicaid provides health insurance to nearly one-third of children in the United States, and it is essential that any restructuring of Medicaid not undermine protections for them in the program. Children have no means of obtaining health insurance on their own – in those instances where children are eligible for Medicaid, it is their sole source of assuring their health. We must not compromise children's health in the name of reform.

This statement was endorsed by the Ambulatory Pediatric Association (APA), American Pediatric Society (APS), Association of Medical School Pediatric Department Chairs (AMSPDC), and Society for Pediatric Research (SPR), the Society for Adolescent Medicine (SAM). The pediatric societies represent pediatric researchers, full time academic and clinical faculty responsible for the training of pediatricians, and the leadership of medical school pediatric departments. The Society for Adolescent Medicine (SAM) includes over 1400

physicians, nurses, psychologists, social workers, nutritionists and others involved in service delivery, teaching or research on the health and welfare of adolescents.

Please consider us as resources throughout your discussions on Medicaid reform.

---

[1] Medicaid Statistical Reports (MSIS/2028 Reports) for Federal Fiscal Year 2002. *Centers for Medicare and Medicaid Services.*

[2] AAP 2002 Medicaid State Reports, based on CMS/MSIS2082 data. *American Academy of Pediatrics.*

[3] Hakim R, Bye B. Effectiveness of Compliance with Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries. *Pediatrics.* 2001; 108:90-97.; Hakim R, Ronsaville D. Effect of Compliance with Health Supervision Guidelines Among US Infants on Emergency Department Visits. *Archives of Pediatrics and Adolescent Medicine.* 2002; 156: 1015-1020.

[4] Ku L. The Effect of Increased Cost-Sharing in Medicaid: A Summary of the Findings. May 31, 2005. *Center on Budget and Policy Priorities.;* Artiga S, O'Mally M. Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences. May 2005. *Kaiser Commission on Medicaid and the Uninsured.*

[5] Zuckerman et al. Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation. *Health Affairs* Web Exclusive. June 23, 2004.; 2002 Pediatric Medical Cost Model. *American Academy of Pediatrics.*

AMERICAN ACADEMY OF PEDIATRICS

POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Committee on Child Health Financing

Medicaid Policy Statement

ABSTRACT. Medicaid is a vital safety net for children that must be maintained. It is the largest single insurer of children, yet millions of children who are eligible remain unenrolled. Every effort should be made to implement expanded eligibility and streamlined enrollment procedures. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits should be maintained for all eligible children. On average, Medicaid covers 30% of a pediatrician's patients, yet inadequate reimbursement affects children's access to care. States should increase reimbursement to at least parity with Medicare. ***Pediatrics*** **2005;116:000;** ***Medicaid, EPSDT, Medicaid managed care, eligibility, equal access.***

ABBREVIATIONS. AAP, American Academy of Pediatrics; SCHIP, State Children's Health Insurance Program; EPSDT, Early and Periodic Screening, Diagnosis, and Treatment; CMS, Centers for Medicare and Medicaid Services.

INTRODUCTION

Every child, regardless of health status, requires health insurance. Research has consistently shown the important role that health coverage plays in children's access to and use of health care services and attainment of positive health outcomes.[1] Medicaid is a vital component of the American health and social safety net, particularly for low-income children and children with special health care needs.[2] The entitlement to Medicaid should be protected to ensure the health and well-being of millions of children.

The American Academy of Pediatrics (AAP) recognizes the achievements of the Medicaid program in improving access to health care services for infants, children, adolescents, and young adults, hereafter referred to as children. The Medicaid program provides documented improvement in health care access, preventive visits, and having a usual source of care, resulting in improved health care outcomes and overall health status of children.[3–5] The AAP and its members have made a strong commitment to the Medicaid program. In general, pediatricians serve more Medicaid patients than do other primary care physicians.[6,7] On average, 30% of a pediatrician's patients are covered by Medicaid,[8] illustrating the commitment of pediatricians to ensure that Medicaid-insured children have access to a medical home.[9]

doi:10.1542/peds.2005-0891

The 1990s brought significant progress in expanding health care coverage for children younger than 21 years through Medicaid expansions and the creation of the State Children's Health Insurance Program (SCHIP). In 2000, annual Medicaid enrollment reached 24.2 million or 30.7% of infants, children, and adolescents younger than 21 years.[10] This enrollment represents an 8% increase in the proportion of children covered by Medicaid since 1993.[11] Between 2000 and 2002, Medicaid and SCHIP covered an additional 3.4 million children and kept the proportion of uninsured children constant (below 12%) even as employment-based coverage continued to drop.[12] Still, an estimated 9.2 million children 0 through 18 years of age were uninsured in 2002, of whom 4.1 million were eligible for Medicaid, 2.4 million were eligible for SCHIP programs, and 2.8 million were not eligible for either program.[10]

With the recent economic downturn, however, state and federal budget deficits threaten to undo gains just when demand for these programs is increasing. Not since World War II have states faced worse financial crises. States are confronting difficult decisions: whether to bypass entitled eligibility, limit outreach, restrict or eliminate benefits, cut provider payments, or alter policy through waivers. In 2003, all 50 states implemented cost-containment strategies, most of which were directed at adults.[13] Because parental insurance is a predictor of children's insurance status, decreasing the eligibility of adults will have a predictable negative effect on children's coverage. In the future, children are likely to be more affected by state Medicaid budget shortfalls.

At the federal level, major program reforms are also under consideration, including allowing states more flexibility in changing Medicaid rules and regulations without waivers, altering eligibility requirements, cutting benefits to optional Medicaid eligibility groups, implementing cost sharing, and offering capped funding allotments or block grants for acute and long-term care. Although children through 20 years of age represent 54% of all Medicaid enrollees, they account for only 23.5% of all Medicaid expenditures.[10] The demographic trend toward more elderly individuals requiring Medicaid long-term care support creates significant pressure on federal and state governments to contain costs. Consequently, state and federal cost-containment strategies targeting children are not likely to yield significant savings and, in fact, may result in far greater state

expenditures. Costs do not disappear when children are cut from or drop out of the Medicaid program as a result of cost-containment strategies. States may experience higher expenditures in areas such as primary clinics in public health departments, increased utilization of emergency departments, and an increase in the number of preventable hospitalizations. Other costs, which are more difficult to quantify, such as school absences for children and missed work for parents when children are sick as well as the adverse consequences of delayed treatment, are also likely.[14] The AAP, therefore, continues to maintain its strong support for the Medicaid program and offers a series of recommendations to support continued improvements. The following recommendations apply to all Medicaid programs, including fee-for-service, managed care, and prepaid programs unless otherwise specified.

ELIGIBILITY

The AAP recommends that states implement the following eligibility provisions to ensure coverage of all children eligible for Medicaid under federal legislation.

1. Maintain, or preferably extend, coverage under regular Medicaid and Medicaid-SCHIP programs to cover children up to a higher family income level.
2. Expand coverage of all low-income adolescents through 21 years of age.
3. Continue to take advantage of the flexibility provided by federal law to disregard certain income, assets, and resources so that eligibility levels for children are higher.
4. Maintain Medicaid eligibility, coverage, and access for children with special health care needs through home- and community-based services waivers* and Katie Beckett programs.‡
5. Adopt and maintain presumptive Medicaid eligibility policies for children who are presumed eligible for Medicaid on the basis of income to enroll temporarily and receive services, similar to the option available for pregnant women.
6. Streamline the eligibility determination process to simplify child enrollment and retention and to decrease administrative costs.[15]
7. Ensure that a redetermination of eligibility be made before disenrolling any children from Medicaid because of changes in their eligibility for cash assistance under the Temporary Assistance for Needy Families (TANF) program or the Supplemental Security Income (SSI) program.
8. Ensure that children who are removed from their homes by the state and placed in the foster care system are immediately enrolled in Medicaid.
9. Congress should pass the Family Opportunity Act, which would permit a Medicaid buy-in option for families with children who have chronic disabling conditions and who are not Medicaid eligible.
10. Implement the Medicaid option to cover youth exiting foster care on or after their 18th birthday.
11. Implement continuous Medicaid eligibility for children through 21 years of age with screening or evaluation only once during a 12-month period.

* Section 1915(c) of the Social Security Act allows federal Medicaid matching payments to be used for certain long-term care services that would otherwise not qualify. These home- and community-based services may be provided to Medicaid beneficiaries who, but for the provision of these services, would require the level of care provided in a hospital or nursing facility of an intermediate care facility.

‡ Section 1902(e)(3) of the Social Security Act, 42 USC 1396a(e)(3), allows states to provide Medicaid coverage to disabled children receiving medical care at home who would qualify for Medicaid if they were institutionalized.

OUTREACH, ENROLLMENT, AND RETENTION

The AAP recommends that states continue their important work to strengthen outreach, enrollment, and retention to ensure that all potentially eligible Medicaid recipients are enrolled in the program.

1. Eliminate means testing, enrollment caps, waiting lists, and requirements that applicants be uninsured for a period of time before enrollment in Medicaid programs.
2. Maintain or increase outreach efforts to reach families whose children are potentially eligible for Medicaid but not enrolled, including but not limited to legal immigrants, SCHIP-eligible children whose family income has changed, and privately insured children in low-income families.
3. Accept applications by mail, by phone, and online, replicating effective strategies of automatic enrollment piloted in Covering Kids initiatives.[16]
4. Continue to expand the use of multiple enrollment sites and "express-lane" eligibility determination, including hospitals, birth certificate clerks' offices, primary care offices, health care centers, emergency departments, urgent care centers, child care centers, Head Start programs, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs, schools, child care resources and referral agencies, and places of worship.
5. Extend automatic enrollment in Medicaid for children in families deemed eligible for Temporary Assistance for Needy Families, Supplemental Nutrition Program for Women, Infants, and Children, and food stamps.[17]
6. Coordinate Medicaid and SCHIP outreach and universal enrollment processes, including the use of common application forms that are short and written in easily understood language and translated into multiple languages.
7. Encourage and provide incentives for collaboration among enrollment entities, health care professionals, and health plans to improve effective communication and coordination to enroll eligible families and retain participating children.
8. Establish federal policy to prevent denial of citizenship because of previous receipt of Medicaid and any other health services.

BENEFITS AND COST SHARING

Medicaid benefits vary by state.[18] The AAP recommends that Medicaid continue to offer all eligible children the Early and Periodic Screening, Diagnosis,

and Treatment (EPSDT) benefit and all other mandatory and optional benefits. In addition:

1. Clearly specify the full scope of pediatric Medicaid benefits, including EPSDT, in consumer brochures, state plan documents, and managed care contracts. States should also inform families about Medicaid benefits excluded from managed care contracts and educate them on how to access these carved-out but covered services.
2. Encourage states to ensure that EPSDT, in combination with other mandatory and optional benefits, covers the benefits outlined in the AAP policy statement "Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years."[19]
3. Ensure that states' EPSDT periodicity schedules are consistent with the AAP periodicity schedule in "Recommendations for Preventive Pediatric Health Care"[20] and *Bright Futures*[21] and that immunization schedules are consistent with the recommended childhood and adolescent immunization schedule published annually by the AAP, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.[22]
4. Ensure that states' medical necessity definitions, consistent with EPSDT policy, are included in all consumer brochures, state plan documents, and managed care contracts. When making medical necessity determinations, state Medicaid agencies should consider whether health interventions for children assist in achieving, maintaining, or restoring health and functional capacity; are appropriate for age and developmental status; and will take into account the specific needs of the child.[23]
5. Encourage states to offer the full scope of pediatric Medicaid benefits, including EPSDT, for children under Section 1115 demonstration waivers and Health Insurance Flexibility and Accountability waivers.§
6. Promote parity of behavioral health benefits with medical benefits in insurance plans.[19]
7. Maintain the policy prohibiting cost sharing on all Medicaid benefits for children, particularly preventive services.

MANAGED CARE

In recent decades, fiscal and policy considerations have encouraged the use of managed health care delivery models for Medicaid programs. At present, nearly 52.2% of Medicaid beneficiaries receive their health care services through managed care plans.[24] The AAP recommends implementing the following safeguards to ensure that the federal government (through its policies) and states (through contracting with health plans, managed care organizations, primary care case management programs, and behavioral health plans) meet the health care needs of children.

1. Ensure that every effort is made by states for Medicaid beneficiaries to make timely and informed selections of managed care organizations and primary care clinicians. This effort includes providing sufficient education and support to consumers, such as face-to-face counselors to provide information on how to choose a health plan, how to access primary care and referral services and out-of-pocket plan benefits, and how to use appeal and grievance procedures.
2. Provide educational materials for families that are culturally sensitive and written at literacy levels and in languages used by Medicaid recipients. Quality-performance data should also be available from states and meaningful to Medicaid consumers. Consumer-education efforts must address the lack of resources, information, and training that prevents many consumers from being involved in advisory and oversight bodies.[25]
3. For Medicaid participants who do not choose and must be assigned to a managed care organization, use practical criteria to assign them, including current and previous relationships with primary care and specialty clinicians, location of clinicians, assignment of other family or household members, cultural and linguistic preferences, choices by other members in the service area, and capacity of managed care organizations to provide special care or services appropriate for children. Pediatricians should be considered primary care clinicians (not subspecialists), eligible to have children assigned to them in all default enrollment systems and state-based enrollment broker options. Every effort should be made to allow Medicaid patients to remain with their medical home.
4. Include in the provider network of all managed care organizations and fee-for-service programs[26] sufficient numbers of appropriately trained and board-eligible or board-certified providers of pediatric care, including primary, medical subspecialty, surgical specialty, and psychiatric pediatric care, or provide a network outside the plan. Physicians and other licensed providers of developmental, behavioral, and substance-abuse services should be accessible or available by referral from the primary care clinician to provide medically necessary services without restrictions from the managed care organization. In addition, Medicaid-eligible children should have access to children's mental health and substance-abuse services, oral health care, social work services, developmental evaluation services, occupational therapy services, physical therapy services, speech therapy and language services, school-linked clinic services, and other necessary public health services. The network should also include hospitals that specialize in the care of children in both inpatient and outpatient settings. In determining network adequacy, states should base de-

§ Section 1115 of the Social Security Act (42 USC 1315) allows states to waive compliance with any provision of Medicaid, in addition to other federal programs authorized by the Act, for any experimental, pilot, or demonstration project that would promote the objectives of the Medicaid program. A Health Insurance Flexibility and Accountability waiver allows states to cut benefit packages and increase cost sharing.

terminations on the number of Medicaid providers accepting all new Medicaid patients.
5. With federal support, states should offer incentives for managed care organizations, fee-for-service programs, and primary care case management programs to identify children with special health care needs and offer plan providers enhanced payments for providing a medical home, including family education, practice-based care coordination, and transition to adult care, for these children.
6. Require state coordination of care between Title V agencies and mental health agencies that serve Medicaid managed care beneficiaries.
7. Encourage states to implement special planning and oversight of the use of managed care for children with special health care needs, including children in foster care and children with mental health conditions. This should cover benefit specifications for specialty or chronic care services, composition of pediatric provider networks, policies for flexible service authorization, care coordination, quality-performance measures for preventive care delivery for children with various types of chronic conditions, family participation, pediatric risk-adjustment mechanisms, and other financial incentives for high-quality care.
8. Encourage states to select managed care organizations on the basis of their ability or demonstrated readiness to provide Medicaid-eligible children with quality care based on the use of quality-performance measures. Also, managed care organizations should be selected on the basis of their abilities to complement and coordinate services with existing maternal and child health programs to ensure maximum health benefits to families.
9. Streamline Medicaid administrative processes to create a minimal paperwork burden for physicians.

ACCESS TO PEDIATRIC SERVICES

The AAP recommends that the Centers for Medicare and Medicaid Services (CMS) and states focus new attention on the availability of and access to a wide range of pediatric services.

1. For all families with children, encourage the availability of medical homes that include access to primary care pediatricians, pediatric medical subspecialists, pediatric surgical specialists, developmental and behavioral service providers, care coordinators, and hospitals with appropriate pediatric expertise. Efforts should be made by state Medicaid agencies and managed care organizations to maintain established relationships of children with their primary care and specialty pediatricians to avoid disruptions in the continuity of care.
2. Ensure that behavioral health panels include mental health professionals with adequate training and experience in caring for children and adolescents.
3. Support the "prudent-layperson" standard‖ and oppose copayments for emergency care to allow timely access to emergency services.
4. Provide pediatric-appropriate medication formularies to provide quality care.
5. Support ongoing research to monitor the Medicaid participation rates of primary care and specialty pediatricians and to evaluate other aspects of access to and quality of care for children under Medicaid.

FINANCING AND REIMBURSEMENT

The AAP recommends that the CMS and state Medicaid agencies reexamine their reimbursement policies that are woefully inadequate for physicians who care for children. Adequate Medicaid reimbursement is necessary to achieve access. Low payment, capitation, and paperwork concerns all relate to low Medicaid participation by primary care office–based pediatricians, pediatric medical subspecialists and pediatric surgical specialists, mental health providers, and dentists.[27] State policy makers should address these 3 factors to ensure sufficient primary care physician capacity to appropriately serve children enrolled in Medicaid. States must pay primary care pediatricians and pediatric medical subspecialists and pediatric surgical specialists adequately so they can continue to provide and improve quality care for low-income children.

Federal and state policy makers and private managed care administrators should ensure appropriate levels of reimbursement and payment rates. All states should regularly review Medicaid reimbursement rates and raise them to at least parity with Medicare. Health care for children is relatively inexpensive when compared with that for adults. Moreover, cutting state funding for Medicaid means losing significant federal matching funds. Failure to invest adequately in the health of children today could have serious consequences for the populations of tomorrow.[28]

The AAP recommends that policy makers:

1. Increase the Federal Medical Assistance Percentage as necessary to provide critical fiscal relief to states and to maintain disproportionate share hospital payments.
2. Oppose the conversion of Medicaid financing to an annual allotment or block grant program with a fixed budget and oppose caps on federal Medicaid spending.
3. Enforce the federal equal-access provision requiring that state plans for medical assistance ensure that payments are "sufficient to enlist enough providers so that care and services are

‖ Section 4704 (b)(2)(C) of the Balanced Budget Act of 1997 (Public Law 105-33) defines the prudent-layperson standard as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."

available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[29] Strong evidence demonstrates that adequate reimbursement is a prerequisite for states to comply with federal law.

4. Require all states to increase Medicaid reimbursement rates to at least parity with Medicare.
5. Require all states to establish a process to review and update Medicaid provider payment rates on an annual basis.
6. Adjust payments for case-mix differences based on chronic conditions, a pediatric diagnostic classification system, or other risk-adjustment mechanism. Because pediatric risk-adjustment techniques are not well developed, contract provisions should be included to address carved-out services, outlier payment, reinsurance or shared-risk arrangements for individual children, and aggregate plan loss or profits.
7. All financing mechanisms should be sufficient to adequately fund the overall costs of caring for children eligible for Medicaid and should provide adequate reimbursement to physicians caring for these patients. New financing approaches should be piloted and evaluated with an analysis of the effect on children, their families, and their pediatricians before broad implementation. When states raise capitation rates, they should ensure funds are used by health plans to improve access, quality, and reimbursement of health services.
8. Eliminate barriers to pediatricians' reimbursement for the behavioral health services that they legitimately provide within their scope of skills as general pediatricians.
9. Provide Medicaid reimbursement for pediatrician-directed care coordination of children with special health care needs.
10. Provide Medicaid reimbursement for observation, rapid-treatment, and 23-hour units, day medicine services, and necessary interhospital transport services.
11. Adjust Medicaid reimbursement, including capitation payments, or create contingency funds to account for advances in pediatric care, including but not limited to new vaccines and new technologies. Timely adjustments to coverage and capitation rates reflecting these medical advances should be included in all state managed care contracts.
12. Adopt health plan reimbursement levels that value services to children. Encourage the CMS to obligate states contracting with managed care organizations to disclose their physician-payment methodologies and rates (whether fee-for-service or capitated) for each child eligibility group on an annual basis. The CMS should require states to make nonproprietary information easily available on request. The adequacy of Medicaid payments should be based on the true costs of delivering care and not on the commercial market rate, which may be inadequate.
13. Initiate a process to modify the resource-based relative-value scale for children to correct inequities pertaining to pediatrics. In particular, a system for the ongoing evaluation of expenses for practice overhead, including expenses specific to pediatrics, should be implemented.
14. Establish a National Medicaid Payment Advisory Commission and a national Medicaid utilization database with AAP representation to address the many child health services payment issues within the Medicaid program.
15. Encourage states to offer a provider-relations committee to address reimbursement issues.
16. Explore innovative methods to establish trust funds to support graduate medical education relevant to the provision of care for Medicaid participants and to ensure a qualified pediatric workforce.
17. Require the federal government to provide reimbursement for trained interpreter services for patients with limited English proficiency to decrease errors in medical interpretation and potential adverse clinical consequences.[30]

QUALITY-IMPROVEMENT ACTIVITIES

The AAP recommends enhancing state Medicaid quality-improvement activities for children, including those with special health care needs, in collaboration with state AAP chapters.

1. Implement quality-performance measures by states that address access to care, utilization, effectiveness, and satisfaction related to preventive, primary, acute, and chronic care for children. Such performance measures should be consistent with current pediatric practice parameters of the AAP.
2. Establish appropriate incentives from federal and state programs so that Medicaid plans and providers deliver high-quality services.
3. Ensure uniform and consistent EPSDT reporting with minimal paperwork burden on providers and a review process and compliance plan that is conducted by persons specifically trained in and practicing pediatrics. Educational and nonpunitive programs should be implemented to ensure effective and uniform EPSDT.
4. Conduct the Consumer Assessment of Health Plan Survey for a representative sample of children enrolled in state Medicaid programs, especially children with special health care needs, and the screener for parents of children with special health care needs. The Agency for Healthcare Research and Quality (AHRQ) and the National Committee for Quality Assurance should include pediatricians in updating the survey and the Health Employer Data and Information System (HEDIS). The AHRQ and other agencies should include pediatricians in establishing new quality-performance measures affecting children.
5. Federal and state agencies should work with the AAP to develop programs to improve the quality

of pediatric care as well as tools and measures to monitor changes, especially in the provision of medical homes for children with special health care needs.

6. States should update meaningful provider-assessment and -certification activities, including peer review, provider credentialing, medical record reviews, and timely analysis and reporting of findings to providers, plans, and beneficiaries.
7. Encourage Medicaid programs to partner with other state agencies such as Title V offices to support practice-level improvements in pediatric care, especially in providing a medical home for children with special health care needs.
8. States should monitor enrollment patterns and reasons for enrollment changes to ensure that managed care organizations do not encourage "high-cost" persons to switch to other plans and do not underserve Medicaid beneficiaries.
9. States should implement general administrative-review processes to ensure that managed care organizations and behavioral health organizations are qualified and available.
10. States should provide timely, linguistically appropriate, and meaningful results of quality-related activities to beneficiaries to facilitate their participation in health care decision-making.

COMMITTEE ON CHILD HEALTH FINANCING, 2003–2004
Thomas K. McInerny, MD, Chairperson
Charles J. Barone, II, MD
Jeffrey M. Brown, MD, MPH
Richard Lander, MD
*John R. Meurer, MD, MBA
Richard Y. Mitsunaga, MD
Mark S. Reuben, MD
Steven E. Wegner, MD, JD
Mark J. Werner, MD, CPE

CONSULTANT
Margaret McManus, MHS

STAFF
Jean Davis, MPP

** Lead author*

REFERENCES

1. Lewit EM, Bennett C, Behrman RE. Health insurance for children: analysis and recommendations. *Future Child.* 2003;13:5–29
2. Ku L, Nimalendran S. *Improving Children's Health: A Chartbook About the Roles of Medicaid and SCHIP.* Washington, DC: Center on Budget and Policy Priorities; 2004. Available at: www.cbpp.org/1-15-04health.htm. Accessed June 8, 2004
3. Inkelas M, Halfon N, Uyeda K, et al. *The Health of Young Children in California: Findings From the 2001 California Health Interview Survey.* Los Angeles and Sacramento, CA: UCLA Center for Health Policy Research and First 5 California; 2003. Available at: www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=71. Accessed June 8, 2004
4. Children Now. *California Report Card 2002.* Oakland, CA: Children Now; 2002
5. Centers for Medicare and Medicaid Services. *Program Information on Medicaid and State Children's Health Insurance Program (SCHIP).* Washington, DC: US Department of Health and Human Services; 2004. Available at: www.cms.hhs.gov/charts/Medicaid/infomedicaid_schip.pdf. Accessed June 28, 2004
6. Grumbach K, Hart LG, Mertz E, Coffman J, Palazzo L. Who is caring for the underserved? A comparison of primary care physicians and nonphysician clinicians in California and Washington. *Ann Fam Med.* 2003;1:97–104
7. Perloff JD, Kletke PR, Fossett JW, Banks S. Medicaid participation among urban primary care physicians. *Med Care.* 1997;35:142–157
8. Yudkowsky BK, Tang SF, Siston AM. *Pediatrician Participation in Medicaid/SCHIP. Survey of Fellows of the American Academy of Pediatrics, 2000.* Elk Grove Village, IL: American Academy of Pediatrics; 2000. Available at: www.aap.org/statelegislation/med-schip/USdpc.pdf. Accessed June 8, 2004
9. American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. *Pediatrics.* 2002;110:184–186
10. American Academy of Pediatrics, Division of Health Policy Research. *Children's Health Insurance.* Elk Grove Village, IL: American Academy of Pediatrics; 2003. Available at: www.aap.org/research/factsheet.pdf. Accessed May 3, 2005
11. American Academy of Pediatrics, Division of Health Policy Research. *FY 1993 Medicaid State Reports.* Elk Grove Village, IL: American Academy of Pediatrics; 1994
12. Cunningham PJ, Reschovsky JD, Hadley J. *SCHIP, Medicaid Expansions Lead to Shifts in Children's Coverage.* Washington, DC: Center for Studying Health System Change; 2002. Available at: www.hschange.com/CONTENT/508. Accessed June 8, 2004
13. Smith V, Ramesh RK, Gifford K, Ellis E, Wachino V. *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004. Results From a 50-State Survey.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2003. Available at: www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22126. Accessed June 8, 2004
14. Shirk C. *Tough Choices: A Policy Maker's Guide to Cost Containment Actions Affecting Children in Medicaid and SCHIP.* Portland, ME: National Academy for State Health Policy; 2004. Available at: www.nashp.org/Files/final_version_chip_23.pdf. Accessed June 8, 2004
15. Fairbrother G, Dutton MJ, Bachrach D, Newell KA, Boozang P, Cooper R. Costs of enrolling children in Medicaid and SCHIP. *Health Aff (Millwood).* 2004;23:237–243
16. O'Brien E, Mann C. *Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP.* Columbia, SC: Covering Kids and Families National Program Office; 2003. Available at: http://coveringkidsandfamilies.org/resources/index.php?InfoCenterID=178. Accessed June 8, 2004
17. Children's Partnership, Kaiser Commission on Medicaid and the Uninsured. *Putting Express Lane Eligibility Into Practice.* Santa Monica, CA: Children's Partnership; 2000. Available at: www.childrenspartnership.org/bbar/chealth.html. Accessed June 8, 2004
18. Kaiser Commission on Medicaid and the Uninsured. Medicaid benefits. Available at: www.kff.org/medicaidbenefits/index.cfm. Accessed June 28, 2004
19. American Academy of Pediatrics, Committee on Child Health Financing. Scope of health care benefits for newborns, infants, children, adolescents, and young adults through age 21 years. *Pediatrics.* 1997;100:1040–1041
20. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. Recommendations for preventive pediatric health care. *Pediatrics.* 2000;105:645–646
21. Green M, Palfrey JS, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.* 2nd ed. Arlington, VA: National Center for Education in Maternal and Child Health; 2000
22. American Academy of Pediatrics, Committee on Infectious Diseases, Advisory Committee on Immunization Practices, American Academy of Family Physicians. Recommended childhood and adolescent immunization schedule—United States, July–December 2004. *Pediatrics.* 2004;113:1448–1450
23. Berman S. A pediatric perspective on medical necessity. *Arch Pediatr Adolesc Med.* 1997;151:858–859
24. American Academy of Pediatrics, Division of Health Policy Research. *FY 2000 Medicaid State Reports.* Elk Grove Village, IL: American Academy of Pediatrics; 2002. Available at: www.aap.org/research/medic00.htm. Accessed June 28, 2004
25. Molnar C. Addressing challenges, creating opportunities: fostering consumer participation in Medicaid and Children's Health Insurance managed care programs. *J Ambul Care Manage.* 2001;24:61–67
26. Skaggs D, Clemens SM, Vitale MG, Femino JD, Kay RM. Access to

orthopedic care for children with Medicaid versus private insurance in California. *Pediatrics*. 2001;107:1405–1408
27. Berman S, Dolins J, Tang SF, Yudkowsky B. Factors that influence the willingness of private primary care pediatricians to accept more Medicaid patients. *Pediatrics*. 2002;110:239–248
28. Freed GL, Fant K. The impact of the "aging of America" on children. *Health Aff (Millwood)*. 2004;23:168–174
29. Omnibus Budget Reconciliation Act of 1989 (Pub L No. 101-239), §1396a(a)(30)(A)
30. Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 2003;111:6–14

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

Testimony Submitted on Behalf of the

American Congress of Community Supports and Employment Services (ACCSES)

and Disability Service Providers of America (DSPA)

Senate Finance Committee

The Future of Medicaid: Strategies for Strengthening American's Vital Safety-Net

June 15, 2005

Marc Kilmer, Executive Director/CEO
1875 Eye St., NW, 11th Floor
Washington, DC 20006
Phone: (202) 466-3355
Fax: (202) 466-7571
www.accses.org

John D. Kemp, CEO
1875 Eye St., NW, 12th Floor
Washington, DC 20006
Phone: (202) 429-6810
Fax: (202) 429-6813
www.dspofamerica.org

This testimony is being submitted on behalf of the American Congress of Community Supports and Employment Services (ACCSES) and the Disability Service Providers of America (DSPA). ACCSES and DSPA are national, nonprofit organizations of community rehabilitation providers committed to maximizing employment opportunities and independent living for individuals with mental and physical disabilities.

Medicaid plays a vital role in the professional life of the disability service provider as well as in the personal lives of the people we serve. Over the past several months, policy changes to Medicaid have appeared more and more imminent and ACCSES and DSPA recognize that there is room for improvement in the overall Medicaid funded system. Our members would like to take this opportunity to outline several principles and suggestions which we hope you will adopt during this important debate.

Importance of Medicaid for Individuals and their Families

The Medicaid program is the primary government program that serves the medical needs of people with disabilities. With services provided by Medicaid, many people with disabilities have the support necessary to hold jobs, live independently, and become taxpayers. Without the support provided by Medicaid, these individuals would lose their jobs and would still be in of need medical services. Cuts would simply shift people with disabilities into more expensive government programs or take them off the tax rolls, will generating no savings in overall government spending.

It is also important to consider the importance of Medicaid on families of people with disabilities. For example, without the supports provided by Medicaid for a person with a disability, a family member will often have to stay at home and care for this person. This is devastating on low-income families. With Medicaid services providing a measure of independence for a person with a disability, there is no need for a family member to forgo a job to care for that person.

Due to examples such as these, we urge you to consider the positive impact of the Medicaid program on the individuals and families it serves as you discuss reductions in Medicaid spending. We also urge you to consider the financial ramifications that could

result from cutting services to people who use Medicaid to provide support services that allow them to work and live independently.

Maintaining the Entitlement to Medicaid

Despite questions about its efficiency, Medicaid is an extremely successful public program. By providing health care coverage and disability services to over 52 million low-income people, the program allows individuals to obtain critical medications and devices, physician services, mental health care services, and home-health care services. Over the past several years Medicaid costs have increased as a result of rising enrollment and increased utilization of these services. While many see such spending increases as a cause for great concern, our members would argue that such escalation reflects the effective and responsive nature of the program. As health care costs continue to grow rapidly and the economy continues to wane in some areas of the country, more individuals are being forced to access safety-net programs, such as Medicaid, in order to obtain acute and long-term care services they cannot afford or access through the private market.

Much of Medicaid's success can be attributed to the program's unique federal-state financing partnership. The financing of Medicaid allows states to effectively respond to changes in demographics, emergencies, and economic downturns. Additionally, the guaranteed federal contribution encourages states to expand services to individuals, such as those with physical and cognitive disabilities, who are not required to be covered under the Medicaid statute. However, over the past several years, there has been increasing support for removing the entitlement of Medicaid in exchange for capped federal funding.

DSPA and ACCSES remain very much opposed to capping or block-granting the federal government's Medicaid contribution. Such attempts to control federal Medicaid spending would only succeed in denying Medicaid services to some of these states' most needy individuals. Additionally, caps would place an increased burden on already financially strapped states, creating a disincentive to provide comprehensive and vital services.

"Optional" Services and Populations

Recipient populations are considered eligible for Medicaid coverage as either "mandatory" or "optional." For example, people with disabilities who qualify for Supplemental Security Income (SSI) (having a monthly income below $579 for 2005 or about 75% of the Federal Poverty Line) are considered a mandatory population under Medicaid, however, many states provide coverage to people with disabilities up to and above the federal poverty line as optional populations.

The Federal government also mandates that states provide certain services to Medicaid recipients. These services include physician services, inpatient hospital services, nursing home care, and homes health services (including durable medical equipment) for those eligible for nursing home care. States may also choose to provide a number of optional services to Medicaid recipients including prescription drug coverage, emergency hospital services, diagnostic services, personal care services, rehabilitative services, case management services, durable medical equipment and intermediate care facility services for the mentally retarded (ICF/MR). Optional services and populations allow states an important form of flexibility. Just as the federal financing guarantee allows states to navigate different economic, demographic and emergency situations, Medicaid "options" allow individual states the ability to effectively serve their neediest populations.

Unfortunately, during the past several months there has been a great deal of discussion involving optional populations and services, including implicit suggestions by the Bush Administration that such services and populations are targets for potential cuts. The members of ACCSES and DSPA believe that it is extremely important to clarify that the term "optional" is a misnomer. Particularly for low-income individuals with disabilities, Medicaid services can be a matter of life or death; independence or institutionalization. What the Medicaid program refers to as "optional" services are often vital disability-related services. It is difficult to argue that a low-income 30 year-old male with severe schizophrenia can do without his daily medications or a 50 year-old female with cerebral palsy making $15,000 per year can afford her home-health services and wheelchair on her own. Yet, if "optional" populations and services were to face cuts,

state would be forced to deny Medicaid coverage to some of the country's neediest individuals.

Removing the Institutional Bias/ Promoting Home and Community Based Services

Historically, people with disabilities have been regarded as incapable of participating in most activities of daily life and thus best served in institutions such as nursing homes or other restrictive environments. However, today we recognize such thinking as archaic and know that many people with disabilities are capable of working, going to school, and fully participating in their communities, often with the assistance of accredited or licensed community service providers, home care providers, job coaches or perhaps personal assistance services. There is strong desire by people with disabilities to live independently in their homes but, unfortunately, Medicaid has not changed to completely reflect this way of thinking.

An institutional bias exists in the Medicaid program as nursing home care remains a mandatory service under Medicaid, while home and community based services (HCBS) are most commonly offered under a "waiver" program. In 2002, 70 percent of Medicaid funding for long-term supports and services was spent on institutional care, whereas only 30 percent of such funding was spent on home and community based supports and services or non-institutional care.

Additionally, Medicaid has not made a commitment to attract highly qualified community providers by offering a competitive rate of reimbursement for their services. This provider shortage will be further discussed later in this testimony but is a major factor in the institutional bias that plagues the Medicaid program.

In 1999, the U.S. Supreme Court ruling in *Olmstead v. L.C.* found that unnecessary institutionalization is prohibited by federal law. The court stated that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment" (*Olmstead v. L.C.*, 521 U.S. 581, 119 S.St.2176). The Olmstead decision has served as a vehicle for change and many states have taken steps toward implementing this important ruling. But much work remains to be done.

The 1915 (c) waiver authority is currently allowing many states to offer home and community based services through the Medicaid program. Under the waiver authority, states are allowed to provide services not usually covered by the Medicaid program if these services are required to keep a person from being institutionalized. Case management, day training, homemaker, home health aide, personal care, adult day health, habilitation, and respite care are included as options under this waiver authority.

Our members support and encourage states to continue to use the 1915 (c) waivers to offer such services. However, we also support the passage of legislation such as the "Medicaid Community-Based Attendant Services and Supports Act (MiCASSA)" and the "Money Follows the Person Act." Such legislation would make it a requirement, rather than an "option," to offer home and community based services to those individuals that desire home care rather than institutional living.

MiCASSA would require that Medicaid offer individuals who are eligible for nursing home care or ICF/MRs the choice as to where their services would be provided – in an institutional setting or in the community and administrated by community service providers. The "Money Follows the Person Act" would create a demonstration project under the Medicaid program where Medicaid dollars would follow a person with a disability from an institution into the community setting.

Long-term care in the home setting is not only attractive in terms of modernizing the program, but is also a way to rein in long-term care spending. For some populations, home and community based services reduce per capita spending on individuals in need of long term care who would otherwise be institutionalized. Additionally, those being provided care in the home setting are able to maintain a greater level of independence and community integration. Such individuals are more likely to remain healthy and some are even able to return to work or school.

As the disability community continues to appeal for long-term care options in their homes and communities, the members of DSPA and ACCSES support permanent changes in the Medicaid system that would reflect this positive shift in demand.

Strengthening the Role of the Provider

Over the past few years, there has been increased attention on the workforce issues faced by private providers and their inability to attract and retain qualified, direct-support staff. It has become increasingly clear that one of the causes of this problem is directly related to insufficient Medicaid payments for wages and other benefits.

Many of the community rehabilitation providers, such as those represented by DSPA and ACCSES, rely heavily on Medicaid reimbursement. However, Medicaid reimbursement has not kept pace with the costs of providing services as well as the demand for such services. In fact, Medicaid usually offers the lowest reimbursement in the system (lower than Medicare or private insurers). In 2000, the median earnings of personal and home care aides were only $7.50 per hour.

The impact of such low reimbursement precipitates many of the other workforce related problems in the Medicaid long-term care system. For example, the wage crisis is a key factor in the high staff turnover rates among private providers. Because of low-wages, many well-trained individuals cannot afford to stay in the industry. In turn, the quality of long-term care services is compromised and the continuum of care is often interrupted. Additionally, provider organizations are regularly faced with considerable recruitment and training costs.

In March of this year, Representatives Lee Terry (R-NE) and Lois Capps (D-CA) introduced the *Direct Support Professionals Fairness and Security Act of 2005* (H.R. 1264). H.R. 1264 would amend the Medicaid statute to provide funds to states to enable them to include additional federal funding to providers to increase the wages paid to direct support professionals who support certain individuals with disabilities through targeted state Medicaid services. The members of DSPA and ACCSES would like to express their support for this important piece of legislation and urge adoption of it in the reconciliation process.

Medicaid reimbursement rates fail to reflect the vital role that providers play in Medicaid's long-term care system. Providers, such as the members of ACCSES and DSPA, are often a locus of knowledge when it comes to the utilization of services for individuals with disabilities as well as the administrative hurdles inherent in the Medicaid program. We are aware that administrative costs are being targeted as a way to reduce

Medicaid spending and the members of our organizations would welcome such discussions. We believe that the provider is central to the efficiency of long-term care delivery and encourage Members of Congress to include disability service providers in the conversations on administrative costs and delivery of services.

Policy Improvement Should Drive Medicaid Reform

The members of DSPA and ACCSES recognize that changes to the Medicaid program are imminent in the coming years and are supportive of meaningful changes that will improve the quality and efficiency of services. However, our members are concerned that current policy discussions are being driven by numerical budget objectives.

Medicaid's fiscal problems are not unique to the program, but rather reflective of a larger problem – ever-increasing health care costs. In fact, Medicaid costs are increasing at a lower rate than health care costs as a whole, and lower than the costs of health care insurance purchased by employers and individuals. As the overall cost of health care increases Medicaid expenditures, the inability of many employers to offer comprehensive health care to their employees swells Medicaid enrollment. People with disabilities receive Medicaid not because they want to, but because the private system has failed them. As this Committee and the full Senate discuss changes to the Medicaid system, we encourage you to consider that the increasing costs in Medicaid are simply a side-effect of a greater problem in need of Congressional attention. Cuts to the Medicaid program will in no way solve the real crisis that our health care system currently faces; million of uninsured and steep annual increases in the cost of health care.

Many are supportive of Medicaid cuts under the assumption that they represent minor reductions in the growth rate of the Medicaid program and are necessary in order to curtail federal spending on domestic programs. These cuts may represent small numbers relative to a multi-trillion dollar budget, but to the recipients who will feel their impact, the loss of Medicaid coverage is in no way minor.

Furthermore, restraining Medicaid spending does not reduce the number of low-income individuals and people with disabilities who need services. For individuals with disabilities, health care coverage is a daily necessity used to maintain one's health and

independence. Therefore, cuts to the Medicaid program will likely increase the number of individuals with acute care needs as their daily continuum of care is interrupted. Should such cuts be implemented, we will undoubtedly witness increases in utilization of community clinics, emergency room visits, greater dependence on other federal programs as people are unable to return to work, and even a return to institutionalization for many individuals with disabilities.

Conclusion

The members of ACCSES and DSPA oppose any changes to the Medicaid program that will threaten the availability of services to Medicaid recipients, especially those with disabilities. However, we do support meaningful changes to the Medicaid program that will result in improvements in the delivery of services, reductions in administrative obstacles, and improved efficiency in the program. We hope that you will include members of the Medicaid community, both consumers and providers, in the coming discussions on changes to the Medicaid program.

We thank you for this opportunity to submit testimony and encourage you to contact us with any questions you may have.

WRITTEN TESTIMONY
Of
Hal Daub

President and CEO of the American Health Care Association (AHCA) &
The National Center for Assisted Living (NCAL)

For the U.S. Senate Finance Hearing
"The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net"

June 15, 2005

On behalf of the American Health Care Association (AHCA) and National Centers for Assisted Living (NCAL), we thank Chairman Grassley and Ranking Member Baucus -- and every member of the Senate Finance Committee -- for conducting this hearing on the future of our Medicaid program, and how we will go about strengthening the healthcare safety net for our nation's frail, elderly and disabled seniors.

This hearing is important and timely – not just because of the budget and healthcare policy implications, but because the decisions that are ultimately made regarding necessary, comprehensive reform will have far-reaching implications on the lives of nearly every American.

Despite the obvious complexities associated with the topic at hand, the debate centers on five central elements of the health care equation: quality, choice, access, accountability and appropriate investment in care.

Regardless of the inevitable differences in reform plans put forward by the National Governors Association, the Medicaid Commission chaired by HHS Secretary Leavitt and others, we must ultimately determine how best to transform and improve the current fragmentary framework of long term care -- making it more integrated, efficient, affordable and quality-driven throughout the entire care spectrum.

Before outlining specific proposals to strengthen Medicaid for the longer term, we believe it is essential to address the growing importance and utilization of home and community based care services (HCBS) throughout America.

At the state level, expansion of HCBS care is among the most significant developments in the context of budgets as well as overall policy, and no discussion of Medicaid reform is complete without a thorough, unemotional, objective discussion of its benefits and liabilities.

In an attempt to grant more flexibility to states, President Bush has proposed decreasing or eliminating hurdles that states currently face in obtaining approval for their home and community based services (HCBS) waivers. The stated purpose of the waiver is to help curb state spending, while also providing more choices to seniors and people with disabilities. Similarly, the NGA also supports improving access to home and community based care, both for better outcomes and for greater efficiencies.

Obviously, this has enormous appeal for state policy makers of both parties attempting to reign in Medicaid costs while simultaneously improving seniors' and people with disabilities quality of life. Every one of us today can agree we would prefer to reside in our homes for the rest of our lives – and forego a move to a long term care facility.

But we are troubled by the development of a well meaning, yet factually unfounded, mindset among elected officials, seniors' and disability advocacy groups and the media that the simple answer to lower Medicaid costs and higher care quality will be found by rapidly shifting a significant population of seniors and people with disabilities out of facilities like nursing homes and intermediate care facilities for persons with mental retardation to home and community care settings.

While AHCA/NCAL always has and always will favor individuals being able to receive necessary long term care services in the most appropriate setting, we are concerned that efforts to ostensibly "save" money may not serve that purpose and may drain essential funds away from care to seniors and persons with disabilities who require the services provided in nursing home settings.

Not only is there very little empirical evidence to suggest the budget "savings" from HCBS expansion is a reality, there is very little evidence to suggest that increased HCBS use is offset by decreased nursing home use. In fact, the claims of budgetary savings may mask added costs in other areas of the budget. An important study conducted by Joshua M. Wiener of The Urban Institute entitled, "Can Medicaid Long-term Care Expenditures for the Elderly Be Reduced? (The Gerontologist Vol. 36, No.6 1996) stated the following:

> "The most persistent dream in long term care is that the expansion of home care and other nonmedicalized residential long-term care services could reduce overall long-term care expenditures. The fundamental hope has been that lower-cost home care could replace more expensive nursing home care. However, there is substantial, rigorous research to suggest that expanding home care is more likely to increase rather than decrease total long-term care costs (Kane & Kane, 1987; Kemper, Applebaum, & Harrigan, 1987; Weissert, Cready, & Pawelak, 1988; Wiener & Hanley, 1992). Older person's aversion to nursing homes explains this increase. Given a choice between nursing home care and no formal services, many elderly people will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset relatively small reductions in nursing home use."

This same study found that three states that are pioneers in the expansion of home and community based services actually saw increases greater than the national average in their long term care programs during the time they reorganized their long term care delivery system. According to Wiener, "both Oregon and Washington had rates of increase in Medicaid long-term care expenditures that were substantially greater than for the United States as a whole." Wisconsin, according to Wiener, did have "a much lower rate of increase, but much of its home and community based services are financed outside of the Medicaid program." The case in Wisconsin demonstrates that the claims of budgetary savings may mask added costs in other areas of the budget. For example, while cost per beneficiary may appear to be lower, costs in other programs may rise to provide additional payments for services already included in nursing home rates -- like housing, meals and social services.

To be clear, AHCA/NCAL supports the expansion of home and community based care. We support an adequately funded, comprehensive, national strategy that ensures that appropriate supports and services are provided in appropriate settings to qualified individuals who are aging and/or have disabilities. We are concerned that a rush to expand these services because they create efficiencies will not provide savings and may siphon funds from those who need 24-hour facility based care.

Moreover, as the fastest growing population of seniors is those eighty and older, now is the time to be *strengthening* our facility-based care infrastructure -- not *divesting* in our capacity to care for patients who will live longer and require higher acuity care. The nursing home of today is treating higher acuity individuals and the infrastructure has not kept up with that demand. Most nursing homes around the country have aging buildings and they need upgrades to their infrastructure to keep up with technology and the needs and choices of today's patients, such as private rooms. We may need less nursing home beds in the future, but we need more technology and physical plant changes to ensure the safest environment and the highest quality of life for patients and residents. Now is not the time to divert funds from facility care. Rather we should provide incentives to make changes that better serve seniors and people with disabilities who need 24–hour care in a facility.

We are also concerned that the quality, safety and training standards inherent in facility care are not extended to the increasingly diverse array of settings we see in states across the nation. This concern was cited by the General Accounting Office (GAO), which warned in a study entitled, "Long Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should be Strengthened." Released in July of 2003, the report issues concern in three primary areas:

- Trends in states' use of Medicaid home and community-based service (HCBS) waivers, particularly for the elderly;
- State quality assurance approaches, including available data on the quality of care provided to elderly individuals through waivers; and
- The adequacy of federal oversight of state waivers.

Comparatively, new federal data from HHS released just six months ago indicates care quality in nursing homes throughout America is improving in important, fundamental ways.

The refrain from HCBS advocates is that "money should follow the person." Under the proper policy framework, we concur – but we also believe "quality care should follow the person" – and this must be addressed under any broader Medicaid reform plan. Facility-based care and home and community based care are not, as some seem to think, mutually exclusive. They are, in fact, complementary – and the challenge is to apportion funding in a manner that reflects reality.

Providing seniors and people with disabilities with maximum choice and flexibility should always be the mission of government and providers when it comes to delivering quality health care services, in all long term care settings. But as consumers benefit from more diversity, we must also ensure costs are what they claim to be, and that care quality is ensured across all settings.

This is an open question in every state, and we encourage Governors Huckabee, Warner and all of our elected state and federal lawmakers to examine the HCBS Medicaid waiver program far more closely – for the benefit of senior and taxpayer alike.

AHCA/NCAL supports other reforms put forward by the NGA. Proposals such as transfer of asset policy, tax credits and tax deductions for long term care insurance, the continuing the Robert Wood Johnson Partnership Plan and especially encouraging citizens to plan for their long term care needs and, therefore, injecting more private dollars into the nation's long term care system.

Over the past several months, AHCA/NCAL has also outlined necessary reforms that will help empower individuals to take more control of financing their long term care needs – and this is central to strengthening Medicaid. We have long recognized that our nation has a patch-work system for funding long term care and this will soon become unsustainable as 77 million baby boomers rapidly move toward their retirement years.

AHCA/NCAL is a staunch, longtime advocate of tax incentives for the purchase of long term care insurance, and we are pleased President Bush has put forward several concepts in his budget centered on promoting personal responsibility, and individual planning for one's long term care needs.

Specifically, we support the NGA's Medicaid reform policy in these areas:

Medicaid Estate Planning

Medicaid was never intended to become the nation's primary long term care financing program and is not sustainable if the baby boom generation uses it as such. While we must preserve Medicaid as a safety net program, we must also take steps to encourage people who are able to otherwise fund their own long term care.

Medicaid is a means-tested public assistance program. However, the eligibility rules and the statutory prohibition on asset transfer have not apparently achieved the desired end of care for the truly eligible for at least two major reasons: first, the prohibition itself is not adequate; and, second, the apparent proliferation of Medicaid estate planning techniques that circumvent the prohibition.

The situation results in the inappropriate use of state Medicaid funds for individuals who should not qualify for such public assistance and the concomitant lack of funds for appropriate reimbursement to providers for care of the truly needy. Thus, both the state and Medicaid providers such as nursing facilities are negatively impacted.

The problem for nursing facilities is exacerbated by state rules that delay and then often deny payment to nursing facilities -- due to various reasons including asset transfers that have violated the Medicaid statute, until the state process -- often long and drawn out -- for determining an individual's eligibility has been completed. Some states have sought to change the date on which penalty periods resulting from improper asset transfer begin. In these cases, a nursing home may admit an individual as a private paying resident, will receive private funds for the cost of care until such funds run out and the penalty period begins, and then will continue caring for the individual when there is no source of payment. Such a period could last many months. Nursing homes will have no option due to a combination of law and reality other than to absorb the cost of care of these residents. Federal law prohibits nursing homes from requiring a third-party guarantee of payment upon admission; thus, there is no other party to turn to. Surely, nursing homes were not intended to provide the entire cost of care while this is settled.

AHCA/NCAL supports additional policy and efforts that both help states retain Medicaid funds for the truly needy and help providers to receive reimbursement for care that has been provided.

On the state level, the look back period is one of the weakest links in the asset transfer law and should be lengthened. In addition, a variety of Medicaid estate planning mechanisms -- trusts and annuities, for example -- have been developed to circumvent the legislative asset transfer rules. These permit middle to higher income individuals to make funds disappear through asset transfer and conversion, which could and should be used to support them when they need long term care services.

Thus, AHCA/NCAL supports the following policy positions aimed at assisting states and providers to preserve Medicaid funds for those truly in need:

- Support Section 1115 waiver applications to increase the look back period from 3 to 5 years but leave the starting date of the penalty period as currently provided in law, and close the loopholes in law that enable individuals to use Medicaid estate planning techniques to circumvent asset transfer prohibition and eligibility rules;

- Eliminate the regulatory prohibition on a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility; and

- Change the state policy and process for determining eligibility of individuals for Medicaid so that exposure to inappropriate loss of payment for the facility is eliminated or minimized. The President's FY 2005 budget included a proposal to establish a State Medicaid option allowing presumptive eligibility for institutionally-qualified individuals who are discharged from hospitals into the community.

We argue that presumptive eligibility should apply to all provider categories so that availability of the presumption would not skew an individual's choice of care site, which should be driven by clinical considerations.

However, at a minimum, the facility provider should be held harmless in the event that Medicaid eligibility is denied due to an asset transfer that violates Medicaid law, i.e., there is no recoupment of state payment that had been made to the provider by the state.

The state, in effect, pays the provider and assumes responsibility for recouping the money from the beneficiary; and the state must make an eligibility decision within 30 days of the application of the resident and facilitate discharge and relocation of the individual if reimbursement is denied.

If the state takes longer than 30 days to make a decision, payment is guaranteed to the provider so long as the provider must furnish services to the individual.

State Partnership Long Term Care Insurance Programs

AHCA/NCAL supports the Robert Wood Johnson Long Term Care Partnership program that, beginning in 1991, allowed states (Connecticut, New York, Indiana and California) to provide individuals dollar for dollar or full asset protection against Medicaid spend-down eligibility requirements when buying a qualifying partnership policy.

While critics of this program point to limited success, we believe it is significant in that it delays one's reliance on the Medicaid program. More importantly, utilizing a long term care policy affords the consumer more choice in care settings than Medicaid, which primarily pays for nursing home care.

We understand that results from this program are not overwhelming but it is important to note that less than 100 people have utilized Medicaid during the 11 years of the life of the program, according to the National Association of Health Underwriters. We support repeal of the provision that stopped expansion of this program. We would like to work with this Committee to expand the use of long term care insurance by eliminating the ban on the Long Term Care State Partnership programs.

Tax Incentives to Encourage the Purchase of Long Term Care Insurance

In recent congressional sessions, legislative efforts to expand the utilization of insurance through tax incentives have found growing support. In addition to tax credits, AHCA/NCAL has supported an "above-the-line" deduction to make the deduction available to a maximum number of Americans.

We continue to support such measures today but recognize that the cost to the federal government has been a hurdle for congressional passage of the legislation. Although he has supported it in the past, we were disappointed that the President did not include a similar provision in this year's budget. Such solutions must allow the nation and its citizens' to move beyond today's pay-as-you-go financing system to one that encourages, supports and protects individuals who choose to plan for their own long term care needs through private insurance and other financial means.

Home Equity Conversion and Other Resources

Other proposals being advanced involve home equity conversion, long term care annuities and inclusion of long term care policies in cafeteria plans. While encouraging citizens to utilize long term care insurance alone won't save the Medicaid program from collapse -- these and family caregiver exemptions and credits are all elements that could be combined with the Robert Wood Johnson Long Term Care Partnership into a comprehensive national long term care policy.

Home equity conversions such as reverse mortgages are particularly intriguing. According to the National Council on the Aging, 48% of America's 13.2 million households age 62 and older could utilize $72,128 on average from reverse mortgages. The value is that these funds are available immediately and could go a long way to pay for help at home and for retrofitting the home to make it safer and more comfortable. These funds could also be used to purchase long term care insurance, or for assisted living or nursing home care for an ill spouse while the well spouse remained in the family home. We are aware of the limitations in utilizing reverse mortgages to fund long term care expenses. Despite the current limitations, the equity that many seniors possess could help them tremendously with their needs and their desire to remain in their homes. We would like to work with Congress to find creative ways to help seniors tap into this resource.

Medicaid Ripe for Reform

For all of the positions stated above and others, AHCA/NCAL supports reform of the Medicaid long term care system – and we seek to work with you to design a model that allows more choice for seniors and people with disabilities, and that injects more private dollars into the long term care system.

Demographic realities require a change in policy and a transformation in thinking. We must fundamentally shift the role of government – from government simply paying for services to government helping individuals save and plan for their own long term care needs, while still preserving the Medicaid program as a safety net for those who truly need it...

As we work to strengthen every citizens' future ability to prepare for their retirement, we urge this Committee to further investigate and address the issues we have discussed today.

Thank you, Mr. Chairman, for the opportunity to submit our testimony, and we look forward to working productively and cooperatively with this Committee to help strengthen retirement security for every American.

#######

ACAP

Association for Community Affiliated Plans

2001 L Street, NW, 2nd Floor · Washington, DC 20036 · ph: 202.331.4601 · fax: 202.296.3526

Statement of Margaret A. Murray, Executive Director, on the Senate Finance Committee's Hearing Entitled "The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net"
June 15, 2005

The Association for Community Affiliated Plans (ACAP) is pleased to submit this statement for the record to the Senate Finance Committee on the topic of the hearing entitled The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net.

ACAP represents 19 Medicaid-focused managed care plans that serve over two million Medicaid beneficiaries in states across the country. The mission of our organization is to improve the health of vulnerable populations through the support of Medicaid-focused community-affiliated health plans committed to these populations and the providers who serve them.

ACAP plans have long experience in helping states organize their Medicaid programs and controlling the costs of services. Our plans have expertise in providing quality care for children and families. Several states currently have or are in the process of exploring expansions of Medicaid managed care because plans such as ours are uniquely positioned to build on their experience to address the complex and challenging health care problems experienced by elderly and disabled Medicaid enrollees. Our plans also bring a value-added benefit in terms of the economic impact for the communities in which they are located; ACAP plans directly employ, on average, over two hundred people with several of our plans employing more than six hundred people.

Medicaid managed care plans have been found to save State and Federal governments from between 2 and 19% over unmanaged fee-for-service Medicaid. Medicaid managed care has generated significant savings for government payers for all populations, but particularly for Supplemental Security Income (SSI) and SSI-related populations. In addition, Medicaid managed care yields significant savings in pharmacy costs and decreased utilization of more costly inpatient services. In fact, most states incorporate some level of managed care in their Medicaid programs and many are expanding managed care to new geographic regions, populations and services.

For Medicaid beneficiaries, enrollment in Medicaid managed care plans means improved quality of, access to, and continuity of care. ACAP plans and similar Medicaid-focused plans improve the quality of care delivered to Medicaid beneficiaries by producing more quality improvement initiatives and measurement programs than either primary care case-management programs (PCCM) or traditional fee-for-service Medicaid.

The decisions made by the Finance Committee and your colleagues will have a lasting impact on the Medicaid program. ACAP believes that any reform to this program should be thoughtfully considered and that policies changing Medicaid should be driven by the long-term needs of the program, and not only to meet budgetary limitations. Tens of millions of Americans rely on

ACAP

Association for Community Affiliated Plans

2001 L Street, NW, 2nd Floor · Washington, DC 20036 · ph: 202.331.4601 · fax: 202.296.3526

Medicaid to receive health care services and budget-driven policy can mean cuts in needed benefits and some beneficiaries losing the coverage they need.

ACAP supports a deliberative process to examine the issues in the Medicaid program. We are prepared to work with federal and state policymakers to offer proven, common-sense solutions to improving the quality of health care while keeping costs down.

As such, ACAP is pleased to note the National Governors' Association's support of giving Medicaid health plans direct access to the Medicaid drug rebate. Created by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to have a rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. At the time the law was enacted, managed care organizations were excluded from access to the drug rebate program. In 1990, only 2.8 million people were enrolled in Medicaid managed care and so the savings lost by the carve-out were relatively small. Today, *12 million people are enrolled in capitated managed care plans.*

Under the drug rebate, States receive between 18 and 20% discount on brand name drug prices and between 10 and 11% for generic drug prices. At the time the rebate was enacted, many of the plans in Medicaid were large commercial plans who believed that they could get better discounts than the federal rebate. Today, Medicaid-focused plans are the fastest growing sector in Medicaid managed care. According to a study by the Lewin Group, Medicaid-focused MCOs typically only receive about a 6% discount on brand name drugs and no discount on generics. **Because many MCOs (particularly smaller Medicaid-focused MCOs) do not have the capacity to negotiate deeper discounts with drug companies, Medicaid is overpaying for prescription drugs for enrollees in Medicaid health plans.**

The Lewin Group estimates that this proposal could save up to $2 billion over 10 years. This legislation has been endorsed by organizations representing both state government and the managed care industry, including the National Association of State Medicaid Directors, the Association for Community Affiliated Plans, Medicaid Health Plans of America, the National Association of Community Health Centers, and now, the National Governors Association.

As Congress is forced to make tough choices to control the costs of the Medicaid program, this proposal offers a "no-harm" option to control costs and ensure that there is not a prima facie pharmacy cost disadvantage to states using managed care as a cost effective alternative to Medicaid fee-for-service. We urge Congress to implement it as part of any Medicaid reform proposal that moves forward.

STATEMENT OF THE BI-STATE PRIMARY CARE ASSOCIATION

TESS STACK KUENNING, EXECUTIVE DIRECTOR

Bi-State Primary Care Association is a private, non-profit organization with a broad membership of nearly forty organizations in Vermont and New Hampshire that provide and/or support community-based primary care services. A "voice" for the medically underserved, Bi-State members include Community Health Centers, rural health clinics, private and hospital-supported primary care practices, health care for the homeless programs, clinics for the uninsured, family planning, Community Action Programs, area health education centers and social service agencies.

Community Health Centers provide care for America's most vulnerable populations. Community Health Centers serve as a safety net for patients who can least afford to pay for medical care, and who would otherwise go without, or delay treatment. Community Health Centers provide access to high-quality, comprehensive and low-cost primary and preventive health care, including: immunizations, prenatal care, maternal and child health services, cancer and other preventive health screenings, chronic disease management, and free and reduced cost prescription drug services.

Community Health Centers are safety net providers of health care to vulnerable populations, serving everyone regardless of insurance status or ability to pay. Community Health Centers place special emphasis and have an expertise in caring for Medicaid patients. Nationally, Medicaid provides more than a third of the funding for Community Health Centers. In New Hampshire, Medicaid comprises 21% of their revenue, and in Vermont, Medicaid comprises 37% of their revenue. Without needed Medicaid funds, Community Health Centers would no longer be able to provide the comprehensive services currently available.

Community Health Centers, which provide critical access to basic and preventive care, actually save Medicaid money. Many independent studies have confirmed that "for every Medicaid patient who receives their care from a health center, the overall total cost of their care is thirty percent lower than the total cost of care for Medicaid patients who get their care elsewhere."[1] When Medicaid beneficiaries seek early treatment through a regular medical provider, the expense of treating illness is much lower than when care is delayed. Reductions in funding to Medicaid could threaten the viability of Community Health Centers, and may inevitably lead to patient decisions to delay care that would drive Medicaid costs higher in the long run. Though Medicaid costs have been rising at a concerning rate, Community Health Centers actually save Medicaid more money than that which is paid to them by Medicaid.[1]

We applaud the important work the Commission has done to date, such as projecting savings coming from changes in Medicaid's reimbursement formula for prescription drugs, as well as the recommendation not to reduce reimbursements for safety net providers, including health centers.

We urge the Senate Finance Committee to make decisions that are based on long-term financial impact, rather than short-term savings. Community Health Centers serve a disproportionate number of Medicaid recipients, and therefore rely heavily on Medicaid's reinforcement and support. Changes to the current Medicaid system need to be addressed holistically, without undermining basic and primary care for those least able to shoulder the burden of care. Please consider the value the Community Health Centers bring to Medicaid beneficiaries knowing that the Community Health Centers are a sound investment for scarce public resources.

[1] NACHC Report "Insurance Coverage & a Regular Source of Care: Talking Points on the Need for Both." December 2003.

Statement of Dale Marsico, Executive Director
Community Transportation Association of America
Washington, D.C.
Submitted for the Record
The Future of Medicaid: Strategies for Strengthening America's Vital Safety Net
Committee on Finance
United States Senate
June 15, 2005

Mr. Chairman and Members of the Committee:

The Community Transportation Association of America (CTAA) is a national, membership association of human services transportation professionals and providers. For more than twenty years, CTAA has worked to improve Medicaid's non-emergency medical transportation (NEMT) services. NEMT is a small, but critical, part of the Medicaid budget, accounting for less than 1% of the total or about $2 billion in state and federal funds.

CTAA is pleased that the Committee is examining ways to improve the Medicaid program and respectfully submits the proposal below in order to achieve a less expensive NEMT program, serving more people, through transportation "brokerages." NEMT brokers are private, non-profit or for-profit management companies and state transportation agencies that have a proven track record of success in improving Medicaid NEMT. For example, LogistiCare, a Georgia-based broker, has reduced the annual cost of NEMT in Georgia, in its first year of operation, from more than $80 million to less than $60 million while increasing the number of Medicaid recipients receiving quality NEMT services by 300 %. LogistiCare has replicated this cost-saving, benefit-enhancing model in the first year of operation in other states, cutting costs in Virginia from $57 million to $41 million, in Connecticut from $28 million to $21 million and in Delaware from $8 million to $7 million. (See attached LogistiCare analysis which shows that the model also stabilizes cost increases over time.)

Medical Motors, a New York-based broker has reduced NEMT expenditures for transportation of kidney dialysis patients by $300,000 in Monroe County, N.Y. (2004 New York State Department of Health expenditure data and Medical Motors' Monroe County billings) These savings are primarily due to improved eligibility verification, auditing transportation provider claims, grouping trips to dialysis centers and, perhaps most importantly, restricting patient access to providers accepting a lower than standard payment rate.

Several Inspector General (IG) reports have also suggested that states could reduce the type of fraud and abuse in NEMT detailed in a recent *New York Times* article (July 18, 2005) **and** save money by moving to brokerage agreements, (See *Controlling Medicaid Non-Emergency Transportation Costs*, Report No.OEI-04-95-00140 and *Medicaid: Proactive Safeguards*, Report OEI-05-99-00070, Office of the Inspector General, HHS, April 1997 and July 2000.)

However, there is a serious statutory barrier to more states moving to brokerage management systems – the Medicaid freedom of choice requirement. Although the freedom of choice requirement may improve access to medical services such as physician services, it promotes mismanagement when applied to NEMT. Thus, we propose to exempt NEMT from the Medicaid freedom of choice requirement (suggested legislative language is also attached.)

In addition, the administration's budget proposal to cap the federal contribution to state Medicaid administrative expenses may seriously endanger brokerage agreements in place in states that fund NEMT as an administrative expense. [These states are Alabama, Colorado, Idaho, Louisiana, Maryland, Massachusetts, Missouri, Pennsylvania, Vermont and Washington. Two other states, Iowa and Wyoming, fund NEMT as an administrative expense to generally streamline the benefit. (Source: CTAA Survey, spring 2005, updated summer, 2005)] **Should the Congress adopt the administration's proposal, it is imperative that Congress simultaneously waive the freedom of choice requirement for NEMT.**

We respectfully request that the Committee include our proposal in the budget reconciliation legislation it is required to report by September 16, 2005. Please let us know if we can provide additional information as you proceed to develop your report to Congress. I may be reached at (202) 247-1922 and at marsico@ctaa.org.

Proposed Legislation to Improve the Provision of Non-Emergency Medical Transportation Services in the Medicaid Program

Title XIX, section 1905 (a) (28) is amended to insert the following and re-designate (a) (28) as (a) (29):

"including non-emergency medical transportation to ensure necessary transportation for recipients to and from the care and services in paragraphs (1) through (28), provided that section 1902 (a) (23) shall not apply with respect to the provision of non-emergency transportation services."

Description of Proposed Legislation

This language does two things:

1. Writes the regulatory requirement for non-emergency medical transportation (current federal Medicaid regulations at 42 C.F.R. Sec. 431.53 require states to provide non-emergency medical transportation services "to ensure necessary transportation for recipients to and from providers") into the Medicaid statute by adding it as subsection 1905 (a) (28) to the list of Medicaid services.

2. Exempts non-emergency medical transportation from the Medicaid "freedom of choice" requirement at section 1902 (a) (23) to allow states to deliver non-emergency medical transportation services on a cost-effective basis through "broker agreements" with transportation management entities. Currently, to take advantage of broker agreements, states must either pay for non-emergency medical transportation as an administrative expense or under the cumbersome Medicaid waiver process.

Note: This provision does not restrict the freedom of choice of Medicaid recipients to any health service and would allow, but not require, states to offer more efficient transportation services without obtaining a federal waiver.

Cost Stabilization:

A proven, long-term benefit of LogistiCare's brokerage model

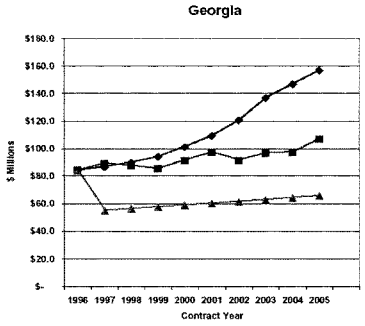
LogistiCare

LogistiCare's experience in cost control is evidenced by our record of reducing and stabilizing costs for our clients. Savings in Georgia, Virginia, Connecticut and Delaware serve as excellent examples of how LogistiCare's brokerage expertise achieves enduring, long-lasting improvements in service quality, program uniformity and access to healthcare, while controlling costs over time. This record of successful cost stabilization is illustrated in the following charts, which compare these clients' expenditures prior to and after contracting with LogistiCare to provide transportation brokerage services. Similar outcomes have been realized across all of our contracts.

Legend: CMS Medicaid Annual Increases | Pre-LogistiCare Consumer Price Index Adjusted | Broker Actual Costs

Georgia

Georgia's non-emergency medical transportation program, administered by the Georgia Department of Community Health, cut costs from $85 million to $55 million after the first year under LogistiCare's management. Over the last nine years, LogistiCare has kept program costs low and highly stable compared with Medicaid's average annual cost increase of 8% for the same period.[1]



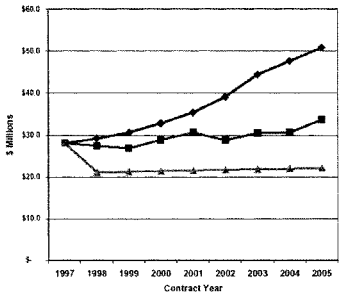
CMS Medicaid Avg. Annual Increase [1]
7%

Pre-Broker CPI Adjusted Avg. Annual Increase [2]
3%

Actual Avg. Program Cost with LogistiCare
- 1%

Connecticut

LogistiCare helped Connecticut's Department of Social Services cut non-emergency transportation costs from $28 million to $21 million in the first contract year. LogistiCare has maintained consistently low program costs for the last nine years, while Medicaid has experienced an annual average cost increase of 8% for the same period. [1]



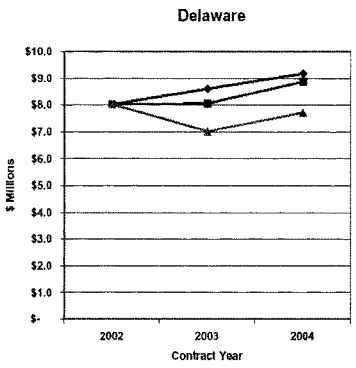
CMS Medicaid Avg. Annual Increase [1]
7%

Pre-Broker CPI Adjusted Avg. Annual Increase [2]
2%

Actual Avg. Program Cost with LogistiCare
-3%

Delaware

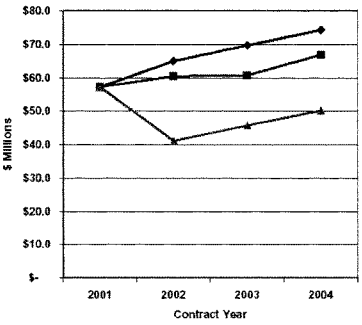
Delaware's Department of Health and Social Services saw costs decrease from $8 million to $7 million in the first year of LogistiCare's management. Over the life of the contract, the program's costs have remained low compared with Medicaid's average annual cost increase of 7% [1] and the state's 10% average annual increase of its consumer price index.[2]



CMS Medicaid Avg. Annual Increase [1]
7%
Pre-Broker CPI Adjusted Avg. Annual Increase [2]
10%
Actual Avg. Program Cost with LogistiCare
-2%

Virginia

Virginia's Department of Medical Assistance Services cut costs from $57 million to $41 million within a year of contracting with LogistiCare to manage its transportation program. Over a three year period, LogistiCare has kept program costs stable even though Medicaid's average annual cost increase was 9% [1] and the state's average adjusted consumer price index was 5% [2] for the same period.



CMS Medicaid Avg. Annual Increase [1]
9%
Pre-Broker CPI Adjusted Avg. Annual Increase [2]
5%
Actual Avg. Program Cost with LogistiCare
-6%

Sources:

[1] CMS Office of the Actuary, Medicaid Financial Management Reports (Form CMS-64), Total Current Expenditures.

[2] Bureau of Labor Statistics

1411 K Street, NW Suite 1200
Washington, DC 20005
Phone: (202) 638-0252
Fax: (202) 638-4557
www.dcpca.org

August 17, 2005

The Honorable Charles Grassley
Chairman
Senate Finance Committee
135 Hart Senate Bldg.
Washington, DC

The Honorable Max Baucus
Ranking Member
Senate Finance Committee
511 Hart Senate Office Bldg.
Washington, D.C.

Re: "The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net" (June 15, 2005)

On behalf of health care clinics and providers in the nation's capital, the District of Columbia Primary Care Association (DCPCA) would like to convey appreciation to the Senate Finance Committee for engaging in productive dialogue with the National Governors Association on ways to improve the Medicaid Program. As you are acutely aware, Medicaid is the single most important program for supporting our nation's poor and vulnerable populations, covering over 50 million Americans, including 13 million children and 6 million disabled individuals

In the District of Columbia, Medicaid's role in promoting and preserving the health of those living in poverty in the nation's capital is undeniable. Medicaid allows the District to provide coverage for over 140,000 residents, roughly half of which are children, who would otherwise lack adequate access to health care. While Medicaid has had a growing impact on the federal budget during this latest economically depressed time, we oppose proposals that would undermine the health care safety net in this country.

Specifically, the National Governor's Association seeks to transfer additional burden from the rise in health care costs to Medicaid recipients through increased cost-sharing and stricter asset testing policies. Our highly effective and comprehensive system of Federally Qualified Health Centers (FQHCs) and other safety net clinics offers us a true picture of individuals who rely on Medicaid; their ability to adjust to an even moderate increase in co-pays or premiums is marginal. Previous experience indicates that these

measures would only serve to cause many enrollees to either delay seeking care even when it is medically necessary or else leave the Medicaid program altogether.

The Governor's also request more flexibility surrounding benefits packages. In the District, we have created innovative programs to effectively manage care and oversee cost while simultaneously expanding coverage to many needy populations. Other states could benefit from such experiments, however, removing federal oversight into the waiver process may instead lead to drastic reductions in eligibility and benefits as states and localities attempt to adjust to fluctuating budget cycles. Any additions to the over 51,000 uninsured residents would encumber the already stretched DC Alliance program, a safety net for individuals ineligible for Medicaid. Furthermore, the area's clinics and health centers, which currently face rising volumes and tightening bottom lines, will be overwhelmed by a rise in the ranks of the uninsured.

In the District, modifications to Medicaid have a particular effect on the health disparities seen in the city. Eighty four percent of enrollees are Black, and Hispanics comprise an additional nine percent. Weakening the program would disproportionately affect people of color, exacerbating the disparities experienced among the uninsured, of which sixty six percent and eighteen percent are Black and Hispanic, respectively.

Of additional concern are proposed barriers to long term care for our elderly populations. In Washington D.C., as with many regions of the country, may seniors reside in nursing home and other long term care facilities. Attempts to scrutinize assets from this population, one which rarely possesses assets of exorbitant value, place a potential impediment to receiving coverage for greatly needed long term care. Any efforts to achieve cost controls and savings should be carefully weighed against their possibly limiting impact upon the very populations Medicaid was intended to assist.

DCPCA is encouraged by the National Governors Association's willingness to seek more affordable prescription drugs for Medicaid recipients. Rising prescription drug costs have a deleterious effect on residents of DC, akin to the rest of the nation. Ways to achieve affordability in the prescription drug market through bulk purchasing and negotiation will ensure better access to vital medications for District residents.

In addition, the NGA proposes eliminating the "clawback" clause of the new Medicare drug law. DCPCA is in agreement with the governors that requiring states to pay the federal government the savings associated with no longer covering prescription drugs for dual-eligible is unwise. In fact, it is likely that this provision would result in increased costs to states and the District, and may offer incentive to reduce eligibility for dual-eligibles to avoid this payment.

As we celebrate the 40th anniversary of Medicaid creation, we cannot forget its role in preserving the health of our nation's most vulnerable populations. As an organization committed to access to primary care and the efficient delivery of health care in the appropriate setting, we believe strongly that maintaining and expanding coverage under the Medicaid program is an imperative investment into the health of the public. As the

rolls of the uninsured continue to rise to unprecedented amounts, we are witnessing firsthand the effects of lacking continuity in primary care. Patients are ending up in our Emergency Departments with severe and costly diseases that could have been prevented through earlier intervention. Preserving the Medicaid program is one step in reversing this trend and enhancing the quality of health in DC and across the U.S.

Sincerely,

Sharon A. Baskerville

Sharon A. Baskerville
Executive Director

FamiliesUSA
The Voice for Health Care Consumers

Statement by
Ronald F. Pollack, Executive Director
Families USA
At the Hearing on
The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net
Before the
Senate Committee on Finance
June 15, 2005

Thank you for allowing us to submit this statement for the record. Families USA is the national organization for health consumers. Our mission is to ensure that all Americans have access to high-quality affordable health care. Like everyone at the hearing, we are deeply concerned about the future of the Medicaid program and look forward to working with the Finance Committee to strengthen and improve Medicaid on behalf of the 53 million vulnerable children, seniors and people with disabilities who rely on the program for their health care needs.

As you know, the Budget Resolution requires the Senate Finance Committee to identify $10 billion in budget cuts over the next five years. Similarly, it requires the House Energy and Commerce Committee to propose $14.7 billion in cuts over the same period. Although the budget resolution does not explicitly direct these cuts to come from any specific programs, Medicaid has clearly been targeted and, in large part, that is why we are all here today.

First, it is important to emphasize that there is no requirement to cut $10 billion from Medicaid. The cuts can occur through savings in other programs and as much of these expected savings as possible should come from programs not targeted toward low-income Americans. What is more, the budget process is not an appropriate forum for a conversation about "reforming" or in any way restructuring Medicaid. The program should be thoughtfully scrutinized to see if there are ways to make it more cost-effective and efficient—and if so, those changes should be enacted. However, it is misguided and dangerous to consider structural reform to Medicaid until such proposals can be examined thoroughly with ample input from the program's very diverse stakeholders, especially so that there is a clear understanding of the impact of changes on beneficiaries' abilities to access needed care.

To the extent that Congress seeks budget savings from the Medicaid program, certain principles should guide their work. This document suggests what those principles should be and ways in which some Medicaid savings can be achieved while protecting from harm the very people Medicaid was designed to serve. The principles include the following:

Health and long-term care coverage must continue to be guaranteed for those who qualify for Medicaid. Like Medicare, Medicaid assures that people who qualify must be enrolled and

1201 New York Avenue, NW, Suite 1100 ■ Washington, DC 20005 ■ 202-628-3030 ■ Fax 202-347-2417
E-Mail: info@familiesusa.org ■ Web site: www.familiesusa.org

FamiliesUSA
The Voice for Health Care Consumers

not be placed on waiting lists. Any changes in this basic principle would leave vulnerable people without access to health care, undermining the very purpose of the Medicaid program.

Financing should continue to be fully shared between the federal government and the states without caps. Today, the federal government guarantees to states that it will pay at least half of Medicaid's costs. Policies that shift costs and risks to the states or that impose caps on federal payments to the states (such as block grants) will lead to fiscal burdens on the states that they cannot afford and will result in significant cutbacks of coverage and a weakening of the health care system.

Benefits and cost-sharing should reflect the needs and economic circumstances of the people served by Medicaid. The Medicaid benefit package should be comprehensive and ensure that people are able to access benefits they need. Needed medical services should be available and affordable to the elderly, children, people with disabilities, and other adults covered by the program whose low incomes make it impossible for them to afford significant out-of-pocket costs. Changes that would effectively deny access to needed care or saddle low-income people and their families with costs they cannot afford to pay are counterproductive and inconsistent with the program's mission.

As the Senate Finance Committee undertakes the reconciliation process, Senators should consider cost efficiencies that will not harm the vulnerable populations Medicaid serves and that could strengthen the program in the long run. Among the cost efficiencies that we believe worthy of consideration are the following:

Prescription drug cost containment: Changes could be instituted to help the federal government and the states reduce the rapidly increasing costs of prescription drugs. Such policies would need to be crafted carefully with appropriate safeguards to ensure that people are able to get the drugs they need and Medicaid gets the best price possible for drugs, and to encourage responsible prescribing, dispensing, and utilization of drugs. Strategies that may be worth considering include: changing the formula for calculating Medicaid "best price" and Medicaid rebates; changing the reimbursement rates to pharmacists for dispensing drugs; and improving the management of the prescription drug rebate program.

Protecting program integrity: Medicaid already does a better job of holding down health care costs than the private market, but policies that increase efficiency by improving the integrity of the program should be considered. If at times a small number of those who make money from Medicaid engage in activities that result in inappropriate or excessive payments at the expense of the program and those who depend on it, these problems should be addressed. This is an area that needs to be explored carefully to see if budget savings can be achieved in ways that would strengthen program integrity and assist states while protecting low-income people and families.

1201 New York Avenue, NW, Suite 1100 ■ Washington, DC 20005 ■ 202-628-3030 ■ Fax 202-347-2417
E-Mail: info@familiesusa.org ■ Web site: www.familiesusa.org ■

Statement for the Record

Governor Anibal Acevedo-Vilá
Commonwealth of Puerto Rico

For the
Senate Finance Committee
Wednesday, June 15, 2005
Hearing on

The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net

"*The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years.... The imbalance affects quality of care issues and creates increased financial stress. Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.*"

National Governor's Association
Policy Position
EC-16. Medicaid Reform Policy

The National Governors Association Policy Position EC-16 recognizes the imbalance that has developed over a period of years in regard to the Federal Medicaid partnership, the Commonwealth of Puerto Rico and the U.S. territories.

I would like to take this opportunity to add my support to the NGA policy and to and to put forward interim steps that begin to address this imbalance.

In 1968, three years after the start of the Medicaid program, Congress established a $20 million limit on the level of federal Medicaid that would be available to the Commonwealth of Puerto Rico. At that time Federal Medicaid costs, nationally, totaled $1.1 billion. The Commonwealth matching assistance percentage (FMAP) continued at the 50 percent level; however, the Federal cap meant that there was no reimbursement for expenses to Puerto Rico once the Commonwealth expended $40 million. From time to time, Congress has raised the cap, but has never reviewed the cap in terms of healthcare or fiscal policy.

Currently, the Commonwealth of Puerto Rico's effective FMAP rate approximates 18 percent. If the 1968 cap had been authorized to grow at the same rate as Medicaid grew nationally, Federal support for Medicaid in Puerto Rico would now approximate $1.7 billion, as opposed to the current Federal support of $219 million. In the states, federal Medicaid support approximates $330 per month per participant as compared to federal support in Puerto Rico of about $20 per month per participant. If Puerto Rico's 1968 Medicaid cap had increased as the Medicaid program increased, nationally, the average monthly Federal contribution would be about $173 per participant, still a fraction of average Federal support.

These are the challenges the Commonwealth's healthcare community confronts while operating in an economy where the cost of living is no less than many metropolitan areas in the states, and all of the Federal regulatory requirements governing healthcare facilities and providers are the same in Puerto Rico as they are in the states.

As Congress moves forward with its review of Medicaid, I would urge that the Committees consider adhering to four principles in terms of addressing Medicaid in Puerto Rico:

1. It is in the interest of both the Federal Government and the Commonwealth that the existing healthcare gap between the Island and the states does not grow any greater, and that measures need to be taken to narrow this gap.

2. Federally mandated expenses resulting from Federal consent decrees and U.S. Justice Department enforcement actions should be reimbursed outside of the cap.

3. Critical healthcare needs, particularly for children, persons with disabilities and the frail elderly, need to be considered as strategic healthcare investments, with the Federal contribution coming outside of the cap.

4. The Federal investment in Puerto Rico's healthcare must be safeguarded and efforts and initiatives, particularly in technology, that can safeguard the Federal investment and make the healthcare system more productive should be encouraged and supported.

In addressing the first principle of not allowing the healthcare gap between the Island and the states to grow any further, I believe that there are three actions which the Committee can take this year that would be meaningful in starting to address the current imbalance:

1. Family Opportunity Act (FOA) (HR1443, S183). The FOA, as drafted, effectively precludes Puerto Rico from participating, as the cap on Medicaid reimbursement will prevent any Federal participation. If Congress enacts FOA this year, it is essential that Puerto Rico be permitted to participate in this program and the New Freedoms Initiatives must be placed outside of the cap, so that families and children with disabilities in Puerto Rico are not left behind.

2. Transitional Medical Assistance (TMA). The Congress requires Puerto Rico to meet all of the same work standards of the Temporary Assistance to Needy Families (TANF), but the Commonwealth is not authorized to participate in TMA. TMA is recognized as one of the most critical elements in the success of moving families from welfare to work. When Congress reauthorizes TANF and TMA, it is essential that Puerto Rico be authorized to participate in and receive reimbursements for TMA so that it is in a stronger position to meet its TANF obligations.

3. Adjustment Factor. From 1998 to 2003, Federal support for Medicaid increased nationally 65 percent while Federal support for Medicaid in Puerto Rico increased 30 percent. The disparity in the growth rate is an issue that must be addressed this year, because each year that it is delayed, there is increasing pressures on the Commonwealth's healthcare system and fiscal strength. I urge the Committee to amend the provisions related to the annual adjustment for the Puerto Rico's Medicaid cap so that the adjustment is no less than the percentage increase in the national Medicaid program. This can be an important step in addressing the overall healthcare gap. It will also be consistent with actions Congress took in regard to the Medicare Modernization Act where the annual adjustment to the Commonwealth's block grant is based upon the annual growth of Medicare Part D.

These three steps start to lay the foundation to address the current imbalance. By including Puerto Rico in the two authorizations and adopting an adjustment policy that reflects changes in the program nationally, Congress will put into practice the principle of not permitting the imbalance of the Commonwealth/Federal Medicaid partnership.

I urge the Committee to consider these proposals as you move forward with budget reconciliation and I am certainly available to work with the Committee to find solutions which start to realign the current imbalance of the Commonwealth Medicaid partnership with the Federal government.

When Congress considers long term comprehensive Medicaid reform, I urge the Committee to examine the issues I raised previously, including:

1. Impact of Consent Decrees. The Commonwealth is under two consent decrees initiated by the US Justice Department requiring the expenditure of funds that are eligible for Medicaid reimbursement, but not eligible for a Federal match in Puerto Rico. My fellow Governors are concerned about the impact of the consent decrees since they are required to pay between 20 and 50 percent of their costs (Federal Medicaid financing the balance). I am particularly concerned as the Commonwealth is not authorized to receive any additional reimbursements for eligible Medicaid costs resulting from the enforcement action of the U.S. Justice Department, and is required to absorb 100 percent of the costs.

2. Critical Needs. Critical healthcare needs, particularly for children, persons with disabilities and the frail elderly must be assessed with consideration given to possible support for strategic healthcare needs investments and should be viewed in the context of Medicaid reform to insure that these vulnerable populations are adequately served. One simple way to begin to take care of these critical needs and to begin to narrow the existing gap would be a new policy that would place the Federal contribution of Medicaid coverage outside of the existing cap for every child born after a date certain. This way, we begin to take care of our children first, and we tackle the existing gap in a slow, but steady fashion.

3. Safeguards and Technology. The Federal investment in Puerto Rico's healthcare must be safeguarded. Efforts and initiatives needed to protect that investment and make it more productive should be encouraged and supported. While technology development has been encouraged in the states with as much as 90 percent reimbursements for improvements, the Commonwealth has not been authorized to receive similar support. The President's initiative on "interoperable health information technology infrastructure" is an opportunity to make great strides in the quality and productivity of the Commonwealth's healthcare system, that can pay

dividends to both the Federal government and Puerto Rico, provided the Commonwealth is authorized to access Medicaid funding for the development of these systems, in a manner similar to the states.

As Congress moves forward with comprehensive Medicaid reform, I encourage the Committee to follow the guidance of the NGA policy where it recommends that Medicaid reform "needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership." The cap established in 1968 is grounded in neither healthcare nor economic policy. The result is an effective FMAP for Puerto Rico of approximately 18 percent, a rate that could not be sustained in any jurisdiction.

The Commonwealth of Puerto Rico has a long history and strong commitment to providing comprehensive healthcare in its communities, and that commitment is not going to change. However, meeting that goal and fulfilling the Federal statutory requirements such as Early and Periodic Screening, Diagnosis and Treatment (ESPDT), and Health Insurance Portability and Protection Act (HIPPA), Federal Court rulings such as *Olmstead* and *Cedar Rapids*, and meeting the Federal regulatory requirements of Health Resources and Services Administration and the Center for Medicare and Medicaid Services without a more balanced Federal partnership creates inordinate financial pressure that has an impact on the type of healthcare provided.

As the Committee moves forward with budget reconciliation I would urge establishment of the principle that the current Commonwealth/Federal Medicaid partnership should not develop any further imbalance, and that this goal can be accomplished by enacting the three proposals I have outlined. Secondly, in terms of comprehensive long term Medicaid reform I urge the Committee to examine the current Commonwealth/Federal Medicaid partnership with the objective of establishing a more balanced partnership, particularly in light of the healthcare needs, consent decrees and opportunities for technological advances.

Working together, sharing ideas, examining the effects of current policy, I believe that we can establish a pathway to rebalancing the Commonwealth/Federal partnership, a pathway that makes economic sense for both the Federal government and the Commonwealth.

Testimony on behalf of the
March of Dimes
Submitted to the United States Senate
Committee on Finance

"The Future of Medicaid:
Strategies for Strengthening American's Vital Safety Net"

Wednesday, June 15, 2005

Submitted by:
Dr. Marina L. Weiss
Senior Vice President, Public Policy and Government Affairs

The March of Dimes Birth Defects Foundation is pleased to submit for the hearing record the following statement on "The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net."

Established by President Franklin Roosevelt in 1938, the March of Dimes devoted its first 20 years to funding research that led to the prevention and treatment of polio. In 1955, when the Salk vaccine was declared 'safe, effective, and potent', the Foundation turned its attention to improving the health of children by focusing on other major health threats including birth defects, prematurity and infant mortality. Central to this mission has been advocating to make health coverage accessible and affordable for women of childbearing age, infants and children.

Because Medicaid provides an essential safety net for the health of women and children, the March of Dimes urges that any changes to the program be designed in ways that protect longstanding benefits critical to the health of these vulnerable populations. In particular, the individual coverage entitlement and pediatric services provided through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program must be preserved.

The March of Dimes supports efforts to improve the Medicaid program, especially proposals that strengthen coverage for beneficiaries, and expand access to the 12.6 million women of childbearing age and 9.1 million children who are uninsured.[1] Women of childbearing age and children have never been cost drivers in Medicaid. Using the most recent data available, the Centers for Medicare and Medicaid Services reports that in 2002, women ages 19-44 and children constituted 69% of Medicaid enrollees, but only 30% of all Medicaid expenditures.[2]

How important is Medicaid to women of childbearing age and children?

- Medicaid finances 37% of all births annually.[3]
- As many as 1 in 3 children are covered by Medicaid at some point during the year.[4]
- Medicaid's coverage of early prenatal care is vital to reducing the incidence of low birthweight and prematurity, the leading cause of neonatal mortality.
- Through the EPSDT benefit, Medicaid-eligible children are guaranteed the right to health services needed "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the [EPSDT] screening services."[5] This benefit was designed to

---

[1] U.S. Census Bureau, March 2004 Current Population Survey. Data prepared for the March of Dimes. October 2004. http://www.marchofdimes.com/files/census2003.pdf

[2] Centers for Medicare and Medicaid Services (CMS), MSIS data for 2002.

[3] National Governors Association. *Maternal and Child Health Update 2002: State Health Coverage for Low-Income Pregnant Women, Children, and Parents.* June 2003.

[4] The March of Dimes uses two principal sources for estimates of children enrolled in Medicaid and SCHIP. The Centers for Medicare and Medicaid Services (CMS) MSIS data for 2002 show that 26 million children under age 19 nationwide rely on Medicaid for their health care coverage at some point during the year (which is about 1 in 3 children). Total population estimate of children is 78 million, from the Bureau of the Census Current Population Survey, March 2004]. An alternative data source on Medicaid enrollment, the Census Bureau's Current Population Survey, shows that nationally, one in four children were enrolled in Medicaid or SCHIP in 2003. While CMS administrative data count all children enrolled at any point in the year, the Census survey data are generally considered to provide a 'point in time' estimate of enrollment. In other words, these data sets tell us that at least 1 in 4 and as many as 1 in 3 children rely on Medicaid or SCHIP.

[5] Social Security Act, Title XIX, Sec. 1905(r)(5).

help vulnerable children with extensive health care needs, so that they can access the medically necessary treatments and services they need.

The National Governors Association (NGA) interim Medicaid Reform Policy paper released June 1, 2005 recommends changes that could undermine vital protections currently provided, including Early Periodic Screening Diagnosis and Treatment (EPSDT). More precisely, the NGA document calls for 'flexibility' that would allow states to narrow the scope of pediatric health screening and treatment. The March of Dimes respectfully disagrees with this recommendation. Our concern is rooted in the Foundation's longstanding commitment to screening as a preventive health strategy and to the guarantee of medical treatment for infants and children with birth defects and other major health conditions.

Like private insurance, the purpose of Medicaid and its EPSDT pediatric benefit is to provide coverage for preventive and ongoing health services to enrollees, and to reimburse for the cost of medically necessary treatment incase of serious illness. In other words, EPSDT is not a luxury or 'Cadillac' benefit, rather it is fundamental to the health and well-being of millions of children who rely on Medicaid for their health insurance. Without the current law EPSDT protections, a child with vision or hearing impairment might or might not be screened to detect the condition. If the child is blind or has a hearing deficiency he or she could be denied the interventions required to treat or correct the problem. The family of an infant born with one or more birth defects, including congenital heart defects, spina bifida, or cerebral palsy, could find the state unwilling to reimburse for specialty care, physical therapy, and other services needed to maintain function and protect against deterioration of the child's health. To roll back the EPSDT guarantee would be to undo a 30- year policy of using preventive health screening to detect and treat pediatric health problems.

While the March of Dimes agrees that Medicaid, like all public programs, should operate in a cost-efficient manner, the definition of "efficiency" should take into account *all* costs and benefits, not just those with short term budgetary impact. For children with inadequate or no insurance, the real costs include receiving care late in the development of a health condition, if they receive care at all, or expensive emergency room visits for conditions that could have been contained with timely outpatient care.[6] The irony is that when uninsured or underinsured children from families of modest means become ill, public dollars pay for their treatment one way or another, through uncompensated care payments from the state and federal government, or through cost-shifting to private insurance.

Rather than transforming the Medicaid program into a substandard benefit package that would place more children at risk, we believe Medicaid should be used as a tool to reduce the incidence of prematurity, birth defects, and infant mortality. The March of Dimes worked closely with Senators Lincoln and Lugar to develop the Prevent Prematurity and Improve Child Health Act of 2005 (S. 710), introduced on April 1st of this year. This is a carefully crafted and modest attempt to improve access to coverage in a number of ways that promote more efficient use of health resources. Key to the structure of the bill is increased flexibility for states to address the health

---

[6] *Health Insurance is a Family Matter*. 2002. Institute of Medicine (IOM). Washington, DC: National Academies Press. p. 122.

coverage needs of women and children in low-income families. Flexibility that states *should* have includes:

- Use of SCHIP to supplement private insurance for infants and children with significant health care needs;
- Permitting SCHIP coverage of pregnant women who meet income eligibility requirements;
- Enrollment of legal immigrant pregnant women, infants and children in Medicaid and SCHIP, thus sharing financial responsibility for the cost of health care consumed by these individuals;
- Use of maternal and pediatric quality measures in federally funded health programs;
- Ability to extend postpartum family planning services beyond the 60-day requirement, thus allowing women at risk for premature delivery to be guided by their physicians in safely timing future pregnancies.

The March of Dimes is prepared to support a number of statutory changes in Medicaid, especially those that strengthen and improve the program for the long term. We look forward to working with Members of this Committee as well as with the Governors to bring greater *meaningful* efficiency and flexibility to the Medicaid program while protecting the women and children who depend on this program for their health insurance.

Medicaid
Health Plans
of America

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004
www.mhpoa.org

October 12, 2005

U.S. Senator Chuck Grassley
Chairman
Committee on Finanace
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: ***"The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net; June 15, 2005"***

Dear Chairman Grassley:

Thank you taking the time to review this letter outlining our organization's Statement of Principles about Medicaid. For the record, my name is Thomas Johnson and I'm executive director of Medicaid Health Plans of America (MHPA). On behalf of our member companies, representing Medicaid managed care organizations (MCO), we appreciate the opportunity to address the importance of Medicaid, the future challenges of Medicaid, and our proposed solutions, for your consideration as hearings proceed on the future of Medicaid.

Today, our nation is experiencing the largest cutback in Medicaid funding, all the while, Medicaid enrollment and costs continue to increase.

Medicaid is an important source of health care financing for approximately 46 million individuals. Those entitled to Medicaid benefits include pregnant women, children and teenagers, the elderly, and individuals who are blind or disabled. The Medicaid program plays an extremely important role in the lives of its beneficiaries, providing access to health care for segments of the population that are economically vulnerable, and who otherwise might not receive the health care they need.

Medicaid Health Plans of America is the leading organization solely dedicated to representing health plans participating in Medicaid managed care. With more than 53 million Americans enrolled, Medicaid is the nation's largest health care program. Medicaid is a valuable health care safety net for millions of people. However, Medicaid must be viable to meet its objective. Because the amount of people needing Medicaid is continues to increase, and the amount of services and costs are increasing, Medicaid will not sustain itself because its funds are limited. If the Medicaid program continues

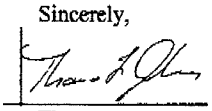
without implementing reform, the funds will be wasted and those in real need will be left without protection. Medicaid functions as an essential last resort to health care coverage for millions of people, and without Medicaid, millions of our people will go unprotected and untreated. MHPA understands and believes in the objectives and our country's need for Medicaid. Because Medicaid funds are limited and in danger of being exhausted, MHPA has identified six priorities in regard to Medicaid reform, they are:

- **Sustainability and Affordability:** The long-term financial health of Medicaid demands attention to financial controls especially strengthening financial integrity; a balanced approach on Intergovernmental Transfer (IGT) policy; legislative initiatives to deploy information and communications technology; and managed care demonstration projects.
- **Promoting Personal Responsibility:** MHPA believes reexamining the level of cost sharing is warranted, allowing enrollees more responsibility for their care, as long as access to primary and acute care services is not materially altered. In addition, MHPA supports proper primary and secondary prevention care; and, considers it essential that member have access to health information. Educated consumers become empowered in making the best decisions in favor of their own health care needs.
- **Modernizing Medicaid:** MHPA supports benefits package flexibility, allowing for different levels of benefits for different populations; the need to increase the ease with which states get current waivers; and, that judicial reform in the consent decree area may be of value to the states.
- **Private Insurance Market Reforms:** MHPA believes that reforms should strengthen the private sector to allow improved access to affordable health care coverage in both individual and employer markets. In addition, MHPA believes that federal and state governments should work together to increase the affordability, accessibility, and quality of high-risk pools.
- **Long-Term Care:** MHPA supports comprehensive incentives – including tax incentives, education and other measures to reserve trends in purchasing of long-term care coverage. More individuals should be able to purchase long-term care, thus relieving the burden that is placed upon Medicaid.
- **Increased Role for Medicaid Managed Care:** Incentives must be put in place at the federal level to foster the positive trends that have resulted from increased Medicaid managed care enrollment.

Medicaid reform and Medicaid managed care need to be at the forefront of Congressional efforts. Policy initiatives are indispensable to Medicaid's viability because they can help prevent abuse of Medicaid's limited funds and ensure that Medicaid continues to provide quality health care for millions of enrollees in a sustainable manner. MHPA endorses comprehensive incentives and other measures that relieve the burden that is placed upon Medicaid. MHPA is committed to and advocates the development of effective healthcare policy initiatives that will support the objectives and integrity of the Medicaid program.

On behalf of Medicaid Health Plans of America and its members, I would like to express our appreciation for your time and effort put forth in protecting and improving the future of Medicaid.

Sincerely,



Thomas L. Johnson
Executive Director

Medicaid Health Plans of America is an organization representing the Medicaid managed care industry. MHPA's primary focus is providing sound research, analysis, and forums that support the development of effective policy solutions to best provide for Medicaid patient., as well as low-income-earning individuals and families seeking quality healthcare from Medicaid managed care organizations.

TESTIMONY
U.S. Senate Finance Committee
"The Future of Medicaid:
Strategies for Strengthening American's Vital Safety Net"
June 15, 2005

Submitted by
Peter Scuccimarri, MD, President
Michigan Academy of Family Physicians
On August 29, 2005
2164 Commons Parkway
Okemos, MI 48864
517-347-0098/800-833-5151
president@mafp.com

Peter Scuccimarri, MD, FAAFP
Ann Arbor, Michigan

Our organization, the Michigan Academy of Family Physicians, represents over 3,200 family physicians in the State of Michigan. We are family doctors. As such, we care for patients of all ages, from obstetrical care to geriatrics in the context of the family and the community. Furthermore, our training and mission is to care for the entire individual and to offer each patient the entire scope of medical care, not just one portion of their anatomy. As Primary Care Physicians we represent the first line of defense in attaining appropriate medical care for the people of Michigan, and particularly, the majority of the Medicaid population. Our members all recognize that in the State of Michigan, as well other states in the Union, we have a serious problem.

The Medicaid program has created a troubling dilemma for physicians. Treating Medicaid patients is viewed as a moral obligation to the communities in which the physicians serve, but reimbursement does not cover the costs of care. The inadequate funding of the Medicaid program has created what amounts to an unfunded mandate. Physicians and hospitals are expected to subsidize the Medicaid program by absorbing low rates of reimbursement and increased administrative costs while maintaining the highest standards of care.

Consequently, physicians are left with the prospect of no longer accepting Medicaid patients, or suffering additional financial losses to their practices. This is especially true for our private practices that operate on a very slim financial margin. Further reductions in reimbursement rates will certainly drive family physicians to eliminate Medicaid patients. This will force them to select much more expensive methods of securing health care, such as Emergency Rooms, further eroding the finances of the state and federal government. Certainly, our legislators must act responsibly as the stewards of taxpayer dollars. However, expecting physicians, hospitals, and health plans to subsidize Medicaid is not fiscally responsible.

Medicaid reimbursement falls well below what commercial insurers pay and likewise, Medicaid in Michigan pays less than 60% of what the federal government reimburses for identical services under the Medicare program. Costs for treating Medicaid patients are no less for treating those insured by commercial carriers or Medicare. Consequently, physicians are left with the difficult choice of treating

patients at a loss or, reducing the number of Medicaid patients they treat. In addition, administrative costs associated with participating in Medicaid are significant as well.

As family physicians, including those of us in private practice with very limited capital reserves, participation in the Medicaid program are typically done out of a sense of moral obligation rather than a business decision. This participation can reduce our ability to move ahead with other requirements such as Electronic Prescribing and Electronic Medical Records,

Reimbursement rates from Medicaid are well documented, and far below actual costs, both in private practices and in hospitals. Participation in Medicaid also means accepting considerable regulatory and bureaucratic burdens. Prior authorization for prescription medications, complex federal requirements, and exposure to additional financial loss if a plan becomes insolvent, are risks associated with physician participation in Medicaid.

Clearly, the federal government never intended for Medicaid to be a financial benefit for physicians, nor do physicians expect Medicaid to be a lucrative endeavor. However, as the State has abrogated its responsibilities to managed care companies and pursued policies that place a greater burden upon physicians, it becomes apparent that the state and federal government need to remedy more than the finances of the Medicaid program. The sense of trust between the Medicaid program and physicians in general has eroded considerably, especially if one considers that it the responsibility of our government to protect its residents. We lose more lives each year to poor health care access than to military casualties and terrorist activities.

Considerations of further reduction in provider payments or taxing health care providers to defray the costs of health care and access to care are dangerous and ill-fated. Before Congress and State Legislators considering reduction in provider payments or, a "Medicaid Tax on Providers", consider the following:

(1) An international study has shown that the United States, compared to the United Kingdom, Australia, Canada and New Zealand, ranks lowest in timely access to health care. This study, published on October 28, 2004 by the Commonwealth Fund, further showed that the United States' health care system contains serious gaps in patients' access to health care, particularly to primary care. The report, based on a survey about patients' experiences, revealed that one-third of American respondents indicated that access to the U.S. health care system "should be rebuilt completely".

(2) On November 10, 2004, at the 132nd annual meeting of the American Public Health Association, the Executive Director of American Public Health Association (APHA) Georges Benjamin, MD cited the increase in infant mortality from 6.9 to 7.0 births per 1,000, a statistic that puts the U.S. 28th internationally in infant mortality, as well as the finding that 14 states have preterm birth rates that exceed 13%. That alarming statistic is likely associated with the fact that 12.6 million American women of child-bearing age are uninsured. "Clearly, there is a connection there that cannot be ignored, and this is something we must address as a nation. Premature births have many factors, from poverty to inadequate prenatal care and infections, but for the clinicians who treat these women, this [increasing prevalence of preterm births] is clear evidence of a healthcare system in crisis.

(3) Opening with the words of John F. Kennedy at his Presidential inaugural speech, Mohan Nadkami, MD, FACP (Public Health and Prevention 2(1), 2004): "If a free society cannot help the many who are poor, it cannot save the few who are rich."

(4) The American health system has developed and evolved mainly in response to the needs of caring for acute illnesses, or for acute exacerbation of chronic illnesses. However, over 100 million Americans have a chronic medical condition, and it is projected that by 2020, 134 million people will suffer from a chronic illness. Forty-four percent of these individuals will have multiple chronic conditions. It is also estimated that by 2020, 1 in 6 Americans over age 65 will become limited by chronic conditions.

Even though the statistics related to chronic illness are daunting, the U.S. healthcare system has been slow to espouse a system of care focused more on helping patients prevent and manage chronic conditions, in order to improve outcomes and reduce costs. The aging of the population, combined with the (literally) growing epidemic of obesity and its fearsome cascade of increased diabetes, hypertension, and cardiovascular morbidity and mortality, demands the redesign of our health system to better help patients manage their chronic illnesses. The impressive technological advances of the past several decades will not be enough to adequately address the needs of an increasing number of chronically ill individuals.

We now have significant amounts of data to show that not only are we failing in our efforts to prevent or optimally manage chronic illness, but that there is also a growing chasm in the care provided and the outcomes achieved among different socioeconomic and ethnic groups. Evidence of health disparities abound; 51% of Hispanics and 46% of blacks over the age of 55 years are limited by chronic illnesses, compared with 23% of whites. Hispanics, blacks, and other minorities are 2.5 to 3 times more likely to have no medical insurance, compared with whites. It has been well documented that individuals without insurance receive less preventive care, are less likely to have a regular source of care, present later in the stage of an illness, are more likely to have emergency admissions to hospitals, and have a higher mortality rate once admitted than do those with insurance.

Currently, with Medicaid insurance or without insurance at all, the situation is worse for the poor and near-poor. One third of people who live at or below the poverty level, and one fourth of those below 200% of poverty level, lack insurance, compared with only 8.4% of people with a family income greater than 200% of poverty level. It is not surprising that poor and near-poor patients have been shown to receive less prenatal care, have lower vaccination and higher infant mortality rates, and have a higher incidence of and worse outcomes associated with chronic illness. The poor are three times more likely to be limited by a chronic illness than are their non-poor counterparts.

(5) The problems facing Medicaid are well documented. What is not as certain is the extent to which Medicaid underfunding could potentially affect the health care system as a whole. Physicians and facilities are continually faced with the decision of limiting the number of Medicaid patients they treat, continue treating patients at a loss, or no longer accepting any Medicaid patients.

(6) Patient access to physicians will continue to decline as physicians are forced to limit their participation in the Medicaid program. It is simply unrealistic for the government to operate under the supposition that physicians and other health care professionals will continue to subsidize Medicaid by operating at a loss. Areas with high concentrations of Medicaid patients will find it difficult to recruit and retain physicians. This will be particularly true for physicians that tend to have a high proportion of Medicaid patients. Specialties such as family medicine, psychiatry, pediatrics and obstetrics typically treat a large number of Medicaid

patients. Therefore, the current network of primary care physicians (family physicians, general internists and general pediatricians), psychiatrists and obstetricians/gynecologists could erode due to the situation facing the Medicaid program.

(7) The proportion of physicians providing charity care to patients declined between 1997 and 2001 by nearly five percent, from 76% in 1997 to 71% in 2001, as reported by the Center for Studying Health System Change. The percentage of physicians whose practices treated Medicaid patients declined from 87% to 85%. The decline is a sign of the financial pressures facing physicians, especially those in the lower income levels typically seen in primary care specialties.

Our members know that there are budgetary pressures, but we cannot reduce funding for Medicaid to pay for other programs. Funding must be maintained for Medicaid. Continued decreases in provider payments will put physician practices and patients at risk. Physicians will be forced to turn away all Medicaid patients and the burden will fall on expensive hospital-based subspecialty clinics and, as noted earlier, the emergency rooms for health care access.

Before Congress considers reductions in provider payments, consider the following cost reduction options for Medicaid:

- Eliminate the need for prior authorization for prescriptions--determine what is covered and what is not.
- Establish standard formularies – HMO formularies should match state formularies, avoiding excessively restrictive formularies.
- Institute a contract billing system for a single billing party.
- Initiate group buying programs for Medicaid providers for normal supplies, i.e. syringes, needles, vaccines, computers, etc.
- Place ceilings on drug expenses by class.
- Most importantly, fortify access to primary care and primary care training programs, especially Family Medicine.

This last point has been well documented:

(1) March 23, 2005 — Communities with more primary care physicians have lower mortality rates, according to a new study, confirming the advantages of wide access to primary healthcare services.

What's more, communities with a greater proportion of specialists did not have a measurable, positive effect on U.S. health status compared with other industrialized countries. With such disparities in primary care, specialty physician distribution is likely to lead to even wider gaps in health status and outcomes, according to the study, published as a Web exclusive on March 15 by the health policy journal *Health Affairs*.

"In view of the strong evidence that having more specialists, or higher specialist-to-population ratios, confers no advantages in meeting population health needs and may have ill effects when specialist care is unnecessary, increasing the specialist supply is not justifiable," writes Barbara Starfield, MD, MPH, a professor in the Department of Health Policy and Management at Johns Hopkins School of Public Health in Baltimore, Maryland, and colleagues.

To assess the effect of physician availability on mortality rates, the research team reviewed age-adjusted mortality rates (number of deaths per 1,000 population) from 1996 to 2000 for 3,075 counties, which represents 99.9% of U.S. counties. All-cause mortality was selected as a main indicator because it is most commonly used in studies on income and inequality in health. They also examined the numbers of primary care physicians and specialists in those counties. Physicians who engaged in office-based patient care in family medicine or general practice, general internal medicine, and general pediatrics were considered primary care physicians; others were considered specialists.

The relationship between primary care and specialty physicians and health was examined by the research team using two approaches. The first used the supply of primary care or specialist physicians as a predictor of mortality indicators, while the second included an adjustment for population characteristics known to be associated with higher mortality rates. These factors include per-capita income; education level; unemployment; location in a metropolitan statistical area; and percentages of population who are elderly, African-American, or have an income below 100% of the federal poverty level.

When state-level economic and demographic factors were controlled for, an increase of one primary care physician per 100,000 population (about a 20% increase) was associated with a 6% decrease in all-cause mortality and about a 3% decrease in infant, low-birthweight, and stroke mortality, the study found. For overall mortality, the same 20% increase in primary care physician per 100,000 population yielded a reduction of 34.6% in deaths per 100,000 at the state level.

Today, the position of the U.S. on leading health indicators among industrialized countries (those in the Organization for Economic Cooperation and Development [OECD]) is at or near the bottom and has worsened during the past decade while the proportion of specialists has grown, according to the authors' analysis of health status. Although the U.S. has approximately the same number of physicians per 100,000 population as the OECD average, "this number masks a very different balance between generalists and specialists," the authors write.

Outside of the U.S., the number of visits to generalists "greatly exceeds" the number of visits to specialists, Dr. Starfield and colleagues write, "It appears that it is the relative roles of primary care physicians and specialists rather than their number that makes the difference in health outcomes. Evidence of this is the three-fold difference between the United States and the United Kingdom in the percentage of people seen by a specialist in a year, even after differences in morbidity burden are controlled for," the study noted.

The excess supply of specialist physicians in the U.S., compared with generalists, fuels policymakers' concern about an increasing inequity in health services, the authors write. Because specialty care is more costly than primary care and the population receiving the care may have to share in some portion of that cost, services are more likely to be located in more economically affluent areas. "Thus, care will be preferentially available to the already advantaged, with increasing social disparities in health."

Despite the policy and health outcome concerns surrounding this imbalance in physician supply, new data on residency positions selected by fourth-year U.S. medical students suggest the trend will not abate anytime soon.

At least 95% of the available residency positions in general surgery, orthopaedic surgery, plastic surgery, and emergency medicine were filled through the National Residency Matching Program, the results of which were released on March 17. However, the number of positions for family practice [medicine] filled by medical students declined for the eighth straight year, officials of the program said.(*Health Affairs*. Published online March 15, 2005.)

(2) Health care policy that encourages expansion of the subspecialty physician workforce undermines the goals of improving America's health care system. That was among the points made by Robert Phillips, M.D., M.S.P.H., director of the Robert Graham Center in Washington, and his co-authors in the March 15 *Health Affairs Web Exclusive.*

In "Adding More Specialists Is Not Likely To Improve Population Health: Is Anybody Listening?" the authors say allowing market forces to determine the number and types of medical specialists harms the quality of Americans' health care. The writers point to an accompanying article, "The Effects of Specialist Supply On Populations' Health: Assessing The Evidence," by Barbara Starfield, M.D., M.P.H., professor at the Johns Hopkins University School of Public Health, Baltimore, and her colleagues. They cite numerous studies showing "lower mortality rates where there are more primary care physicians." They add, "Increasing the supply of specialists will not improve the United States' position in population relative to other industrialized countries, and it is likely to lead to greater disparities in health status and outcomes."

Phillips, Starfield and their co-authors say a glut of subspecialists fragments medical care and increases both costs and health care disparities.

The conclusions of Starfield and her co-authors "offer pause for the recent rush to declare a coming physician shortage, particularly of specialists," Phillips and his colleagues write, adding, "Policymakers should pay attention to Starfield and colleagues' troubling finding that having more specialists is not a good thing, and that primary care is."

Apparently, they are not doing so. The Council on Graduate Medical Education (COGME) *16th Report to Congress* recommended a 15 percent increase in the number of medical school graduates and a 12.5 percent increase in residency positions. Simultaneously, COGME dropped its recommendation of several years that half of U.S. medical school graduates become generalists. Instead, the COGME report says, the marketplace should determine the ratio of primary care to subspecialty residency slots.

Such recommendations reflect the consumer-demand model, rather than the patient-need model, for predicting physician workforce needs, says Phillips. Thus, health care becomes an "economic engine" running on ability to pay. However, with 45 million uninsured and 80 million underinsured Americans, that economic engine fails to provide many with health care, Phillips continues. Moreover, it perpetuates health care disparities that "needlessly cost the lives of nearly 900,000 African- Americans" between 1991 and 2000.

"This conflict suggests that a choice should be made -- do we respond to market demands and use our health care system to stoke our economic engine, or do we aim for better population health?" Phillips and his colleagues ask.

(3) Primary care resources may partially moderate the effects of income inequality on health outcomes at the county level.

There is strong theoretical and empirical evidence for the association between strong national primary care systems and improved health indicators. US ecological studies have demonstrated an association between the primary care physician-to-population ratio and various health outcomes. Better health outcomes were found in states with higher primary care physician-to-population ratios after sociodemographic measures (elderly populations, urban residents, minority populations, education, income, unemployment, pollution) and lifestyle factors (seatbelt usage, obesity, and smoking) were controlled for. Geographic areas with more family and general physicians had lower hospitalization rates for conditions preventable with good primary care. Individual-level and state-level measures of primary care resources were also significantly associated with lower heart disease and cancer mortality rates. *Primary Care, Social Inequalities, and All-Cause,Heart Disease, and Cancer Mortality in US Counties,* Leiyu Shi, DrPH, MBA; James Macinko, PhD; Barbara Starfield, MD, MPH; Robert Politzer, ScD; John Wulu, PhD; Jiahong Xu, MPH Am J Public Health. 2005; 95 (4): 674-680.

> (4) Purpose: The impact of comorbidity on use of primary care and specialty services is poorly understood. The purpose of this study was to determine the relationship between morbidity burden, comorbid conditions, and use of primary care and specialist services.
>
> Methods: The study population was a 5% random sample of Medicare beneficiaries, taken from 1999 Medicare files. We analyzed the number of ambulatory face-to-face patient visits to primary care physicians and specialists for each diagnosis, with each one first considered as the "main" one and then as a comorbid diagnosis to another. Each patient was categorized by extent of total morbidity burden using the Johns Hopkins Adjusted Clinical Group case-mix system.
>
> Results: Higher morbidity burden was associated with more visits to specialists, but not to primary care physicians. Patients with most diagnoses had more visits, both to primary care and specialist physicians for comorbid diagnoses than for the main diagnosis itself. Although patients, especially those with high morbidity burdens, generally made more visits to specialists than to primary care physicians, this finding was not always the case. For patients with 66 diagnoses, primary care visits for those diagnoses exceeded specialist visits in all morbidity burden groups; for patients with 87 diagnoses, specialty visits exceeded primary care visits in all morbidity burden groups.
>
> Conclusion: In the elderly, a high morbidity burden leads to higher use of specialist physicians, but not primary care physicians, even for patients with common diagnoses not generally considered to require specialist care. This finding calls for a better understanding of the relative roles of generalists and specialists in the US health services system.

The impact of comorbidity on use of services is poorly understood. One study of Medicare beneficiaries found a relationship between the number of comorbid chronic conditions and total costs of care, frequency of ambulatory-care–sensitive hospitalizations, and the occurrence of complications of care.[1] Another study found the salience of primary care services in the presence of several diagnoses both in children and adults by showing that the average number of primary care visits was greater than the number of visits to specialists, for the diagnosis itself as well as for comorbid conditions.[2] Only a few diagnoses were studied, however, and the population was limited to individuals younger than 65 years of age, when comorbidities occur less frequently. Comorbidity and the Use of Primary Care and Specialist Care in the Elderly

Barbara Starfield, MD, MPH, FRCGP; Klaus W. Lemke, PhD; Robert Herbert, BS; Wendy D. Pavlovich, MHS; Gerard Anderson, PhD. Ann Fam Med. 2005;3(3):215-222.

Medicaid underfunding has already had a devastating effect on our nation's health care system. Physicians cannot simply afford any more cuts. Help maintain family physicians and family practices. The Medicaid program must be viable for the patient and physician alike. As we can see in other well-developed countries, the success of the Medicaid programs and any hope we have of making health care for all is tied into the strength and viability of primary care, especially the specialty of Family Medicine. There simply is no other medical discipline or subspecialty that can offer the range of services that spans the entire lifetime or gender of a person.

Peter Scuccimarri, M.D. is a practicing family physician. He is board certified in family medicine by the American Board of Family Medicine, with a Certification in Added Qualification in Geriatric Medicine. He is a graduate of the University of Pennsylvania School of Medicine in Philadelphia and completed his family medicine residency at Providence Hospital in Southfield, Michigan. He also completed a one-year subinternship and research in Pathology at Bryn Mawr Hospital in Bryn Mawr, Pennsylvania. Dr. Scuccimarri is in solo practice in Ann Arbor, Michigan.

The Michigan Academy of Family Physicians, headquartered in Okemos, Michigan, is a constituent chapter of the American Academy of Family Physicians, headquartered in Leawood, Kansas. The AAFP represents more than 94,000 family physicians.

OFFICIAL DEFINITION OF THE SPECIALTY OF FAMILY MEDICINE:

Family Medicine is the medical specialty that provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical and behavioral sciences. The scope of family medicine encompasses all ages, both sexes, each organ system and every disease entity.

OFFICIAL DEFINITION OF FAMILY PHYSICIAN:

The family physician is a physician who is educated and trained in family medicine—a broadly encompassing medical specialty.

Family physicians possess unique attitudes, skills, and knowledge that qualify them to provide continuing and comprehensive medical care, health maintenance and preventive services to each member of the family regardless of age, or type of problem, be it biological, behavioral, or social. These specialists, because of their background and interactions with the family, are best qualified to serve as each patient's advocate in all health-related matters including the appropriate use of consultants, health services, and community resources.

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Linking patients, communities, and providers together for better health.

"The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net"

Statement of the Michigan Health & Hospital Association

to the

Committee on Finance
United States Senate

August 31, 2005

The Michigan Health & Hospital Association (MHA) welcomes the opportunity to comment on the future of Medicaid and to offer our approach to Medicaid reform. The MHA represents 145 nonprofit community hospitals throughout the state of Michigan.

Medicaid provides access to health care financing for our most vulnerable populations. Michigan's Medicaid program serves 1.5 million people and is dominated by the elderly, the disabled and working families who have no employer-sponsored health care coverage. Before the economic downturn of the late 1990's, the program served less than one million people. Even accounting for the expansion of coverage to new populations, Michigan Medicaid grew dramatically in the past five years. This should be considered a success. If Medicaid were not expanding to cover these new beneficiaries, they would become a part of the uninsured population.

While Medicaid population increased, Michigan's finances faltered. Today's state general fund budget is the same size it was 10 years ago, but the state's responsibility for the health care of its citizens has doubled. The primary reasons for Medicaid growth as a percentage of the state general fund over the past five years include an increased number of people who need Medicaid, lower state revenues and decreased federal support. As budgets have increasingly tightened, providers of services to Medicaid beneficiaries have been cut by $540 million. This is not a reduction in the growth of Medicaid payments; these are actual reductions in the rates that Michigan pays physicians, hospitals and nursing homes. In addition, the state no longer covers crucial services like dental care for adults.

While some providers are able to opt out of serving Medicaid beneficiaries, hospitals can not. As the cost of running a hospital increases, and Medicaid funding decreases, MHA members become responsible for balancing the needs of Michigan citizens with the bottom line. Efficiency is a requirement for operating a hospital in Michigan with a substantial Medicaid case load. A Detroit hospital contained costs over a five-year period to an increase of 2.5 percent, or one-half percent annually, despite its own increases in labor and pharmaceutical costs. Many Michigan hospitals face decisions about closing vital services

SPENCER JOHNSON, PRESIDENT

CORPORATE HEADQUARTERS ◆ 6215 West St. Joseph Highway ◆ Lansing, Michigan 48917 ◆ (517) 323-3443 ◆ Fax (517) 323-0946

CAPITOL ADVOCACY CENTER ◆ 110 West Michigan Avenue, Suite 1200 ◆ Lansing, Michigan 48933 ◆ (517) 323-3443 ◆ Fax (517) 703-8620

www.mha.org

because our Medicaid program cannot pay the cost of delivering services. Several hospitals have eliminated obstetrical programs; one eliminated its residency program for pediatrics.

Medicaid reform must concentrate on improving the health of those served, not on further funding reductions. The state-federal partnership of financing should be continued and improved. States are sharing in the increased cost; states should also share in the savings when innovation leads to more efficiency and lower costs. Federal participation should increase during times of economic stress, not be capped by arcane methodologies that fail to recognize sudden changes in enrollment or increased severity. Without adequate financing, access to health care will continue to regress. In Michigan the average reimbursement for a physician office visit endangers the ability of physicians who care for Medicaid patients to keep their offices open. The Medicaid program must invest in ensuring access to health care for everyone. With one in seven Michigan citizens eligible for Medicaid, most families will need it at some time or another. Inadequate financing threatens reasonable access to all types of services, but especially specialty care. Medicaid financing must also recognize the need for more investment in best practices, technology and capital improvements. With respect to best practices, the MHA Keystone Center for Patient Safety and Quality has become a national leader in developing intensive care unit (ICU) processes that lead to enhanced patient safety, which results in reduced costs.

The Medicaid program should also recognize the growing cost of prescription drugs. Others with much more expertise have made many suggestions for reducing the growth of these costs, including evidence-based coverage of drugs and more transparent drug pricing. The MHA supports and recommends that the Congress act to exercise more control over Medicare drug coverage and reduce state clawback payments. For several years Michigan has taken the initiative to cover prescription drugs for low income seniors through its Elderly Prescription Insurance Coverage (EPIC) program. This prescription drug insurance program covers seniors who are not eligible for Medicaid, but do not have prescription drug coverage through a retirement benefit or cannot afford to purchase a Medicare gap policy that provides coverage. Michigan uses a portion of its tobacco settlement funds to pay for this coverage. Certainly the state should not be penalized when it must eliminate EPIC in support of the Medicare prescription drug program. At the very least, Congress should act to provide that states are held harmless under the clawback provision.

Medicaid should become more flexible to allow states to cover different populations with different benefit packages. However, the MHA is reluctant to wholly endorse ideas such as increased copays and deductibles, or penalties for noncompliant patients. Patient pay requirements become reduced payments for providers. In addition to what is essentially a rate cut, hospitals must try to recover these patient payments. The cost of billing a patient for a $25 copay numerous times will cost the hospital several times the original copay, whether or not it is ultimately paid. Further there is no evidence that these techniques result in better health outcomes or improved quality of care for the Medicaid beneficiaries.

As many have already testified, the cost of Medicaid is concentrated in a small percentage of the beneficiary population. High-cost cases and the long term care beneficiaries account for the majority of the Medicaid expenses. Federal funding for Medicaid should reward states for management of chronic illness and prevention. Michigan's population has a high incidence of diabetes and chronic disease. Continuing investment is necessary to reduce the impact these diseases have on the overall cost of health care. Medicaid reform should recognize that the return on investment will be long term, for which savings will not be measurable in the next fiscal year, but over the five or 10 year time frame used in the 2005 budget resolution.

The MHA and its member hospitals would welcome the opportunity to work with the Committee on the critical issue of Medicaid reform, and stand ready to offer our resources to help craft positive solutions. If the Committee staff has any questions about the information included in this statement, please contact Laura Appel, MHA Senior Director for Legislative Policy at 517/703-8606 or lappel@mha.org.

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Statement on

COMMUNITY RETAIL PHARMACY AGENDA FOR MEDICAID REFORM

"The Future of Medicaid"

Committee on Finance
United States Senate
Wednesday, June 15, 2005

National Association of Chain Drug Stores (NACDS)
413 North Lee Street
Alexandria, VA 22314
703-549-3001
www.nacds.org

Mr. Chairman and Members of the Senate Finance Committee, the National Association of Chain Drug Stores (NACDS) is pleased to submit this statement for the record regarding Medicaid program reform. The Medicaid program provides important health care coverage for about 50 million low-income Americans. While an optional health care service, all state Medicaid programs provide coverage for outpatient prescription drugs because they are the most cost-effective form of medical treatment.

Community retail pharmacies provide prescription services to millions of Medicaid recipients each year. In fact, Medicaid paid for more than 558 million prescriptions in 2003, about 15 percent of all retail pharmacy prescriptions. While the Centers for Medicare and Medicaid Services (CMS) sets and enforces broad policies and procedures for state Medicaid programs, individual states control specific Medicaid policies, including pharmacy reimbursement. NACDS recognizes the fiscal pressures that state Medicaid programs are experiencing, especially in their prescription drug programs. We have been working with many states to help them find savings in their Medicaid prescription drug programs. NACDS would encourage policymakers to consider the following issues as they consider reforms to the Medicaid program.

Medicaid Prescription Co-payments

Many state Medicaid agencies have recently imposed or increased Medicaid prescription co-payments. States are using these co-payments to shift some of the program's cost containment burden back to the recipient, or are using differential co-payments (i.e. $1 for a generic drug, $3 for a brand name drug) to encourage recipients to use lower-cost drugs.

Although nominal in nature, ranging from 50 cents to $3 per prescription, NACDS supports the use of reasonable cost sharing to encourage the appropriate use of prescription services. Some have suggested that these cost sharing amounts should be increased, or based on a percentage of the prescription amount, given that the average cost of a brand name Medicaid prescription was about $101.73 in 2003. Given that the average Medicaid recipient takes more medications than non-Medicaid recipients, excessive co-pays could create significant economic burdens for Medicaid recipients. This may result in some patients forgoing much needed medications. However, since these co-pay structures have not been updated in some time, we agree that policymakers should revise this important Medicaid cost management tool.

But, Congress needs to address a fundamental issue with Medicaid co-payments that currently reduce their effectiveness. That is, the Medicaid program prohibits pharmacies from denying services to recipients who are unable to pay their co-payments or co-insurance. Additionally, Federal regulation prohibits states from compensating pharmacies for uncollected co-pays. For pharmacies, this means that Medicaid prescriptions are often dispensed at an economic loss if the patient cannot pay the co-pay. As state Medicaid drug budgets escalate, more states are increasing co-pays, further placing pharmacies at economic risk and potentially threatening the participation of pharmacies in Medicaid. While no truly needy Medicaid recipient should go without needed medications, the collection of Medicaid prescription co-pays must be enforceable.

For that reason, the Federal regulation prohibiting states from compensating pharmacies for uncollected prescription co-pays should be repealed, and states should be required to reimburse pharmacies for these uncollected co-pays. As a matter of fairness and equity, retail pharmacies should not be forced to bear the burden of uncollected prescription drug co-payments.

Cost Management of the Medicaid Prescription Drug Program

Congress will shortly embark on a reconciliation process to identify $10 billion in mandatory program savings over the next 5 years, including through potential Medicaid program spending reductions. Given that Medicaid prescription drug spending is one of the fastest-growing components of the program, it is only logical that policymakers will look for ways to reduce spending in this particular portion of the program.

States with the most success in managing their Medicaid drug budgets have done so through a combination of programs that promote cost-effective drugs, especially generic drugs, and use preferred drug lists coupled with supplemental rebates. That is because 85 percent of the average state's Medicaid pharmacy budget goes to pay for brand name drugs. Thus, it is important to focus on how to better manage the largest component of drug spending in Medicaid. Every time a Medicaid program uses a generic drug instead of a brand name drug, the programs saves on average about $100. Alternatively, those states that have focused on reducing pharmacy reimbursement as their prime or sole strategy to managing their pharmacy program budgets have met with little success because pharmacy reimbursement rates do not drive Medicaid drug program spending.

Pharmacy Reimbursement: Federal law requires States set Medicaid payment rates to be consistent with efficiency, economy, and quality of care. The payment rates for brand name drugs should be based on the state's "estimate" of the pharmacy's acquisition costs (known as EAC) for these drugs.

NACDS believes that reducing pharmacy reimbursement is an ineffective and unfair way to control Medicaid prescription drug spending. Pharmacy reimbursement rates are not the cause of escalating Medicaid prescription drug expenditures, and pharmacies have no control over the price that manufacturers charge pharmacies to purchase the prescription drugs. In fact, over 80 percent of the average reimbursement paid by a state to a pharmacy for dispensing a Medicaid prescription represents the pharmacy's "cost of goods"—that is, the cost of the medication paid by the pharmacy to the manufacturer or wholesaler. The remaining 20 percent represents the pharmacy's gross margin, which is needed to pay for operating expenses, including salaries and rent. However, to save money, states are continuing to propose reducing the rates paid to pharmacies for providing Medicaid prescriptions.

At the end of the day, pharmacy's net margins on Medicaid prescriptions are in the low single digits. Medicaid prescription costs are rising because more prescriptions are being used, and because Medicaid recipients are using higher-priced prescription drugs. Thus, reducing pharmacy payment does not provide a credible, effective solution to increasing Medicaid prescription drug expenditures.

NACDS supports state Medicaid reimbursement that accurately reflects the cost of dispensing prescriptions to recipients. It is a widely held misconception that Medicaid provides more favorable reimbursement to pharmacy providers than the reimbursement paid by private plans. Bad debt, administrative paperwork, and the absence of private plan financial incentives make the costs of dispensing under Medicaid far higher than under private plans. It generally costs more for a pharmacy to dispense a Medicaid prescription than to dispense a private third party prescription. Therefore, each state should regularly survey pharmacies' cost of dispensing under Medicaid and set rates accordingly.

To achieve some of its Federal budget savings targets for the next 5 years, the Administration has proposed using the concept of "Average Sales Price", known as ASP, rather than Average Wholesale Price (AWP) to reimburse pharmacies for Medicaid prescriptions. In fact, unlike most states that reimburse pharmacies for both the cost of the drug used to fill the prescription, as well as a reasonable dispensing fee, the administration proposes to reimburse pharmacies ASP plus 6% for the cost of the drug and the dispensing costs. This proposal, according to CBO, would generate $5.2 billion in Federal savings over the next 5 years, or a combined savings of $9.2 Federal and state savings.

Policymakers should understand that all of the savings under this policy would be achieved at the expense of pharmacists – none of the savings would come from reducing the pharmacy's costs of prescription drugs, which are 80 percent of the program's total costs, because pharmacies have no upstream leverage with brand name manufacturers. Thus, this policy would leave untouched 80 percent of the cost of the Medicaid drug program – the costs of the prescription drugs. This policy will hit low-margin pharmacies particularly hard, taking a total of $9.2 billion out of pharmacy gross margins over the next 5 year, or almost 23 percent of gross margins in Medicaid. This could result in significant access problems for Medicaid recipients, as pharmacies may have to reduce hours or close stores in response to this significant loss of gross margin revenues.

This proposal is problematic on many other levels for retail pharmacy. For example, ASP is calculated as a "weighted average sales price" across all payors (except direct Federal sales) for a particular pharmaceutical, net of various discounts and rebates given by the manufacturer that might accrue to the purchaser. However, retail pharmacies are generally charged higher prices than other pharmaceutical purchasers, and don't have access to the same discounts, rebates, and price concessions of other purchasers.

Therefore, the use of weighted average ASP could drive down the reimbursement for a drug well below retail pharmacy's purchasing price. Even adding a markup factor to the ASP amount (e.g. ASP +6%) may not make a pharmacy whole just for acquiring the drug, no less the costs of storing, inventory, warehousing, and distribution of the drug. This could force participating pharmacies to provide these products at a loss, and create potential access problems for Medicaid recipients.

- **ASP does not Represent Acquisition Costs to Pharmacies:** ASP does not represent a drug's acquisition costs to retail pharmacies. It represents the net revenues to the manufacturer for the sales of that drug in a particular calendar quarter.

There are other costs involved in getting the drug to the pharmacy that ASP does not account for, such as the pharmacy's costs to manage an inventory, the costs of getting the drug to the local pharmacy site, and the costs of complying with state and Federal pharmaceutical regulations.

- **ASP is Not Market Based:** There is nothing "market based" about an ASP reimbursement price. In fact, ASP is an outdated price, since it is calculated on data that is two calendar quarters old. It does not take into account that manufacturers have different "class of trade" pricing, and it leaves pharmacies at a loss when brand name drug manufacturers raise prices.

- **ASP Proposal Doesn't Envision Higher Medicaid Pharmacy Dispensing Fees:** The President's budget proposal does not include additional funds for pharmacy dispensing fees that would compensate for reductions in payment for drug products resulting from the new ASP methodology. Medicare moved in January to an ASP plus 6 percent reimbursement for the few drugs covered by Medicare Part B, but CMS had to pay a supplying fee of $24 per prescription. This was because CMS recognized that the move to an ASP-based system requires a significant increase in the pharmacy's dispensing fee, or access problems will result.

- **Pharmacies Have to Absorb Manufacturers' Price Increases Under ASP:** If ASP had been in effect on January 1, 2005 for Medicaid, community retail pharmacies would have been significantly affected regarding Medicaid reimbursement for brand name drugs because many brand name manufacturers increased prices in excess of 6 percent at the beginning of the year. Because the first quarter 2005 ASP rates would have been based on third quarter 2004 (July-September) sales data reported by the manufacturers, retail pharmacies would have to absorb any price increases after September 2004, the end of the third quarter 2004, all the way through March 2005.

- **ASP doesn't Encourage Generic Dispensing:** Under Medicaid community retail pharmacies are not given incentives to dispense lower-cost generics under an ASP-based system. Because generics have a lower cost basis that brand name drugs, an ASP-based system gives pharmacies incentives to dispense brands because they would make more money under an ASP plus 6% system for brands than generics (i.e. 6% of a $100 brand is $6, more than 6% of a $20.00 generic, which is $1.20 cents). An ASP system does not encourage pharmacies to dispense generic drugs.

We are encouraged that many members of Congress and other policymakers are recognizing that the use of ASP as an alternative reimbursement metric to the current formulae may create more issues than it solves. We want to work with policymakers to assure that any alternative Medicaid reimbursement formula that may be used is fair, real-time, market based, and reflect the costs to retail pharmacies to obtain and manage a comprehensive pharmaceutical inventory.

Generic Drugs: Substituting generic pharmaceuticals for their brand-name equivalents is a cost-effective way of achieving savings under Medicaid. In 2003, the average price of a brand-name prescription drug was about $107.39, while the average price of a generic equivalent drug was about, $19.73, less than a fifth of the price of a brand name drug. State Medicaid programs are using generic drugs in an average of 50 percent of all prescriptions that they pay for. States that are below this average should assess their generic use policies. The need to ensure maximum use of generic equivalent drugs will become even more important over the next four years as billions of dollars worth of brand name drugs come off patent.

Some states have increased their generic drug use through the development of mandatory generic substitution programs. These programs require the use of a generic where one is available rather than the brand name innovator drug, unless prior authorization is obtained from the Medicaid program. Moreover, it is critical that states reimbursement rates for generic drugs are sufficient so pharmacists can encourage their use in Medicaid programs.

Researchers consistently find that increased use of generic drugs for off-patent brand name drugs could provide considerable savings to consumers and plan sponsors, including states and the federal government. In fact, as the budget reconciliation process moves forward, policymakers should consider whether increased use of generic drugs in Medicaid will generate most of the savings that might be needed for the budget target. For example:

- A study published in this month's *Annals of Internal Medicine* examines generic substitution for a large, nationally representative sample of adults. This study found that although over half of this group's outpatient prescriptions from 1997-2000 were for multiple source drugs, only 61 percent were dispensed as generics. If identical generic drugs had been dispensed in every instance where an off-patent brand name drug was dispensed, national savings could have been around $8.8 billion per year.[1] For dual eligibles, the savings from generic substitution in Medicaid was $1.7 billion per year, while for the non-dual Medicaid population, the savings was $388 million per year.
- A study published in 2003 by the journal *Health Services Research* estimated that Medicaid could have saved up to $229 million in 2000 if identical generic drugs had been broadly substituted for off-patent brand name drugs.[2]
- Two NACDS chain members recently estimated significant savings from increased use of generics in Medicaid. If generic dispensing in Medicaid increased to 60.5%, one chain estimated that Medicaid could save at least $3.5 billion each year.

These studies all focus on substitution of identical generic products for off-patent brand name products. Even greater savings could be achieved if patients were able to use a generic drug that provided similar therapeutic benefit in place of a patented, sole source brand – even if that generic were a different chemical entity.

[1] Haas, et al., Potential Savings from Substituting Generic Drugs for Brand Name Drugs: MEPS, 1997-2000; Annals of Internal Medicine, June 2005

[2] Fisher, et al., Economic Consequences of Under Use of Generic Drugs: Evidence from Medicaid and Implications for Prescription Drug Benefit Plans, Health Services Research, 2003; 38: 1051-63.

Preferred Drug Lists (PDLs) and Step Therapy: NACDS supports the use of PDLs, prior authorization (PA) and step therapy programs as quality improvement and cost savings mechanisms for state Medicaid programs. State Medicaid programs throughout the country have begun to recognize that the PDLs and supplemental rebates guarantee significant Medicaid cost savings through effective and safe medication utilization management. NACDS supports PDL and PA programs that are based on sound clinical judgment, and the clinical needs of Medicaid recipients in the state.

Traditionally, PDLs have included categories of drugs such as arthritis drugs, gastric acid reducers, antihistamines, and antibiotics. After garnering more experience with how these programs work, some states have recently started adding mental health drugs to these PDL programs, such as antidepressant drugs. These drugs have been added with important procedures and safeguards to assure that necessary medications are made available to patients with unique medical needs.

A Pharmacy and Therapeutics (P&T) committee should be used to make recommendations for the PDL, prior authorization, and step therapy programs. The P&T committee, comprised of physicians as well as pharmacists, should be charged with recommending drugs for inclusion in these programs based on sound clinical judgment and cost effectiveness.

Prescription Limits: Some states are limiting the number of prescriptions that a Medicaid recipient can obtain in any one month. For example, some states allow Medicaid recipients to obtain four brand name prescriptions and unlimited generic prescriptions in any given month. Additional brand name drugs can be obtained with prior authorization. On the other hand, some states are limiting the total number of prescriptions in any month, regardless of the medical needs of the patient.

Hard and fast prescription limits may not be in the best interest of the patient since they can deny cost-effective prescription medications to those in need. Systems that limit the number of brand name drugs but allow an exceptions process for additional brand name drugs or unlimited generics may result in better outcomes for Medicaid recipients. Such a system helps assure that patients are getting all the medications they need, but makes the physician and pharmacist consider less expensive alternatives (i.e. generic medications) that may be equally effective for the recipient before prescribing another brand name drug.

Multi-State Purchasing Pools: States that have effectively used PDLs have become concerned that some of their Medicaid program's negotiating clout with drug manufacturers will be lost as the "dual eligibles" transition over to the Medicare program in 2006. That is because these dual eligibles represent a significant amount of drug spending in the typical state Medicaid drug program.

Some states have formed multi-state purchasing pools so that they can pool their purchasing clout over multiple states and still retain their negotiating leverage with drug manufacturers, even as the lose a significant part of their Medicaid patients to Medicare in 2006. Properly structured, these multi-state pools can help states continue to obtain lower net prices for drugs dispensed to Medicaid recipients.

Medication Therapy Management: Pharmacies can provide certain professional services that can help assure the appropriate use of the most cost-effective drugs. A number of public and private entities have instituted programs that provide reimbursement to pharmacists to provide drug therapy management services. These programs are designed to improve care coordination, increase medication compliance and reduce avoidable medical complications and service utilization.

Mississippi was the first state in the nation to receive federal approval to provide reimbursements for pharmaceutical care under Medicaid. Under its waiver program, approved by CMS (then HCFA) in 1998, Medicaid pays specially credentialed pharmacists a flat fee of $20 for each 15 to 30 minute patient encounter. These visits allow pharmacists to evaluate patients, review drug therapies with physicians, and educate patients about managing the disease and adhering to the drug regimen.

Iowa's Medicaid program offers a Pharmaceutical Case Management program for patients identified by Medicaid as at high risk for having trouble taking their medicines safely and effectively. Under the program, pharmacists and physicians partner to establish treatment goals for patients and provide follow-up services to ensure compliance, achievement of treatment goals and identification of side-effects.

Electronic Prescribing: Electronic prescribing allows the physician to send prescriptions electronically to the pharmacy. Known as E-Rx, this process can reduce the number of prescription-relate errors that are inherent in a paper based system, but it can also help improve quality of care for Medicaid recipients and save money for the Medicaid program. That is because the physician has information in a "hand held" or similar device relating to the state's PDL, prior authorization, or step-therapy processes. This makes them easier to comply with and helps reduce the burden on physicians and providers to obtain prior authorization requests if the scope and nature of covered prescription medications is known at the point of prescribing.

In mid-2003, the Tampa, Florida-based e-technology developer Gold Standard and the Florida Medicaid program, under a project approved by the Centers for Medicare & Medicaid Services, partnered to launch the wireless eMPOWERx system. eMPOWERx is an e-prescribing system that transmits prescriptions to dispensing pharmacies, allowing the prescribing physician to transmit a Medicaid prescription to any pharmacy in the state.

It also includes a patient history database, which now includes 100 days of prescription history,[3] The database is updated daily over a secure, wireless connection and alerts physician prescribers to patient doctor-shopping by showing all medications dispensed to individual patients by all prescribers. Physicians who discover patient fraud or abuse can report that abuse to the state using the eMPOWERx tool. The system also includes a drug interaction screening tool that alerts physicians to potential adverse interactions, and provides prescribing physicians with an electronic version of the state's preferred drug list.

[3] When the project began, the system included only 60 days of patient history.

Since implementing eMPOWERx, Florida Medicaid has seen a four percent reduction in significant drug interactions and has achieved cost savings of about $700 per month for each of the 1,000 prescribing physicians enrolled in the initial pilot program. The Florida Medicaid program's only administrative responsibility has been to enroll those physicians who write a significant number of Medicaid prescriptions.

In January 2005, Florida expanded the project to a total of 3,000 physicians who write 80 percent (25 million) of all Medicaid prescriptions written in Florida. The eMPOWERx system handles 150,000 to 160,000 Medicaid prescription transactions each day. The system has been so successful in Florida that Mississippi Medicaid has asked Gold Standard to implement a similar pilot program – partially funded by a grant from the Mississippi Academy of Family Physicians Foundation – for the 225 of Mississippi's physicians who write the highest number of Medicaid prescriptions in the state.

Conclusion

NACDS supports initiatives by policymakers to institute reforms in the Medicaid programs. These reforms, however, must not ultimately result in Medicaid recipients being denied access to reasonable and necessary care, or shift the cost of care to providers. Medicaid recipients are entitled to health care services that are comparable to those needed by the rest of the population. The program should be structured to recognize that Medicaid recipients tend to need and use more health care services because they are sicker, frailer, and of limited means. However, it is appropriate to require some contributions to their overall health care by those Medicaid recipients that have an ability to pay.

Program reforms would also include better management by pharmacy providers of the drug product component of the Medicaid budget, which can result in reduced spending for prescription drugs and other health care services and an overall improvement in quality of care. Key to management of this spending is the use of lower-cost generic drugs.

National Association of
Children's Hospitals

N · A · C · H

June 27, 2005

Senate Committee on Finance
Attn: Editorial and Document Section
Room 203 Senate Dirksen Office Building
Washington, DC 20510

Ph: 202/224-4515

Re: "Statement for the Record for the June 15, 2005, Hearing on the Future of Medicaid: Strategies for Strengthening Americans' Vital Safety Net"

Dear Senate Finance Committee;

I am submitting the attached 7-page statement for the June 15th hearing record.

If you would like any additional information or material, please contact me at 703/797-6006 or pwillson@nachri.org.

Thank you very much.

Sincerely,

Peters D. Willson

Peters D. Willson
Vice President for Public Policy

Enclosure: Statement for the June 15 Finance Committee Hearing Record

401 Wythe Street, Alexandria, VA 22314
(703) 684-1355 Fax (703) 684-1589
www.childrenshospitals.net

An Affiliate of the National Association of
Children's Hospitals & Related Institutions

National Association of
Children's Hospitals

401 Wythe Street
Alexandria, VA 22314
(703)684-1355 Fax (703)684-1589

N•A•C•H• TESTIMONY

**STATEMENT
FOR THE HEARING RECORD**

**LAWERENCE A. MCANDREWS
PRESIDENT AND CEO
NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS
ALEXANDRIA, VA**

**PRESENTED TO THE
COMMITTEE ON FINANCE
U.S. SENATE
WASHINGTON, DC 20510**

**"THE FUTURE OF MEDICAID:
STRATEGIES FOR STRENGTHENING AMERICANS' VITAL SAFETY NET"**

JUNE 15, 2005

Mr. Chairman, as president and CEO of the National Association of Children's Hospitals (N.A.C.H.), I appreciate the opportunity to submit testimony for the record of the June 15 committee hearing, "The Future of Medicaid: Strategies for Strengthening Americans' Vital Safety Net."

Founded in 1995, N.A.C.H. is the public policy affiliate of the National Association of Children's Hospitals and Related Institutions (NACHRI). N.A.C.H. represents more than 130 children's hospitals nationwide, including independent acute care children's hospitals, independent children's specialty and rehabilitation hospitals, and children's hospitals within larger hospitals. N.A.C.H. assists them in fulfilling their missions of clinical care, education, research, and advocacy devoted to the unique health care needs of all children in their communities.

Overview: Four Key Points In this statement for the hearing record, I would like to underscore four points.

- **The nation's children and children's hospitals have a huge stake in Medicaid reform.** The nation's children's hospitals welcome Congress' interest in taking a serious look at how to sustain, strengthen, and modernize Medicaid. No one has a more vested interest in efforts to ensure the financial integrity and strength of Medicaid than children and their providers. Children are more than half of Medicaid recipients, although they account for only 22% of Medicaid spending. Reductions in Medicaid spending that do not protect children's eligibility and benefits can put children and their providers at serious risk.

- **Changes in Medicaid can affect all children, as well as poor children.** Medicaid has become a vital partner in health care for **all** children, rich and poor alike. It pays for the care of one in every four children. On average, it represents more than 30% of a pediatrician's payments and 50% of a children's hospital's revenues. In many states, the proportions are much higher. When Medicaid support for children tightens, it can have such a large financial impact on children's providers that it can affect their ability to serve their privately insured and publicly insured patients, as well as uninsured patients.

- **N.A.C.H. supports some NGA recommendations while expressing strong concern about others.** N.A.C.H. supports the NGA's recommendations against federal Medicaid block grants and caps, for better coordination of Medicaid and the State Children's Health Insurance Program (SCHIP), and for federal incentives to deter loss of private insurance. N.A.C.H. recommends great caution in considering NGA recommendations for flexibility on cost-sharing and benefits. Children should be exempt. N.A.C.H. also urges the retention of the Medicaid's judicially accountable entitlement to coverage for eligible individuals.

- **N.A.C.H. supports reforms that address the unique and very real challenges children face in Medicaid today.** The biggest challenge facing Medicaid coverage for children is not out-of-control spending or benefit packages that are inappropriate to their needs. The real challenges are failed enrollment, a dearth of pediatric quality and performance measures, and the absence of adequate payment, much less any reward or incentives for better performance for children's health care providers. N.A.C.H. recommends reforms that would dramatically improve enrollment of millions of eligible but unenrolled children in public insurance programs, make a meaningful investment in the development of quality and performance measures for children's health care, and support a national demonstration that would give children's hospitals the opportunity to receive better Medicaid payment for performance, which adult hospitals already receive under Medicare.

Medicaid Is a Vital Partner in Health Care All Children Both directly and indirectly, Medicaid has become a vital partner in the provision of health care for all children.

Medicaid not only covers 26 million children; along with the State Children's Health Insurance Program (SCHIP), it also protects children from the loss of health insurance plaguing growing numbers of adults. According to the Census Bureau, it is only because of Medicaid and SCHIP that the number and proportion of children who are uninsured has not increased, at a time when employer-sponsored health insurance has been declining and the number of all uninsured people has continued to grow.

At any point in time, Medicaid pays for the health care of one in four children, nearly one in three children with special health care needs, and one in three infants in the U.S. In some of the nation's poorer states, Medicaid pays for the health care of nearly one in three children and one in two infants. And over the course of a year, Medicaid provides coverage for at least some period of time for an even larger proportion of children.

Since Medicaid pays for the health care of so many children, it should not be surprising that children, including children with disabilities, represent more than half of all Medicaid recipients. What is surprising to many is that coverage of children does not drive the growth in Medicaid spending. Children, including children with disabilities, account for only 22% of all Medicaid spending. On average, Medicaid spends $1,388 per non-disabled child, compared to $1,790 per non-elderly, non-disabled adult, $11,408 per disabled individual, and $10,694 per elderly adult per year, as of FY 2002. Annual per capita spending for all children, including children with disabilities, is $1,773, compared to $4,891 for all non-elderly adults, including

those with disabilities.

The low Medicaid cost per child reflects the fact that children are generally healthier than adults. It also reflects the fact that in the last decade, the major strategy used by states to control Medicaid spending has been capitated managed care plans. Children have led the Medicaid managed care revolution in both public and private insurance, with the majority of all children assisted by Medicaid now enrolled in managed care but only the minority of adults and the elderly.

Taken together, these facts mean two things. First, because Medicaid affects such a large proportion of children's health care over time, it literally can affect all children. Second, because children account for such a small amount of Medicaid spending, there is little opportunity to achieve substantial Medicaid savings from children's health care, except at the potential expense of their health.

Medicaid Is the Financial Backbone of Children's Hospitals' Service to All Children In the U.S., children's hospitals are indispensable to children's health care, because children's health services, particularly specialty care, are concentrated in relatively few institutions.

- **Children's hospitals are the major providers of both pediatric inpatient and outpatient services.** Less than 5% of all hospitals, children's hospitals provide more than 40% of all hospital care for children, and more than 80% of hospital care required by children with serious illnesses, such as cancer or heart disease. For some conditions, such as the need for organ replacement, children's hospitals provide 98% of the care.

- **Despite their small proportion of all hospitals, children's hospitals train the majority of the nation's pediatricians,** virtually all of its pediatric subspecialists, and the large majority of pediatric research scientists.

- **Children's hospitals house the nation's leading pediatric biomedical and health services research centers.** More than a third of all of the National Institutes of Health's pediatric research funding supports the pediatric research in children's hospitals or their affiliated medical school departments of pediatrics.

- **Children's hospitals are the major safety net providers for children, in terms of both economic and medical vulnerability.** They are often doctor, clinic, dentist and hospital for low-income children. Children's hospitals work hand in glove with community health centers in providing staff and taking referrals for children needing specialty care. They are the frontlines of support for child abuse prevention and treatment, as well as public health and safety advocacy for children.

Although almost all are private institutions, children's hospitals depend on Medicaid financing to serve all children, as well as children of low-income families, because Medicaid plays an extraordinarily large role in the financing of these institutions. On average, children's hospitals devote about 50% of their patient care to children assisted by Medicaid. It is not unusual for a children's hospital to devote 60%, 70%, or more of their care to children assisted by Medicaid.

Since 2001, children's hospitals, along with pediatricians, have struggled annually to avoid state Medicaid provider reimbursement cuts or cuts in children's coverage, as almost every state has adopted repeated, annual reductions in its Medicaid program. Medicaid falls short of paying the cost of the care required for the children it covers. On average, Medicaid pays for 73% of the cost of patient care provided by a children's hospital. Even with disproportionate share hospital (DSH) payments, a children's hospital receives, on average, only about 80% of

the cost of its care. For outpatient primary and specialty care, as well as physician care, the picture is even worse.

Taken together, these facts mean that Medicaid plays such a large role in the financing of children's hospitals that any changes in Medicaid potentially could affect the financial ability of the hospitals to serve all children, as well as low-income children, because they cannot reduce services for only poor children in order to absorb Medicaid losses. They must absorb their Medicaid losses in their clinical, training, and research programs that benefit all children, by increasing waiting times for services, closing the financially weakest services, delaying expansion or launching of new services, curtailing their training programs at a time of growing pediatric subspecialist shortages, or curbing the development of their research enterprises.

Children's Hospitals' Response to the NGA Recommendations The growth in Medicaid spending is unquestionably a serious challenge for state governments, which governors understandably are seeking to address, both on their own and with the help of the federal government.

But in considering the NGA recommendations, it is important to recognize that the annual rate of growth in Medicaid spending is actually less than it is for private insurance, and most of the Medicaid growth rate is attributable to the major cost drivers in health care overall, not to the Medicaid program itself and certainly not to the cost of Medicaid coverage for children.

Children's hospitals support some of the NGA recommendations while expressing strong concerns about others.

Incentives for the Retention of Private Coverage Clearly, one of the major contributors to the growth in Medicaid spending is the continued loss of private, employer-sponsored coverage. N.A.C.H. supports the NGA recommendations for financial incentives to stem the loss of private coverage, which often is greatest for dependent, rather than employee coverage.

Block Grants and Caps N.A.C.H. strongly supports the governors' recommendations that Congress neither block grant nor place caps on federal Medicaid funding to states. As the governors have said, such federal financing limits would only exacerbate Medicaid budget shortfalls that have plagued states since 2001 and pit children's health care services against adult health care services.

Transition Between Medicaid and SCHIP Enrollment and retention of eligible children is a major challenge to fulfilling the promise of both Medicaid and SCHIP to millions of uninsured children. N.A.C.H. supports the governors' recommendations that efforts be made to ensure a smooth transition of children moving back and forth between Medicaid and SCHIP, as their families' income levels and therefore their eligibility for the two programs continually change.

State Flexibility N.A.C.H. strongly recommends caution in considering the governors' proposals for increased flexibility in how they administer federal Medicaid funds. Accountability for Medicaid spending, particularly for children's care, is essential, because children's health care needs are so different from adult health care needs, and because failed health care for children can have life-long consequences for both their health and economic productivity, which can vastly exceed the original cost of failed or missed health care.

- **Benefits** The governors' request for flexibility to provide different benefit packages for different populations promises little in real savings from children's health care and does not reflect the reality of children's health care needs. When healthy, children are very small consumers of health care. Nationwide, 95% of children account for only about

6% of personal health care spending. But a healthy child can become seriously ill in the blink of an eye. When that happens, they need the full scope of Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits. They were designed for children's unique health care needs, particularly children with disabilities who are disproportionately represented in Medicaid.

There is a myth that Medicaid is an expensive benefit package for children. In fact, its cost per child actually is comparable to private coverage. That means Medicaid is a more cost-effective purchase, because Medicaid covers more children with disabilities and it does not impose arbitrary limits on medically necessary care in the way that private insurance does, such as day limits on inpatient care, limits on occupational and physical therapy visits, or limits on the replacement of medical devices, even when children outgrow them. In addition, the cost of Medicaid coverage for healthy children is minimal, while the cost of its coverage for children with complex needs is essential.

Congress should retain the EPSDT benefit package for Medicaid eligible children; it should not permit it to be waived. At a minimum, EPSDT should be retained for all mandatory eligible children, all children with family incomes below 150% of poverty, and all eligible children with disabilities, including optionally eligible children with special health care needs, such as "Katie Beckett" and "medically needy" children.

- **Cost Sharing** Congress should retain current Medicaid law's exemption of children from cost sharing. Research has demonstrated that cost-sharing can discourage health care utilization, with adverse impact on health status. At a minimum, new cost sharing obligations should not be imposed on children with family incomes below 150% of poverty. For children with incomes above 150% of poverty, cost sharing obligations should be no greater than what is permitted by SCHIP. Such cost sharing should be limited to co-payments and deductibles; it should not include insurance premiums, which, if unpaid, would leave a child uninsured. And parents' failure to pay cost-sharing should not prevent children from receiving the care they need.

Judicial Reform NGA has recommended changes in the ability of the judicial system to hold states accountable for the implementation of the federal guarantee of coverage for eligible individuals. N.A.C.H. recommends retention of the legal enforceability of federal Medicaid policy.

Children's Hospitals' Recommendations for Modernizing Medicaid for Children Budget is not the major challenge facing children under Medicaid. The real challenges are unfulfilled enrollment, the dearth of pediatric quality and performance measures as well as federal Medicaid investment in their development, and the absence of any reward for quality and performance in pediatric care.

To address these challenges, N.A.C.H. recommends reforms that would:

- **Enroll All Eligible Children** Two-thirds of the nation's uninsured children are eligible but not enrolled in Medicaid or SCHIP. President Bush, as well as leaders in both parties in Congress, supports proposals that would help states modernize their enrollment and retention policies for children. If all eligible children were enrolled, the nation would have virtually eliminated the problem of lack of health insurance – and the health risks that accompany it – for most children.

  N.A.C.H. recommends both financial and administrative reforms to promote effective enrollment and retention.

- **Invest in a Federal Quality Initiative for Children** Although children are the least expensive population covered under Medicaid, there still is the need for reforms that rewards efficiently and effectively delivered care for children. However, there is a serious dearth of pediatric quality and performance measures for children's health care, because private payers are investing primarily in the development of measures for adult care and the federal government is investing primarily in the development of measures for the health care of Medicare recipients. Although it is the nation's single biggest payer of children's health care, the federal Medicaid program has done little to invest in pediatric quality and performance measures. Most states do not have the resources, much less a sufficiently large population of children, for the development and testing of effective pediatric measures.

  N.A.C.H. recommends the establishment of a children's program coordinating data, quality, and performance measures for children covered under both Medicaid and SCHIP within the Centers for Medicare and Medicaid Services (CMS). We also recommend federal funding for the National Quality Forum to develop consensus-based pediatric quality and performance measures, Agency for Health Care Quality and Research grants for the development and testing of new pediatric measures, and CMS to support state, multi-state and provider demonstrations of disease and care management, health information technology, and innovations in the delivery of more efficient and effective pediatric care.

- **Provide a National Demonstration for Children's Hospitals** Like critical access hospitals and federally qualified health centers, children's hospitals are indispensable to the nation's health care safety net but vulnerable because of the volume of service they provide to children of low-income families, with reimbursement often substantially below costs. However, unlike critical access hospitals or rural hospitals, which receive cost-based reimbursement under Medicare, there is no federal recognition of the need such payment need for children's hospitals. In addition, adult hospitals serving Medicare programs have opportunities to participate in demonstrations providing better pay for performance, whether it involves Medicare market basket updates on inpatient reimbursement in exchange for hospitals reporting on agreed upon quality measures or it involves enhanced Medicare reimbursement for hospitals participating in the Premier demonstration. Children's hospitals have no such opportunities.

  N.A.C.H. recommends the development of a national demonstration of pay for performance under Medicaid for children's hospitals. Children's hospitals would have the opportunity to receive an enhanced Medicaid reimbursement in exchange for their reporting and demonstration of performance against agreed upon measures. Medicaid would have the opportunity to test and evaluate quality and performance measures for children's hospitals, an opportunity that does not now exist. In addition, such a demonstration would represent an important step toward a payment system that is sufficient to cover the cost of care as well as rewards the quality and performance of care.

N.A.C.H. also recommends that Congress amend Sec. 340(B) of the Public Health Service Act to permit independent children's hospitals to qualify for drug purchasing discounts if they meet the criteria for the other participating disproportionate share hospitals, with the exception that they be Medicare prospective payment system (PPS) hospitals. Independent children's hospitals are exempt from Medicare PPS.

Conclusion: Work on Medicaid as If It Matters to All Children

Medicaid faces many challenges today in large part because of its success in helping the nation address so many different challenges that our health care system otherwise is not designed to address: the long-term care needs of millions of middle and low-income Americans, the chronic health care needs of adults and children with serious disabilities, basic as well as catastrophic health care needs of low-income senior citizens and the basic as well as catastrophic health care needs of millions of low and middle-income children.

As Congress focuses on the fiscal future of children, we urge it to act as if its decisions will have the potential to affect, directly or indirectly, every child in this country, including our own children and grandchildren.

NBCC
NATIONAL BREAST CANCER COALITION
« grassroots advocacy in action »

June 29, 2005

The Honorable Charles E. Grassley
Chairman
Senate Finance Committee
United States Senate
Washington, D.C. 20515-6200

The Honorable Max Baucus
Ranking Member
Senate Finance Committee
United States Senate
Washington, DC 20515-6200

Dear Chairman Grassley and Ranking Member Baucus:

On behalf of the National Breast Cancer Coalition, and more than three million women living with this disease, I want to thank you for holding the hearing, *The Future of Medicaid: Strategies for Strengthening American's Vital Safety Net (June 15, 2005).* NBCC agrees with the Committee that the lack of affordable health coverage is a severe and growing problem in this country and must be adequately addressed.

As you know, The National Breast Cancer Coalition, comprised of hundreds of member organization and tens of thousands of individual members, worked with the Members of this Committee in 2000 to enact the Breast and Cervical Cancer Treatment Act (PL 106-354), legislation which guaranteed coverage for the treatment of breast cancer to low-income women screened and diagnosed through a federal program. While we are proud of that important step towards expanding access to health care for women diagnosed with breast cancer, we are concerned about current threats to the Medicaid program. In addition to protection of individuals' current health care coverage, NBCC's highest legislative priority is to develop and enact a strategic approach to guarantee high quality health care for all. We appreciate the Committee's attention to this issue, and look forward to working with you this year to ensure that all Americans have access to the health care they deserve.

While many different approaches to address the issue of the uninsured are being discussed, we are all aware of the devastation that uninsured women and their families face when they are diagnosed with breast cancer. In order to capture some of their stories, NBCC has developed the *Stop Breast Cancer: Personal Stories, Public Action Campaign*. As a part of this campaign, NBCC is collecting stories from women across the country regarding their experiences with accessing breast cancer treatment. Enclosed are a few testimonials that demonstrate some of the challenges they have faced. **We request that these stories be made a part of the hearing record.**

NBCC recognizes that there are no easy answers to the issue of access to health care. We also understand and appreciate the hard work that Congress, the Administration, and other organizations representing constituencies concerned about this issue, are doing. NBCC recently held a plenary session at our Annual Advocacy Training Conference in which panelists representing the Heritage Foundation and the Center for American Progress, and many, if not all, of the nearly 800 Conference participants agreed on the need to ensure that all Americans have access to the health care they need and deserve. NBCC shares that goal, and looks forward to working with Congress to protect the Medicaid program (and the low-income women diagnosed with breast cancer who benefit from it) and to expand access to high quality health care for individuals all across the country.

Thank you again for the work that you have done, and the work that you continue to do on this critical issue. Please do not hesitate to contact me, or NBCC's Government Relations staff if you have questions, or need additional information.

Sincerely,

Fran Visco
President

Enclosure

NATIONAL BREAST CANCER COALITION FUND
STOP breast cancer: Personal Stories. Public Action

Story #1 (Submitted May 2005):

"When I was diagnosed seven years ago due to the nature of my husband's seasonal work, I was a few weeks from having insurance. Through two reoccurrences I've had insurance with a deductible and copay. In the off seasons I've paid COBRA and had bills sent to collections. Recently, Medicare is covering more of the cost. Hence, I am limited in earning income and working in my chosen career. MY heath care decisions have been based on rushed and inadequate information. The treatment is implemented and then you're on your own to find follow-up resources and care. This hasn't changed in seven years.

I am grateful to kind health care workers. However, I was treated crudely by one doctor when I asked about alternative options. Another doctor used my appointment to lecture on his political world cause. He missed symptoms showing reoccurrences. There needs to be a whole person, whole body consideration taken in all health care approaches."

-Carla Clements, Missoula, MT

Story #2 (Submitted May 2005):

"Prior to diagnosis, I was uninsured. I noticed some changes in my breast, so I applied for insurance. I cannot afford it. IT costs $187/month with a $5000 deductible and covers only me. MY daughter and sister help me pay my bill (insurance).

By the time I was able to get into a doctor, my breast looked deformed. Once I was covered, appointments with doctors were timely; my wait from first visit to diagnosis was three weeks. But I have a very aggressive form of breast cancer that spreads quickly and within the two months since I 'd first notices changes, I was diagnosed as a stage four.

Overwhelmed and in shock, I found it difficult to understand all the information I was receiving. IT was more like this is your situation, here's what we're going to do, these are the die effects, no time for a second option, no time to become educated about treatment options. I was only given information on the type of cancer I had and what my doctor, whom I had never met, was telling me what we would do. I mean, its up to you, the decisions, but you have to make these decisions under stress without any alternate plans.

I am now over $10,000 in debt, making payments, being sent to collection agencies because I can't afford my bills. If I'm forced to make choice, feed and clothe my kids, pay the mortgage, cay payment or pay the Doctor, the doctor has to come last. I lose sleep over this. It's not that I don't want to pay the bills, its simply easier to let them go to collection and make one payment a month. One I still can't afford. I make only $8.35 an hour at my job.

I believe my doctors practice evidence-based medicine, but I have to trust that because I am not aware of the clinical trials of their results. Occasionally, I have read an article or seen information on a website that confirms the treatment I am undergoing.

Recently, because I have had trouble paying my $6700 bill to my oncologist, I was not given an expensive hormone shot. I am on Estrogen Replacement Therapy and was receiving Lupron to shoe down my hormone. The pharmaceutical company would pay for this hot because I am eligible but I don't have prostate cancer or endometriosis. Lupron has been used for treatment of breast cancer for years, but the FDA has not approved it for this use-so no shot. Hopefully, I will stay in menopause and the aromatse inhibitor I am taking will still work. If not, who knows. But I feel like I am being discriminated against. If I had the money, I would have the shot."

-Jayne Collie, Stevensville, MT

Story #3 (Submitted March 2004):

"I am writing to ask for your support for people that don't have health insurance, adequate insurance, or the people that have a job, but still don't have affordable health insurance.

When this happens we have to look for help, as I did two years ago. Once I was no longer working, I had no health care. I worked for 26 years and thought I would have insurance once I retired. I didn't find out until I did retire that I could only get insurance if I paid $9,000/year premium out of my $615/month retirement benefits. I had to figure out if I was supposed to eat, pay my mortgage, or afford the health insurance available to me.

Many people in my position will not see a doctor because of the cost. I was fortunate to find the *Iowa Breast and Cervical Early Detection Program* (BCCEDP). Had it not been for that program, I would have never had a mammogram, or had my breast cancer diagnosed. IF they had not stepped in and gave me help, I don't know what I would have done.

I didn't ask for breast cancer, but because I have breast cancer I qualified for the BCCEDP Title XIX Treatment Act-it has covered all my medical needs. However, had my breast biopsies been benign, I would still be paying for the anesthesia, the hospital charges, all the costs not covered by the NCCEDP, all on my $615/month pension.

Please continue to support the funding of programs like the NCCEDP. But also work for universal health care for all persons. I am grateful for the service and treatment that was available to me through the BCCEDP, and I am doing my part, by writing and telling you have a lack of insurance has impacted me."

-Alice Reed, Waterloo, IA

Story #4 (Submitted April 2004) :

"In February 2003, I stated my own cleaning business. I was struggling financially to support myself and my daughter, but I was doing it, with out the help of child support, an ADC check, or food stamps. I almost had enough regular houses to pull my ad out of the newspaper when I found out I had cancer.

It was hard enough to hear the words breast cancer, but to make matters worse, I didn't have insurance. Having breast cancer is not easy, it makes you sick, tired, and its hard to get through some days. But to face all of that, and also know that I had no insurance to pay for it, I was devastated.

I was enrolled in the Iowa Breast and Cervical Cancer Early Detection Program. The coordinator told me that I qualified for the Breast and Cervical Treatment Act-Title XIX. IT saved my life. Without this program, I would have lost my home, and my daughter and I would have been on the street. My daughter doesn't have a father, so I am the only parent she has got. Without this Treatment Act that pays for all my cancer treatments, I probably would have chosen not to get treatment, and would no have lived to raise and support my daughter. It's horrible to have to choose life or debt.

Even with the help of the Treatment Act, I'm still finding myself in debt. Because of the effects of the treatments, I Can't work as much. I've had to get on food stamps and had to charge lots of bills. I owe the bank a lot of money now, but I would never have made it at all without the help of the Iowa program."

-Vivian Pavelec, Waterloo, IA

Story #5 (Submitted March 2004) :

"I had been working as a NYS certified nursing assistant for almost 7 years when I resigned to enter graduate school. It was an intensive 3-year program of which I was told that I would not have the time nor the energy to work if I had wanted to pass. I then obtained school health insurance where I was covered only for liability to attend my internships.

After being in the program for over a year, I was diagnosed with Stage 1 breast cancer and I obtained Medicaid. After being in "remission" for 4 months, I had agonizing sciatic pain as well as pain in my neck and back and I could barely walk nor drive. I went to my local emergency room where I was told nothing was wrong and was given a vicadin. The next day I went to another ER, only to be told the same thing. The day after that, I returned to the same ER and refused being sent home until they took tests to tell me what was causing me my excruciating pain. Low and behold, I had a bone scan and it was then confirmed that I had bone metastasis in my skull, spine, ribs, sternum, pelvis, and shoulder area. To say the least, I was floored. I could believe the diagnosis, but I could not believe that I was overlooked and not seen as someone who should be taken seriously. I then went on disability and my journey began.

Since then, I graduated, but still in pain. Fortunately a lot of it has subsided for now, but I cannot work because of disability and Medicaid. If I work, I will lose both since I must stay at the poverty level to keep my benefits. If I lose my benefits from working then I will not be covered for my metastasis. I have been on chemotherapy for 4 years now and my status can worsen at any time, leaving me vulnerable to venture out to work on a consistent part time basis. I have lost my independence in the work force before it even started and am left broke and disheartened.

I have been mistakenly dropped from Medicare and Medicaid a couple of times now, causing doctors to send me away without being treated and pharmacists being unable to give me much needed prescriptions. I feel degraded and alone. Dealing with the healthcare system is a daily struggle and something needs to be done to rectify this situation IMMEDIATELY."

- Christine Sansone, Commack ,NY

NCCNHR National Citizens' Coalition for Nursing Home Reform

Barbara J. Hengstebeck, President
Alice H. Hedt, Executive Director
1828 L Street, NW, Suite 801, Washington, D.C. 20036
202.332-2275; Fax 202.332-2949; www.nursinghomeaction.org

Statement of the National Citizens' Coalition for Nursing Home Reform

The Committee on Finance has been given a difficult responsibility under budget reconciliation instructions to find $10 billion in savings from programs within its jurisdiction. The National Citizens' Coalition for Nursing Home Reform would like to thank Chairman Grassley and Ranking Member Baucus for holding hearings presenting a spectrum of viewpoints and recommendations on ways to achieve Medicaid savings – including eliminating fraud and abuse – without jeopardizing essential health and long-term care services. NCCNHR also appreciates the committee's decision to hold the record of this hearing open to receive additional viewpoints from beneficiaries and providers.

As an advocate for frail elderly and disabled Americans who need long-term care services, NCCNHR is concerned that this year's debate about Medicaid is taking place in the context of mandated budget cuts. With 43 million men, women and children uninsured today and with the over-85 population projected to triple by 2040, a longer, more thorough examination of Medicaid's role in health care and long-term care is critically needed before substantial changes are enacted. NCCNHR therefore urges the committee to:

- Minimize cuts to Medicaid in the budget reconciliation process;
- Seek savings from other programs;
- Strengthen federal and state efforts to curb fraud and abuse (see NCCNHR's statement for the record of the committee's June 28-29 hearing, *Medicaid Waste, Fraud and Abuse: Threatening the Health Safety Net*); and
- Adopt short-term Medicaid savings that will not weaken the long-term care safety net.

NCCNHR would like to make the following specific comments and recommendations:

Transfer of Assets

- Reject the National Governors Association recommendations to extend the look-back on asset transfers to five years and begin the exclusion period at the time of application for Medicaid benefits.
- Adopt recommendations of the National Academy of Elder Law Attorneys to curb practices that attorneys who represent elderly clients believe may be used deliberately to evade Medicaid spenddown. These include self-canceling loans, private annuities, and balloon annuities.

At the Medicaid Commission meeting on August 17, an NGA representative said the governors' proposals were intended "to send a lesson" that Americans must save for their own long-term care. NCCNHR believes enactment of measures that would withhold help from people when they are elderly, poor, severely disabled, and out of options would send a very different message to our citizens and the world: America is no place in which to grow old.

When Governor Warner and Governor Huckabee testified before the committee, neither could answer the question how many people actually transfer assets with the intent of obtaining Medicaid benefits. As a result, the governors' proposal casts a wide net to force all Medicaid applicants to prove that they have not made a contribution to their church, given money to a charity or political candidate, or helped a family member who was in need or who was providing them unpaid care. Who are these people who – in the NGA's parlance – would be expected *to show that in the previous five years they, their spouse, or someone acting on their behalf had not transferred or sequestered resources or the right to receive resources, income, or both, from any source, resulting in the transfer or sequestration of funds that could have been used to pay for medical assistance*?

- The typical nursing home resident is at least 85 years old.
- 75 percent are women, and 83 percent have no living spouse.
- 55 percent are confined to a wheelchair or cannot walk without extensive support, and 96 percent require help with activities of daily living.
- 45 percent have Alzheimer's disease or another form of dementia.
- Some studies estimate that from one-half to two-thirds have no immediate family.

Moreover, 84 percent of elderly people at highest risk for needing nursing home care – because they do not have a spouse, are 85 or older, and have cognitive impairments -- do not have enough assets to pay for a nursing home for a full year.

Even so, at a time when they were financially destitute, nursing home residents would have to prove that neither they, their spouse, nor anyone supposedly acting for them had used funds that now, up to five years later, could have contributed to their nursing home expenses. NCCNHR urges Congress not to enact punitive legislation aimed at its poorest, frailest adult citizens.

Waiver Reforms

- Reject proposals to make it easier for states to obtain waivers when the effect is to make it easier to deny eligibility, benefits, protections, or appropriate services to those who need long-term care and cannot afford to pay for it.
- Retain essential federal assurances that Medicaid beneficiaries will have access to services that are comparable, statewide, and consistent in amount, duration and scope.
- Oppose different treatment of optional beneficiaries. More than one-half of *all* nursing home residents in the United States are optional Medicaid beneficiaries.

Medicaid waivers have allowed nursing home-eligible people in many states to receive long-term care services in settings they prefer, including their own homes, thus nibbling away at the institutional bias in Medicaid that thrusts many people into nursing homes whether or not they need or prefer that type of care. NCCNHR therefore agrees with the NGA that waivers of normal rules can allow states to experiment with new types of care delivery and refine the programs before they are expanded to other beneficiaries or regions of the state (if, as has occurred in some states, the waivers provide opportunities for consumers to be involved in all aspects of the approval, design and evaluation of the programs).

Unfortunately, it is also true that some states have seen the waiver process as an opportunity to limit Medicaid participation by many elderly and disabled people who have no other resource for long-term care and to exclude meaningful consumer participation in decision-making. It is chilling that the NGA proposes waiving with a simple "check box" such fundamental protections as freedom of choice, comparability, statewideness, and consistency of programs in amount, duration, and scope. The wholesale waiver of such protections would indeed save costs – by diminishing the quality and accessibility of services.

It may be difficult to believe that states would cut beneficiaries from Medicaid without implementing alternatives for those who have no other source of payment. However, even without proposed reforms, recent state actions show that fears that this could happen on a widespread basis are well-founded. Tennessee has proposed a waiver that the Center on Budget and Policy Priorities estimates would cost 30,000 nursing home residents their Medicaid benefits. In Georgia last year, 1,700 residents lost Medicaid eligibility when the state decided to end its medically needy program. Many of the residents had no family who could help them. They were saved from eviction only by the determined effort of the long-term care ombudsman program and legal services agencies to enroll them in Qualified Income Trusts, a mechanism under which any income that exceeds the state cap is transferred into a trust and paid to the nursing home.

These are only two recent state actions that foretell what would happen if states obtained blanket authority to waive federal requirements.

NCCNHR urges Congress not to change Medicaid rules until it can assure that:

- Adequate funding will be available for comprehensive long-term care services, including nursing home and home and community-based services.
- Medicaid beneficiaries will be able to get the type of care they need and prefer.
- Services will be "sufficient in amount, duration and scope."
- Consumers will be integrally involved in planning and assessing HCBS programs.
- Beneficiaries of these services will not summarily lose coverage when there are budget cuts, which now occurs in some states.

- Optional Medicaid beneficiaries, *who constitute more than half of all nursing home residents*, will not be treated differently than other beneficiaries.

Quality Assurance

- No expansion of waivers for home and community-based services should be authorized without appropriate federal regulations and oversight systems in place and strong state inspection and enforcement procedures implemented.

Federal and state oversight and quality assurance must be addressed before states are allowed to expand Medicaid coverage of home and community-based services (HCBS). In 2003, the General Accounting Office conducted a study for Senator Grassley and then-Senator John Breaux of state and federal quality assurance in HCBS programs authorized under Medicaid section 1915(c). The GAO found minimal federal oversight of quality; "little or no information on state quality assurance approaches" in applications for waivers; and no state mention of complaint systems or enforcement tools in most applications. CMS reviews showed that common problems included failure to provide authorized or necessary services, inadequate assessment or documentation of beneficiaries' care needs; and inadequate case management.

Judicial Reform

- The ability of Medicaid beneficiaries to ask the courts to protect their legal rights to care should not be repealed by legislation to make it more difficult to obtain or defend consent decrees.

States have increasingly sought to terminate benefits for optional Medicaid beneficiaries, even if – as in the Georgia situation described above – it meant that hundreds or even thousands of impoverished beneficiaries had no other option to pay for long-term care. In Kentucky, more than 2,500 people lost Medicaid coverage for nursing home care or were denied benefits to pay for nursing home services when the state changed its rules determining the level of care required to qualify for Medicaid. These residents' ability to stay in their nursing homes was saved by a lawsuit that ended with a consent decree in which the state agreed to restore its regulations to comply with federal rules that protected their eligibility.

Ruth Morgan is a local Kentucky ombudsman who knew 46 of the Medicaid beneficiaries who were told they did not qualify for Medicaid under new state rules. Her stories put a human face on the plight of these real people:

- One of them was Vada Kerr. Ms. Kerr was 90+ years old and a double-leg amputee. She had multiple health problems, but she was a fighter and valued her independence. She insisted on transferring herself from her electric wheelchair to the commode and bed alone despite the recommendation from her physician that she be assisted. Ms. Kerr had no living family other than a nephew and his wife, both of whom were also disabled. She did not own a home, and would have had nowhere to

go. Placement [in a personal care home without nursing services] would have been totally inappropriate for her. Her niece contacted the ombudsman, and we assisted her in filing an appeal. We then put her in touch with the attorney who filed the class action suit against the state. Ms. Kerr was the named client in that action. Unfortunately, she did not live to see the outcome. Her niece thinks she grieved herself to death.

- I remember one other 90+ lady who had been a school teacher all of her life. She lived at the facility for several years. She also had no family and had sold her home to pay for her care. She had adjusted to facility life quite well and thought of the facility as her home. She planned to live there till she died. She told me how awful she felt when she learned that the state of Kentucky no longer considered her to be their problem. When I told her that she had won her appeal, she cried and said, "Oh, thank you. I worried every day and decided that if I lost, I would just as soon be dead."

- One of our residents was extremely distraught about being moved out of her nursing home of seven years to a personal care facility where she did not get the help she felt she needed. The family is convinced that she threw herself out of her wheelchair intentionally. She suffered a fractured hip and was moved to skilled care. The family believes this was her goal. She died before the regulations were changed.

Nursing home residents in Kentucky and other states will be at much greater risk of dangerous and inappropriate discharges if Congress passes proposed legislation that would make it easier for states to return to court to overturn consent decrees in which they agreed to comply with Medicaid requirements. Litigation to establish or enforce consent decrees protected thousands of nursing home residents from eviction in the past year alone when states stripped them of their Medicaid eligibility.

At this time in our history, the government should initiate a strong and thoughtful bipartisan process to determine how to pay for long-term care in the future, to enable those who need financial assistance to choose from an array of appropriate services, and to ensure that all Medicaid-reimbursed long-term care is of high quality. In this budget reconciliation process, nursing home residents ask only that Congress avoid choices that would put their rights, dignity, access to care, or health, safety and quality of life at risk.

National Committee to
Preserve Social Security
and Medicare

Barbara B. Kennelly
President &
Chief Executive Officer

Senate Committee on Finance
Hearing on "The Future of Medicaid:
Strategies for Strengthening America's Vital Safety Net"
Statement of Barbara Kennelly, President
National Committee to Preserve Social Security and Medicare
June 15, 2005

Mr. Chairman and Members of the Committee:

Chairman Grassley, Ranking Member Baucus, and members of the Committee, I appreciate your leadership in holding this hearing on the future of Medicaid—a program of vital interest to our nation's seniors.

Over the next few months, Congress will be considering a number of changes to Medicaid, likely involving substantial cuts to the program. On behalf of the 4.6 million members and supporters of the National Committee to Preserve Social Security and Medicare, I strongly urge you to oppose cuts to the Medicaid program.

For the past forty years, the Medicaid program has played a crucial role in our country's health care system by providing public health insurance for low-income Americans. The program protects those that are among the most medically and economically vulnerable—children, adults, disabled individuals, and seniors—who do not have access to or cannot afford private health insurance. According to the Congressional Budget Office, in 2005 Medicaid will provide health coverage to 58.5 million people (including 5.4 million senior citizens and 9.2 million disabled individuals)[1].

Older Americans benefit from an array of important services provided by Medicaid, such as: hospitalization, physician services, long-term care, prescription drugs, clinic services, prosthetic devices, hearings aids, and dental care. While seniors represent only 9 percent of Medicaid's enrollees, they receive over a quarter of Medicaid's expenditures. Seniors receive a larger share of Medicaid's expenditures because they require more frequent and expensive medical attention. The Kaiser Family Foundation estimates that in 2003 the Medicaid program spent almost $13,000 per senior.[2]

Senior citizens also benefit from Medicaid because of its leading role in our nation's long-term care system. The program's spending accounts for 43% of our nation's total spending on long-term care. For example, Medicaid provides vital financing for nursing homes, which rely on the program for about half of their total funding. Further, nearly 60 percent of all nursing home residents receive Medicaid.

---

[1] Congressional Budget Office. "Fact Sheet for CBO's March 2005 Baseline: Medicaid and the State Children's Health Insurance Program". Washington, D.C.: March 2005.
[2] Kaiser Commission on Medicaid and the Uninsured. "The Medicaid Program at a Glance." The Henry J. Kaiser Family Foundation. Washington, D.C.: January 2005.

The fiscal year 2006 budget resolution passed by Congress targets the Medicaid program for billions of dollars in reconciled cuts over the next five years. The National Committee strongly opposes any cuts or funding caps to the Medicaid program. Cutting the program or imposing caps on federal payments to the states would disproportionately hurt seniors by ending coverage for millions of beneficiaries and/or shifting rising health care costs on to state governments that are already struggling to meet the needs of an aging population.

It is impossible to make meaningful reforms to the Medicaid program without examining the flaws in our nation's health care system. The growth in Medicaid spending is symptomatic of the larger problems with health care, such as: growing health care costs, skyrocketing prices of prescription drugs, declining employer-sponsored health care coverage, and the increasing number of the uninsured. Despite these daunting facts, Medicaid's overall growth rate is significantly lower than that of private health insurance premiums (6.9 percent for Medicaid versus 12.6 percent for private insurance premiums)[3].

About twenty-two percent of National Committee member households have incomes below $15,000 per year and many are eligible for Medicaid benefits. Our members know that the program's financing structure has proven highly successful in responding to difficult economic times because it guarantees coverage to all those who are eligible. Therefore, we believe it is essential to preserve the current structure of the Medicaid program.

Thank you for giving me this opportunity to discuss Medicaid and to share the National Committee's views on the program before this Committee. As always, I look forward to working with you on the host of issues impacting America's seniors.

[3] These figures refer to the average growth rate per enrollee for acute care from FY2000-2003. For additional information, see John Holahan and Arunabh's article "Understanding The Recent Growth In Medicaid Spending, 2000-2003" from the January 26, 2005 edition of Health Affairs.

NCLR
NATIONAL COUNCIL OF LA RAZA

THE FUTURE OF MEDICAID: STRATEGIES FOR STREGTHENING AMERICA'S VITAL SAFETY NET

Submitted to:

The U.S. Senate Committee on Finance

Submitted by:

Janet Murguia
President and CEO

NATIONAL COUNCIL OF LA RAZA
The Raul Yzaguirre Building
1126 16th St. NW
Washington, DC 20036
(202) 785-1670

June 15, 2005

Introduction

I submit this testimony on behalf of the National Council of La Raza (NCLR), the largest national Latino civil rights and advocacy organization, which is dedicated to improving life opportunities for more than 40 million Latinos who live and work in the U.S. As an umbrella group with more than 300 affiliates, we hear directly from the community about the troubled state of health care and the importance of a strong safety-net system. As a result, we have a deep commitment to promote policies that preserve Medicaid and enhance the quality of care given to Latinos under this program. While the future of Medicaid is under discussion, there has been little examination of the effectiveness of Medicaid for Latinos who have a great deal at stake in this policy discussion.

The Health Status of Latinos

The Latino population currently faces a number of significant health challenges and disparities. Latinos experience disproportionately high rates of diabetes, asthma, HIV/AIDS, tuberculosis, and heart disease. Young Latinos who account for one in every five children in the U.S., struggle with these and other serious health risks, including the highest teen birth rate in the nation and high rates of mental illness and depression. Many of the health concerns that plague the Latino community could be prevented or more effectively managed given access to quality health care. Unfortunately, there are significant barriers that too often stand between Latinos and their ability to access such care.

Hispanic Americans, at 13% of the U.S. population, have become the largest minority group in the country. However, despite their high work participation rates, they are also more likely to lack health insurance than any other group of Americans; for example, 33% of Latinos in the U.S. are uninsured, compared to 19% of non-Hispanic Blacks and 10% of non-Hispanic Whites. Similarly, 24% of Latino children lack health insurance, a rate nearly twice that of any other group. Latinos in the U.S. face numerous barriers to health coverage and additional obstacles to actual care for those who are covered. These include lack of affordability, eligibility bars for immigrants – including those lawfully present in the U.S. – structural barriers within individual health programs, language access, and cultural competency among providers. As a result of the lack of continual care and issues related to being uninsured, many Hispanics do not have access to appropriate preventive care, which could ameliorate the severity of preventable or manageable conditions like diabetes and heart disease.

Latinos and the Medicaid Program

Due to the low rates of employer-based coverage in Latino families and the high cost of private health insurance, many qualified low-income Latinos have used Medicaid as an important access point to health care for their family. The most recent report by the Centers for Medicare & Medicaid Services (CMS) notes that more than 10 million Latinos living in the U.S are qualified for Medicaid. In many states, Latinos make up a sizeable portion of the population that uses Medicaid. For instance, according to a Georgetown Health Policy Institute analysis, more than half (52%) of all Medicaid-eligible persons in California are Latino.

Since the Medicaid program is a significant safety-net for Latinos, it is impossible to overstate the importance of this program to the Latino community. Therefore, NCLR strongly opposes

budgetary plans that alter access to the program by dramatically cutting funding for Medicaid, including $10 billion in funding reductions instructed by Secretary of Health and Human Services Michael Leavitt to a newly authorized Medicaid Commission. The proposal, which is more than the President's FY 2006 Budget Request, would prevent Medicaid from assisting low-income beneficiaries. Cuts of this magnitude would compromise Medicaid's mission by removing poor and vulnerable persons from the program, despite their inability to afford the expense of health coverage.

In addition, some state and federal proposals which purport to increase flexibility, will, if enacted, cause dramatic cuts in services. One such proposal models Medicaid after the State Child Health Insurance Program (SCHIP), allowing states to make more decisions about patient eligibility and capping funds available to states. While SCHIP is an important program that helps to protect the health and well-being of children, its goals are substantially different from the goals of Medicaid. SCHIP is a program that often serves uninsured children and adults living at or above the poverty level. On the other hand, the Medicaid program seeks to provide a health care service for those living in destitution or those with extreme health care needs, such as persons with HIV/AIDS or a disability. Under a program modeled after the SCHIP block grant, the federal government could cap payments to states resulting in the less coverage for individuals would be served, even when demonstrating eligibility. In addition, groups covered under the optional categories of Medicaid would be at risk of losing benefits as states would have the flexibility to reduce coverage for many individuals currently receiving Medicaid.

Furthermore, NCLR cannot support a reduced benefits package that does not provide a complete health care plan. Prevention and comprehensive treatment plans are the primary way to ensure that health costs are controlled and to encourage people to maintain healthy lifestyles. Reduction in benefits package which deprive beneficiaries of needed care would be fiscally unwise and unethical.

Finally, NCLR cannot support proposals that shift the burden of cost to the patient. Increased cost-sharing will deter Medicaid beneficiaries from using vital resources, resulting in the aggravation of existing health conditions. Cost-sharing would particularly impact Latinos who, according to the U.S. Census, experienced an overall 2.6% decline in income in 2003 and made $14,780 less on average than non-Hispanic Whites in the same year. Increased health care costs for those in poverty would increase the burdens on household budgets sustained by families who already worry about having the resources to cover basic needs.

Enhancing the Medicaid Program

There are a numbers of ways the Medicaid program could be strengthened to both increase the health of recipients through preventive services and help to cut the costs created by unnecessary care or exacerbated health conditions.

Restore Access to Medicaid for Recent Legal Immigrants

Due to restrictions imposed by the 1996 "welfare reform" law, legal immigrants are ineligible for Medicaid and other federal means-tested public benefits for five years after they have entered the country. Even after the five-year bar, immigrants face numerous barriers that hinder them from participating in the program. Thus, many low-income immigrants and their families suffer from

a lack of coverage from any source. Without access to care, many immigrants rely on emergency health services for routine health care, increasing costs for all consumers. In addition, because many immigrants live in households that contain non-citizens and citizens alike, there are often many citizen family members, primarily children, who do not apply for programs for which they are eligible for fear that this will expose ineligible immigrant family members to the authorities. Immigrants should not be penalized simply because of their legal immigrant status. They contribute tax dollars to the very programs from which they are barred. Congress should enact new eligibility laws that provide all uninsured individuals affordable access to vital services and include a full repeal of anti-immigrant eligibility restrictions. For instance, Congress could immediately take steps to enact the "Immigrant Children's Health Improvement Act" (H.R. 1233, S. 1104), which would allow states to provide health care coverage to legal immigrant children and pregnant women through Medicaid and SCHIP.

Reduce Barriers that Affect Quality of Care

Currently, approximately 21 million persons living in the U.S. have language barriers that can hinder their ability to interact with the U.S. health care system. NCLR recommends that CMS develop comprehensive practices to ensure that linguistically appropriate services are provided during the Medicaid enrollment process. In addition, CMS should enforce patient rights under Executive Order 13166 and the Civil Rights Act of 1964, ensuring linguistically appropriate care is given to Medicaid recipients. These measures will enable more eligible limited-English proficient (LEP) patients to be enrolled, increasing both the efficiency and quality of care for LEP Medicaid patients.

In Medicaid, many eligible LEP persons face problems during their first attempts to access the program, due to pervasive lack of translated forms and interpreters. In a Kaiser Family Foundation poll, an overwhelming number of Spanish-speaking parents (46%) failed to enroll their eligible children in Medicaid due to lack of materials in their language. Half of all the surveyed uninsured persons eligible for Medicaid said they were much more likely to go through the enrollment process if they could speak to someone in their primary language. At a minimum, CMS should take steps to translate essential resources, such as template enrollment forms, and outreach to communities where with significant LEP populations.

In addition, the Medicaid program should take steps to ensure that providers receiving Medicaid funds are providing the appropriate language services to their patients. The absence of language services in health care settings diminishes the quality of health care for LEP individuals. A Kaiser Family Foundation/Pew Hispanic Center survey showed that 29% of Latinos had difficulty communicating with health care providers because of language barriers. Another study found that over one quarter of LEP patients who needed, but did not get, an interpreter reported they did not understand their medication instructions, compared with only 2% of those who did not need an interpreter and those who needed and received one. Providing language access will help to increase the chance that patients follow the medical regimen recommended by their health care provider and reduce waste and error that comes as a result of poor communication in health care settings.

Increase Preventive Education
Currently, within the health care system "sick care" is emphasized much more often than the promotion of healthy lifestyles, prevention of disease, and proactive treatment of illness. In the Latino community, we have seen many negative health outcomes that result from this approach to health. For instance, Latinas are less likely to obtain common medical procedures, such as mammograms. Thus, while Hispanic women have fewer instances of breast cancer, they are more likely to be diagnosed with an advanced stage of the disease. Medicaid should institute programs that increase awareness of procedures for early detection of disease, ensuring that health conditions can be more easily managed and cost for treatment is reduced. Furthermore, culturally competent and linguistically appropriate curricula should be developed to inform the Latino public about health conditions and preventable diseases. For example, there is an increasing need to promote healthy pregnancy practices in the Latino community. Latinas are less likely than non-Hispanic White women to secure prenatal care during the first trimester, increasing the cases of low-weight births and infant mortality. Many of these complications could be diminished if outreach and prevention efforts were increased.

Preserving Medicaid's Integrity
Medicaid is an efficient program; however, like all programs it should be scrutinized to determine best practices. Any attempts to streamline the program should be made without loss of benefits that would be detrimental to beneficiaries.

Maintaining Judicial Protections
As a civil rights organization, NCLR believes that all rights of due process should be upheld. Ensuring that Medicaid recipients are able to report and act upon violations of law will ensure that state Medicaid programs are conforming to the rules issued under the federal law. Continuing to do so will decrease the amount of error and abuse under the program. NCLR opposes any measures that seek to neutralize or place time limits on consent decrees. Consent decrees are carefully negotiated agreements that ensure compliance from local, state, and federal government agencies. Furthermore, NCLR feels that those who support limitations on current consent decrees are misguided by believing that such laws would increase their ability to administer the Medicaid program. Rather, it becomes incentive for plaintiffs to enter into endless litigation to ensure that a case judgment is upheld over time.

Reform of the Drug Rebate Program
Medicaid spending on prescription drugs outpaced other spending under the program by 7% during 2000-2002. A recent Government Accountability Office (GAO) stated that inadequacies were found in the prescription drug rebate program, resulting in inconsistent practices to determine price of drugs and lowering the sum of rebates returned to states. In addition, there continue to be manufacturers that delay the issue of drug rebates or withhold them permanently. In Medicaid, there are opportunities to strengthen oversight of the Medicaid prescription drug rebate program or reform the program in such a way that CMS can better negotiate drug prices. Immediately, CMS should issue clearer guidance to ensure that the prices used to calculate rebates are determined in a consistent manner and should also monitor and enforce the issuance of rebates. In addition, NCLR believes CMS should explore reform or elimination of the drug rebate program, which would allow the Department of Health and Human Services to negotiate the price of prescription drugs prior to drug purchase. The ability to negotiate for such a large

pool of patients could bring heavy discounts on prescription drugs, helping to increase savings for the Medicaid program.

The national debate on Medicaid reform should not move forward without addressing concerns of the Latino community. NCLR is committed to working with key stakeholders in Medicaid reform to ensure that equitable and affordable access to health care is assured for all low-income families in the U.S.

Thank you for your consideration of these views.

Partnership for Medicaid

Partnership for Medicaid

STATEMENT FOR THE RECORD

BY

THE PARTNERSHIP FOR MEDICAID

before

UNITED STATES SENATE
COMMITTEE ON FINANCE

Hearing

on

"THE FUTURE OF MEDICAID:
STRATEGIES FOR STRENGTHENING AMERICAN'S VITAL SAFETY NET"

JUNE 15, 2005

Contact

Licy M. Do Canto
Partnership for Medicaid
2001 L St, NW 2nd Floor
Washington, DC 20036
LDOCANTO@nachc.com

Partnership for Medicaid

Partnership for Medicaid

The Partnership for Medicaid, a group of safety net providers and other key organizations dedicated to preserving and improving the Medicaid program, appreciates the opportunity to submit its core set of principles on Medicaid for the record.

The Partnership is a non-partisan, nationwide coalition that is committed to strengthening Medicaid's long-term financial health and assuring that the program continues its crucial role as a safety net for our nation's most vulnerable populations. Although we represent a broad range of specific interests and points of view, we stand unified in our resolve to ensure that Medicaid continues its vital role as a strong safety net for vulnerable Americans. By working in a bipartisan manner with all levels of government and affected constituency groups, we seek to provide viable solutions to improve the quality and delivery of services, with the aim of constraining costs without undermining the program's fundamental goals.

The Partnership has consistently called for bipartisan action to strengthen and preserve Medicaid, and we believe that any such effort should seek to preserve the program's federal guarantee of coverage, and not reduce or eliminate the its services or consumer protections.

We hope that the Senate Finance Committee will look to the **Partnership for Medicaid** as a source of expertise and experience as it seeks ways to constrain Medicaid's costs while also improving the quality and delivery of its services. Accordingly, we stand willing to discuss ways to improve the Medicaid program with the Commission and its members, and to lend whatever assistance we can to this critically important effort.

AMERICAN ACADEMY OF FAMILY PHYSICIANS
AMERICAN ACADEMY OF PEDIATRICS
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
AMERICAN HEALTH CARE ASSOCIATION
ASSOCIATION OF CLINICIANS FOR THE UNDERSERVED
ASSOCIATION FOR COMMUNITY AFFILIATED PLANS
AMERICAN DENTAL ASSOCIATION
NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS
NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
NATIONAL ASSOCIATION OF COUNTIES
NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS
NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE
NATIONAL HISPANIC MEDICAL ASSOCIATION
NATIONAL RURAL HEALTH ASSOCIATION
AFL-CIO

Partnership for Medicaid

American Academy of Family Physicians

American Academy of Pediatrics

American College of Obstetricians and Gynecologists

Association of Clinicians for the Underserved

Association for Community Affiliated Plans

American Dental Association

American Health Care Association

AFL-CIO

National Association of Children's Hospitals

National Association of Community Health Centers

National Association of Counties

National Association of Public Hospitals and Health Systems

National Council for Community Behavioral Healthcare

National Hispanic Medical Association

National Rural Health Association

CORE PRINCIPLES

The Medicaid program plays a vital role in financing necessary health care services for more than 51 million beneficiaries. Unfortunately, rising healthcare costs and increased numbers of uninsured, coupled with a federal deficit of more than $400 billion and pressures to increase spending on other federal responsibilities, are driving legislative and political attention both at the federal and state levels to consider systemic changes to Medicaid that could dramatically alter the fundamental goals and structure of the program.

Medicaid is too important to fail. No matter what shape reform takes, participants in the **Partnership for Medicaid** urge policy makers – at all levels and working in a bipartisan manner – to protect the public's health and assure that Medicaid continues its crucial role as a safety net for vulnerable populations, even as it produces real savings in health and prevention. Thus, as lawmakers consider ways to reform Medicaid, the **Partnership** is united behind the following core set of principles:

Preserve the Federal Guarantee of Medicaid Coverage, Services and Consumer Protections

Federal law establishes certain minimal protections for Medicaid beneficiaries. Beneficiaries are provided a minimum set of benefits to ensure access to medically necessary services. For children, the early and periodic screening, diagnosis and treatment benefit guarantees access to preventive services necessary for healthy development. Cost-sharing that would make Medicaid unaffordable to the low-income beneficiaries is prohibited. Moreover, cost sharing must be income sensitive and should neither deter enrollment nor diminish timely access to appropriate care. These statutory provisions must be maintained in Federal law.

The **Partnership** believes that reform efforts should not eliminate current federal coverage guarantees, nor should they result in reducing or eliminating coverage for currently eligible individuals and that individual and provider protections, including a private right of action to enforce those protections, should be maintained, and access to culturally appropriate care should be promoted.

Preserve the Federal Financing Role in Medicaid

We urge lawmakers to reject proposals to replace the current financing of Medicaid with an upper limit or cap on federal spending for Medicaid. Such caps have historically not kept pace with the costs of care for enrolled populations, shifting the risk of under-funding onto states, counties, providers, and beneficiaries. Any such cap or limit would likely result in an arbitrary cut-off of benefits for otherwise eligible individuals and eliminate the program's assurance of coverage.

Instead, the **Partnership** believes that the Congress should update the matching formula to more adequately account for Medicaid's counter-cyclical nature. During economic downturns, increased unemployment, public health emergencies, or other unexpected events (such as a hurricane or terrorist attack), more people rely on Medicaid. Yet under the program's financing mechanism, Medicaid is most vulnerable to funding shortfalls when circumstances create the greatest need. Federal matching funds also should provide an incentive to states to increase health coverage and services above federal minimums, and the Federal government should share the burden of these costs with the states and local governments.

Assure Adequate Provider Participation

During recent state budget shortfalls, provider rates in nearly every state were lowered or scheduled increases deferred. As Medicaid reimbursement rates decline and medical costs rise, many providers are forced to see fewer Medicaid patients or to absorb financial losses. To ensure appropriate access to care for beneficiaries, the program should provide fair and adequate compensation to providers for each class/type of care in the most appropriate setting, including the cost of providing culturally appropriate services.

The **Partnership** believes that any use of 'medical necessity' criteria must never restrict care that meets professional standards of practice and is clinically appropriate.

Use the Medicaid Waiver Process to Foster Improvements and Innovation, Not to Eliminate Federal Protections or Reduce Benefits

Medicaid and State Children's Health Insurance Program (SCHIP) waivers were created as a way to help States try innovative approaches to delivering or financing health care services for their most vulnerable populations. But waivers have sometimes been used to limit benefits, increase cost sharing, and cap enrollment.

The **Partnership** believes that Medicaid waivers should be approved *only* if they "promote the objectives of" Medicaid or SCHIP, and do not erode the program's ability to provide comprehensive services to all eligible beneficiaries.

Improve the Integrity of Medicaid

Appropriate approaches should be developed to ensure that the financing of the Medicaid program is sound. It is critical that such approaches not threaten care for beneficiaries in the program nor undermine the existing federal/state/local matching structure.

Recognize the Interdependence of Medicaid and the Public Health System

Medicaid plays a critical role in supporting vital public health services – notably in the areas of disease prevention, detection and management. This vital interdependence between Medicaid and public health is essential to removing barriers to care, reducing costs, and improving the continuity of care and health outcomes for Medicaid beneficiaries.

Policies must be developed that recognize this interdependence and promote linkages among primary, acute and long-term care services. Support for identified safety net providers (those who care for disproportionately high numbers of Medicaid and uninsured individuals) must be continued.

Work in a Bipartisan Manner to Address the Issue of Reforming Medicaid

To the extent that reform of Medicaid is necessary, effective and successful reform efforts will require bipartisan action by lawmakers at all levels. Finding solutions to the challenges facing the Medicaid program can be daunting, but lawmakers must strive to forge a bipartisan consensus that aims to strengthen Medicaid's long-term financial status and ensure that Medicaid benefits and services remain a reality for low-income individuals in the future.

Medicaid's success should be judged by its ability to provide the populations it covers with access to appropriate, quality health care. Accountability and performance measures should be added to the program and reviewed federally. To the extent that reforms result in program savings, those savings should be re-invested to extend coverage to more low-income people who cannot find affordable coverage elsewhere. Federal matching funds should also provide incentives to states to increase coverage above federal minimums, and the Federal government should share the burden of these costs with the states and local governments.

We all see the potential of health information technology to monitor patient health, facilitate the use of scientifically-supported best practices, and regularly review the relationship between service use and health status. We all agree that everyone who is eligible for Medicaid should enroll and receive the preventive care that may forgo greater costs down the line. And most of all, we all agree that Medicaid is too important to fail.

Pediatric Nurse Practitioners
NAPNAP 20 Brace Road, Suite 200, Cherry Hill, NJ 08034-2634 856-857-9700 F 856-857-1600 www.napnap.org

July 15, 2005

The Honorable Charles E. Grassley
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

Attn: Ted Totman

Dear Chairman Grassley:

On behalf of the National Association of Pediatric Nurse Practitioners (NAPNAP), I am writing to express our concern about two specific Medicaid recommendations put forth by the National Governors Association (NGA) at the Finance Committee's June 15 meeting.

NAPNAP represents approximately 7,000 members, as the professional association for pediatric nurse practitioners and other advanced practice nurses who care for children. Pediatric nurse practitioners are registered nurses with advanced education and clinical experience and provide primary, acute, and specialty care services to children from birth to 21 years of age.

We are concerned that NGA's proposal on cost-sharing and benefit package flexibility – if adopted – would negatively alter the framework of the Medicaid program, specifically with regard to pregnant women and children. According to the NGA proposal[1], "*...states (would) have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services, and could make them enforceable.*"

Medicaid law has always prohibited states from imposing cost-sharing requirements on services provided to eligible children. Eligible pregnant women are provided with the same protections for health care related to a pregnancy. In addition to these protections, current law also prohibits Medicaid cost-sharing requirements for all emergency and family planning services. NAPNAP is concerned that if the NGA proposal is adopted, fewer Medicaid-eligible children, adolescents and pregnant women will seek preventative and primary care services – health care that is critical during the developmental stages of life.

The NGA proposal recommends that states be given greater flexibility to decide who gets what Medicaid benefits. According to the NGA[2], "*Medicaid reform should include the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as*

[1] Medicaid Reform: A Preliminary Report from the National Governors Association, June 15, 2005, pages 5-6.
[2] Medicaid Reform: A Preliminary Report from the National Governors Association, June 15, 2005, page 6.

those for whom Medicaid serves as a traditional health insurance program." If Congress adopts the NGA proposal, states may opt to make these changes strictly for budgetary reasons. These changes could signal the end of many vital services for children – such as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services provided to children under the age of 21. EPSDT was established as a mandatory service in 1967 and provides preventative services and treatment to children enrolled in Medicaid. Under EPSDT, children receive screening, vision, dental and hearing services.

NAPNAP urges the Finance Committee not to look to the State Children's Health Insurance Program (SCHIP) as a guidepost for Medicaid benefit and coverage decisions, as suggested in the NGA proposal. SCHIP participants have higher incomes than Medicaid beneficiaries, and unlike SCHIP, the federal government has long considered Medicaid an entitlement for mandatory low-income populations. Since 1997, states have modeled their SCHIP benefit packages on a variety of models – no one is alike. Some closely mirror their state's Medicaid package, and others more closely resemble a commercial health insurance or state employee plan health plan. Like Medicaid, SCHIP does not impose co-payments for preventative health care services. If Congress were to add co-payments to Medicaid, it would unfairly expose a lower-income population to payments not currently required by the SCHIP program.

If the NGA proposal is adopted, Medicaid beneficiaries could be exposed to cost-sharing expenses of up to 5 percent of the family's income (for families with incomes *below* 150 percent of the poverty line) and 7.5 percent of income for families above 150 percent of the poverty line. This means that a family of three with a family income of $16,100[3], could be required to pay $1,200 in co-payments, premiums, and deductibles over a year's time.

States currently have a number of methods for managing the care they provide to Medicaid beneficiaries. Many states are using managed care to coordinate and deliver care. States are also enjoying increased flexibility to "waive" federal Medicaid rules through the use of Section 1115 demonstration projects.

We hope the Committee will protect Medicaid's long-standing commitment to low-income pregnant women and children and maintain the federal protections that provide vulnerable populations with access to primary and preventative care services. We would be happy to sit down with you or a member of your staff to discuss our concerns. Feel free to call our Washington representative, Amy Domske at (202) 857-6484 if you have any questions or require additional information.

Sincerely,

Jo Ann Serota

Jo Ann Serota, MSN, RN, CPNP
President

[3] Federal Poverty Levels: Federal Register, Volume 70, Number 33, February 18, 2005, pages 8373-8375.

University of Michigan
Hospitals and
Health Centers

Hospital Financial Services
2500 Green Rd. Suite 100
Ann Arbor, Michigan 48105-1500
734-647-3321

August 31, 2005

United States Senate Committee on Finance
Statement for the Record, Hearing on June 15, 2005
The Future of Medicaid: Strategies for Strengthening America's Vital Safety Net

Submitted by:
University of Michigan Hospitals and Health Centers
1500 East Medical Center Drive
Ann Arbor, Michigan 48105

I am writing on behalf of University of Michigan Hospitals and Health Centers (UMHHC), to urge Congress to reject proposals made by the Administration that shift responsibility for Medicaid funding from Federal to State government. Under most of these proposals, the burden is ultimately shouldered by health care providers, and public hospitals such as UMHHC in particular. As Congress considers how to achieve the $10 billion in Medicaid savings over the next five years recommended in the FY2006 Congressional Budget Resolution, we believe that efforts should be focused on initiatives that will reduce the rate of growth in the cost of Medicaid, instead of focusing on the responsibility for funding the program. In particular, we are very concerned about proposals that will significantly curtail intergovernmental transfers, limit Medicaid payments to public hospitals and reduce State resources derived from health care-related taxes and assessments.

As you know, UMHHC is a vital part of Michigan's health care delivery system, providing high quality, accessible health care to all of Southeastern Michigan and treating citizens from every county in the State. We are heavily reliant on government sources of income, including Medicaid which covers 12% of our patients. We are one of the largest providers of service to the Michigan Medicaid population. In our Fiscal Year 2004, we estimate that we incurred losses under Michigan Medicaid of $20 million (expenses in excess of Medicaid payments). The Michigan Hospital Association estimates that Michigan hospitals in the aggregate lost $300 million. These losses would be significantly larger were it not for Michigan Medicaid's use of intergovernmental transfers and health care-related taxes and assessments.

The State of Michigan, like many states, is in no condition to absorb a reduction in federal Medicaid funding. If Michigan Medicaid resources are reduced, the response is certain to include further cuts in hospital payments, or cuts in benefits which directly result in increased uncompensated care losses for hospitals because the affected patients generally cannot pay for services. The majority of the burden falls on a relatively small number of hospitals, such as

UMHHC, as Medicaid services are not evenly distributed across the provider community. In fact, 12% of Michigan hospitals provide 60% of hospital services to Medicaid beneficiaries.

We are especially concerned about the proposal to limit payments to public hospitals to "cost". Our understanding is the intent of this provision is to create additional restrictions on the use of intergovernmental transfers. However, in Michigan and undoubtedly other states, this provision could result in significant losses to public hospitals and create a competitive imbalance. In Michigan, public hospitals are not provided special status as perhaps they are elsewhere. We are reimbursed under the same payment systems and requirements as private hospitals, and compete for both private and publicly-funded patients on equal footing. To implement a payment limit on only one portion of the hospital community is simply unfair.

On the surface, it would seem that a cost limit would have no effect on UMHHC, given that our cost exceeded Medicaid payments by $20 million last year. However, under the costing methods required by CMS, UMHHC could be subject to a reduction of several million dollars. CMS' method of allocating certain payments gives the appearance that UMHHC has a positive margin on traditional Medicaid business, which would be subject to the cost limit, and extremely large losses on Medicaid HMO business which may not be offset under the cost limits. Further, CMS does not consider provider assessments to be allocable to Medicaid, even though they are clearly a cost of doing Medicaid business. The upshot is, the cost limits could result in significant, unintended losses for Michigan's public hospitals.

Lastly, we are concerned about the Allotment limits for Administrative Costs. We agree with the limit in principle, but oppose the base year. In light of State budget pressures, we have begun to identify services provided by the University in support of the Medicaid program. These are legitimate within the existing policy and would continue to be allowable costs if no limits were in place. However, by selecting a historical base period, the proposal would eliminate consideration of costs not yet reimbursed and therefore understate the true cost for Medicaid administration in Michigan. We also feel that this regulation will create very complex and cumbersome reporting requirements.

We would welcome the chance to discuss these issues and the opportunity to more fully describe the situation at our hospital relative to Medicaid.

Sincerely,

Douglas L. Strong

Senior Associate Director and Chief Financial Officer

The Future of Medicaid:
Strategies for Strengthening American's Vital Safety Net
June 15, 2005

Statement to the Finance Committee
August 30, 2005
Deborah Stein, Director of Federal Policy and Advocacy
Voices for America's Children
1522 K Street, NW Suite 600
Washington, DC 20005

Voices for America's Children is a nationwide network of child advocacy organizations that speak on behalf of children at the federal, state and local levels. Voices members are not service providers, accept little or no government funding, and receive no financial benefit from the Medicaid program. Our sole interest is in the well-being of children.

Because one out of every four American children rely on Medicaid for their health insurance, it is critical to ensure that any changes do not jeopardize their health and well-being. Children's health care is a sound investment; prompt treatment of children's illness or injuries can prevent far more expensive treatment later on. Moreover, we know that children with access to health insurance do better in school, enabling them to become productive citizens.

There are two policy changes being widely discussed which, if applied to children, could severely harm them. We urge the Finance Committee, if it is considering these policies, not to apply them to children.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The first change under consideration would give states the flexibility to determine benefits packages for different populations. While this might be feasible for various adult populations, the federal guarantee of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is essential to children's well being and should not be relaxed for any children, either mandatory or optional populations.

Children need access to comprehensive medical care to grow up healthy, do well in school, and become productive adults. Because EPSDT provides comprehensive medical care, any changes in Medicaid must preserve children's access to EPSDT.

When children have access to EPSDT's preventive services, children are healthier. EPSDT starts at birth, provides screening at key points in a child's life, allows for further diagnostic tests if the screening finds tests are necessary, provides necessary treatment, and educates parents about the significance of preventive care.

- ***When children have access to early health care through EPSDT, they receive the care they need for healthy development.*** Studies indicate that brain growth is most rapid during the time period from a child's birth to age three. Therefore, early screening gives children a better chance of being healthy during the years of critical development.

- ***When children have regular periodic health care through EPSDT, problems can be identified and treated promptly.*** Children need regular doctor visits, particularly in their early years, to identify promptly any health problems that may develop and provide intervention when it can be most effective.

- ***When children receive comprehensive screenings and check-ups through EPSDT, health conditions can be identified and treated before they become severe.*** EPSDT screenings include an assessment of physical and mental health development, a comprehensive physical exam, vision, hearing, and dental services, appropriate immunizations, laboratory tests, and lead toxicity screening. The broad range of physical, mental, and developmental examinations allows for the identification of potential illnesses, special health care needs, and disabilities that, if not treated early, can impair childhood growth and development.

- ***When children have complete diagnostic services through EPSDT, illnesses and developmental delays can be detected in their early stages.*** When an exam reveals a child may have a health condition, EPSDT covers all necessary diagnostic tests that detect physical, mental, and developmental conditions. The diagnostic services are critical, especially during the first three years of a child's life, because early detection is more likely to lead to successful treatment.

- ***When children have all necessary medical treatment through EPSDT, children are less likely to develop chronic health problems.*** EPSDT ensures children receive treatment to correct or improve illnesses and health conditions, even if the condition cannot be prevented or cured. Furthermore, EPSDT gives children access to any medically necessary health care service that Medicaid covers even if the state does not cover the service for adults. Children's access to this comprehensive treatment is integral to their long-term well-being.

EPSDT serves additional purposes beyond the immediate medical services to children. When children are served through EPSDT, parents and guardians learn how to fulfill their responsibility to keep children healthy. EPSDT recognizes that early detection and treatment of health problems is only one facet of preventive care. EPSDT provides education and counseling to families about healthy lifestyles and accident and disease prevention. Studies indicate parenting is the single most important determinant of healthy growth and development; families who are knowledgeable about the significance

of preventive care can use this information to create environments where children can live and grow to be healthy adults.

EPSDT also helps children become productive adults. Research shows that children who have good physical health and sufficient motor and language skills are better prepared for school. Preventive health care allows children develop the cognitive, social, and emotional skills needed to thrive in the classroom. In addition, children in fair or poor health are almost seven times as likely as children with very good health to have missed eleven or more days of school in the past year due to illness or injury, making it difficult for them to keep up with their classmates.

When children have access to EPSDT, society benefits. EPSDT gives children in all states access to quality, cost-effective health care that is vital to building a strong country. Because EPSDT serves more than one in every five children, it is critical not just for individual children but for our society, our military and our economy. Children need comprehensive care to grow up prepared to be productive citizens; if one fifth of our children are denied that care, it will affect our entire society. In fact, EPSDT was enacted initially in the 1960s when too many draftees failed the military induction exams. Even today, one out of every two members of the military received health care through Medicaid at some point in their childhood.

Cost Sharing Requirements

The second change under consideration that should not be applied to children is cost sharing requirements such as premiums and co-payments. Federal law currently prohibits such requirements for all children and pregnant women. That federal protection needs to remain in place. Research shows that low income children's visits for needed, effective medical care drop almost by half when cost sharing is imposed. This drop is far greater than for other children, or even low income adults. For children to have meaningful access to health care, the federal government must continue to prohibit cost sharing for very low income children.

An Urban Institute study indicates that even modest premiums can cause children to lose access to essential health services because the cost deters families from enrolling in coverage. When low-income beneficiaries are charged premiums, fewer families are enrolled. Research shows:

Charged Premiums (percentage of family income)	**Enrollment Declines (percentage of fewer families enrolled)**
1 %	16%
3%	49%
5%	74%

Research also shows that when premiums decline, dis-enrollment rates decrease, allowing more children to retain access to Medicaid's critical services.

These findings apply to "optional" Medicaid children as well as "mandatory" childrenl. In fact, Virginia and Maryland reversed decisions to charge premiums in their SCHIP programs when they learned how many children would lose coverage as a result.

Similar research from RAND reveals that co-pays harm low-income children more than they harm middle and high-income children. Co-pays reduced effective care for low-income children by 44% while other children only saw a 15% reduction in effective care. In the RAND study, low income was defined as the lowest third of the income distribution, which is roughly equivalent to being below 200 percent of the poverty line. Thus, even "optional" Medicaid children would be harmed by the imposition of co-payments. Most importantly, this drop is in access to care children need – the research specifically looked at the drop in effective care.

When federal standards exempt children from cost-sharing, the government makes a cost-effective investment. Most obviously, when children gain access to health care because it is affordable, children receive critical services that can prevent future costly treatment for chronic illnesses and disabilities. But this investment pays off in other ways as well. Children who have access to health care do better in school, which will enable them to become productive citizens. The investment in children is particularly cost-effective: Medicaid spends only 22.9% of its budget providing services to children even though children comprise over 50% of the Medicaid population.

When federal standards exempt children from cost-sharing, children – especially those with complex health conditions – can receive timely medical care. Research shows that requiring cost-sharing for low-income children caused those children to avoid or delay essential medical care. The result was that those children developed more untreated dental problems or anemic conditions than those children without cost-sharing obligations.

Cost-sharing has the most detrimental effect on children with disabilities and those with complicated health problems because these children need frequent, extensive treatment and need various types of prescription drugs. Even nominal cost-sharing obligations add up quickly for these children.

When federal standards exempt children from cost-sharing, families are less likely to be faced with financial decisions that can jeopardize overall child well-being. Studies show that families require two to three times the official federal poverty level to meet their daily needs – without any provision for savings for the future, recreation, or conveniences. Thus, even families receiving "optional" coverage are often struggling to meet their families' essential needs. When families do not have to pay out-of-pocket costs on their children's health care, they are less likely forced to choose between paying for their children's needed health services and paying for other basic needs, such as food, housing, or child care. Maintaining federal protections against cost-sharing eases the daily hardships low-income families face to ensure their children have a successful start to life.

When federal standards exempt children from cost-sharing, families can act responsibly in seeking health care for their children. Without financial obstacles to accessing needed health care, families can seek timely health care for their children before the health condition becomes more complex and costly to treat. Affordable coverage encourages families to take personal responsibility in ensuring their children grow healthy.

When federal standards exempt children from cost-sharing, future health care costs are avoided. Although cost-sharing appears to save Medicaid money, it does not generate meaningful savings. Deterring children from accessing needed services creates more complex health conditions that will increase health care costs. In fact, cost-sharing may lead to "adverse selection" where healthier children who cannot afford coverage dis-enroll, leaving enrolled those children who have complicated conditions that are more expensive to treat. In addition, if children cannot afford to enroll in coverage, more children will become uninsured, and the cost of their uncompensated care will ultimately increase other health care costs.

Because Medicaid is such a critical program for children, we urge the Finance Committee to enact only those changes which will protect children. If those changes do not meet the full $10 billion in reconciliation cuts requested, please find the additional savings that you need from other programs that do not serve low income children and families.

Volunteers of America®

Statement
for the Senate Finance Committee hearing

"The Future of Medicaid: Strategies for Strengthening America's Vital Safety Net"

June 15, 2005

Submitted by:

Charles W. Gould
National President
Volunteers of America
1660 Duke Street
Alexandria, Virginia 22314

Mr. Chairman and Members of the Senate Finance Committee, on behalf of Volunteers of America, we appreciate the opportunity to offer a service provider's perspective on the Medicaid policy decisions the states and federal government must address in order to protect and strengthen this vital safety net for millions of low income adults, children and families.

Volunteers of America is a national nonprofit, spiritually-based organization that has been providing local human service programs and opportunities for individual and community involvement for over 100 years. Volunteers of America's ministry of service focuses on caring for the most vulnerable members of our society, the elderly and persons with disabilities, homeless individuals and at-risk children.

We serve Medicaid beneficiaries across a broad spectrum of home-and -community based programs, as well as in facility-based settings in our skilled nursing facilities, assisted living communities, outpatient substance abuse centers, residential programs for people with developmental disabilities and mental retardation, supportive housing for homeless individuals, community corrections diversion programs, foster care for children, home health care, and mental health programs. Our philosophy of care is to serve our clients in the least restrictive setting that allows them to maximize their dignity, independence, and quality of life.

Our statement will cover the following points:

- In the states where we operate, Medicaid's payment rates are below the actual costs we incur in providing long-term care services and supports.
- Although some states have managed to fund rate increases to service providers, these rate increases have not kept pace with health care cost inflation.
- Many states fund rate increases to service providers through the use of provider taxes. Proposed new restrictions on the use of provider taxes will widen the existing reimbursement gap.
- The aging of the population with chronic care needs and severe disabilities is projected to grow substantially over the next several decades, adding to the enormous fiscal pressures on providers to find ways to shift costs or absorb the payment shortfalls.
- A solution is needed to ensure sustainable financing for long-term care in the 21st century.
- Medicaid long-term care for seniors and non-elderly persons with disabilities should have its own dedicated means for financing. The funding earmarked for long-term care should be coupled with the flexibility to allow states to allocate the resources across a full range of home, community-based, and facility-based health and social services, without obtaining waiver approval from CMS. Methods of financing could be accomplished in a number of ways and would by no means preclude development of other forms of private coverage. Other Medicaid funds, generated through the state and federal matching process, would remain in place for covered services, other than long-term care.
- Improved integration of the Medicaid and Medicare programs for the 6.2 million dually eligible individuals will also produce better health outcomes and cost savings.

Medicaid Today: A Service Provider Perspective

A focus of today's hearing and a dominant theme of the current debate on Medicaid reform concerns how federal and state governments can continue to finance and provide quality health care to millions of Americans in the face of rising costs and spiraling demand.

As a service provider, we face the same challenge on a daily basis, but with an even greater degree of personal urgency. Every day, Volunteers of America serves thousands of frail and vulnerable men, women and children who are in desperate need of quality long-term care services. Increasingly, however, we find that we must ask ourselves: How can we continue to effectively provide high quality long-term care to vulnerable and frail individuals when the level of Medicaid reimbursement is inadequate to cover rising costs and spiraling demand?

The simple fact is that in the states where we operate, Medicaid's payment rates are below the actual costs we incur in providing long term care to our patients and clients. And Volunteers of America is not unique in this regard. According to a recent study, the average shortfall in Medicaid nursing home reimbursement is $12.58 per Medicaid patient day. The estimate of unreimbursed Medicaid allowable costs in nursing homes for all 50 states was almost $4.5 billion[1]

Fortunately, despite considerable fiscal pressures in their state economies, there have not been widespread reductions in Medicaid payment rates to nursing homes[2] Unfortunately, in states where there have been rate increases, the increases have not kept pace with the rate of nursing home cost inflation. Many states funded rate increases to hospitals, managed care organizations, nursing homes and intermediate care facilities for the mentally retarded through the legal application of provider taxes.[3] Provider taxes are used to augment a state's Medicaid budget and pay providers a rate more in keeping with the actual costs of care or used to continue to cover optional services[4].

We recognize the importance of ensuring the integrity of the Medicaid program. At a time, however, when states are struggling to find more resources for their Medicaid programs, proposed new restrictions on the use of provider taxes will make it more difficult for providers to ensure that vital long term care services for frail elderly and disabled individuals are continued[5].

The Reimbursement Gap Will Widen with the Aging of America

Today's Medicaid reimbursement gap will widen substantially as the number of the elderly persons with disabilities increases over the next several decades, coinciding with the aging of the baby boom generation. According to estimates of the Bureau of Census, the number of elderly people age 65 and older in the United States will increase by two and one-half times between 2000 and 2050. Medicaid long-term care expenditures for seniors are projected to rise from about $195 billion in 2000 to $540 billion (in 2000 dollars) by 2040.[6]

The aging of America will also place increased demands for long-term care by people with disabilities, not just the elderly with chronic care needs. In 2005, an estimated 9.2 million

non-elderly children and adults with significant disabilities rely on Medicaid[7]. As many non-elderly individuals with disabilities live longer with the aid of medical advances and supportive care, it is likely that many of them will live into their own retirement and outlive their family caregivers. The elderly and disabled are high users of the most expensive acute and/or long-term health care services.

At present, the Senate Finance Committee and House Energy and Commerce Committee are looking at a number of measures in order to meet reconciliation instructions to find $10 billion and $20 billion, respectively, in savings from programs under their jurisdiction, including Medicaid. Additionally, the Medicaid Commission will be reporting to Congress on September 1, 2005 a package of recommendations totaling at least $10 billion in program savings.

Reforms aimed at achieving program efficiencies may produce modest savings over the short term. However, the enormity of demand for long-term care services posed by the aging of the population make it imperative to identify ways to ensure sustainable financing for long-term care over a longer time horizon.

We recommend that Medicaid long-term care have its own dedicated means for financing. The funding earmarked for long-term care should be coupled with the flexibility to allow states to allocate the resources across a full range of home, community-based, and facility-based health and social services, without obtaining waiver approval from CMS. Methods of financing could be accomplished in a number of ways, and would by no means preclude development of other forms of private coverage. Other Medicaid funds, generated through the state and federal matching process, would remain in place for covered services other than long-term care.

The basis for this recommendation is that the need for long-term care is unpredictable and, when extensive service is required, financially catastrophic. Long-term care is best dealt with as an insurable event, where the risk of needing services is effectively spread across the population through pooled risk. Similar options for financing long-term care have been discussed in recent congressional hearings exploring Medicaid reform[8].

Although we do not endorse a particular method of financing, we recognize that a number of models have been proposed that range from public financing to proposals that combine aspects of private and public financing.

Regardless of the particular method chosen, a dedicated means for financing Medicaid long-term care will have the following benefits:

- States would have a stable and dependable funding source vital to ensuring continuity of care and access that is important for the good health of consumers.

- States would have the authority and resources to ensure the Medicaid program provides fair and adequate compensation to providers for each class/type of care in the most appropriate setting.

- States would have adequate resources and the flexibility to more fully develop their home and community-based services (HCBS) infrastructure to meet the growing demand and preferences of the majority of seniors and disabled individuals.

- As states move to rebalance their long-term care systems, the institutional bias in Medicaid would be reduced.

- Seniors and people with disabilities would be ensured better access to long-term care services.

- The financing system would promote a more equitable distribution of the burden of providing and paying for long-term care services.

- State and federal governments would not be precluded from developing other forms of private coverage, measures to promote personal responsibility, and methods to improve the effective and efficient administration of the Medicaid program.

Need for Improved Integration of Medicaid and Medicare

One final note. Amid all the discussion that has taken place in congressional hearings and the Medicaid Commission, little or no mention has been made of the need for improved integration between the Medicaid and Medicare programs. The Centers for Medicare and Medicaid Services estimates there are 6.2 million people in the U.S. who are eligible for both Medicare and Medicaid. Many in this group have complex medical and chronic care needs that require lengthy stays in a variety of long-term care settings. Yet, these two programs have conflicting financing and administrative rules, which result in significant and costly fragmentation of financing, case management and service delivery. This fragmentation is not only costly; it often leads to serious gaps in providing what is needed.

Volunteers of America recently convened a Policy Forum to make recommendations to the 2005 White House Conference on Aging on ways to improve the integration of housing, health care and support services for the coming wave of baby boom retirees. One of our chief recommendations dealt with the need for improved integration of Medicare and Medicaid. We are pleased to note that Senator Grassley is also a member of the Policy Committee for the 2005 White House Conference on Aging.

We recommend the Senate Finance Committee consider the improvements in health care outcomes and cost-savings that would result from a concerted effort to better integrate the Medicaid and Medicare programs for those people who are dually eligible for both programs.

There are two bills currently pending in the Senate, which we support, and would begin to address this issue:

- ***The Improving Long Term Care Choices Act,*** recently introduced by Senator Grassley, contains an important provision aimed at removing administrative barriers

that impede the offering of integrated acute and long-term care services for dually eligible individuals.

- ***Meeting the Housing and Service Needs of Seniors Act of 2005 (S. 705)*** introduced by Senator Sarbanes, calls for formation of a federal interagency council to examine and recommend way to reduce duplication among programs and services by federal agencies and departments that assist seniors in accessing health care, housing, nursing assistance and assistance with daily activities where they live or in their communities.

Conclusion

Volunteers of America provides an extensive array of long-term care services in a variety of facility and home and community-based settings. Every day, we witness first hand the vital difference that our services make in the quality of life for our clients and patients.

Like most long-term care providers, we receive Medicaid payments that are lower than the cost of providing care to program beneficiaries. In the coming decades, the reimbursement gap will substantially widen as the demand for long-term care services skyrockets along with the aging of the population and medical inflation continues to drive up costs.

Reforms aimed at achieving program efficiencies may produce modest savings, but given the enormity of the long-term care challenge facing us in the near future, a more stable and sustainable financing solution is needed to ensure the solvency of the Medicaid program well into the 21st century.

A dedicated means for financing Medicaid long-term care would provide a stable and dependable source to ensure continuity of care for patients and consumers. States should have the authority to allocate the new resources among an array of home, community-based and facility-based health and social services without obtaining waiver approval from CMS.

Financing could be accomplished in a number of ways and would, by no means, preclude development of other forms of private coverage. Other Medicaid funds, generated through the state and federal matching process, would remain in place for covered services, other than long-term care.

Further, consideration should be given to the cost savings and better health outcomes that would result from improved integration of the Medicaid and Medicare program for the 6.2 million individuals who are dually eligible for both programs.

End Notes

[1] *A Report of Shortfalls in Medicaid Funding for Nursing Home Care*, BDO Seidman LLP, prepared for the American Health Care Association, April 2005.

[2] *Medicaid Nursing Home Payments: State Payment Rates Largely Unaffected by Recent Fiscal Pressures*, General Accountability Office, GAO-4-143, October 2003.

[3] In FY 2005, a total of 20 states increased or imposed new provider assessments or taxes. New of higher provider taxes were most frequently imposed on nursing facilities, managed care organizations, hospitals, and intermediate care facilities for the mentally retarded. **Source:** ***The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005***, Kaiser Commission on Medicaid and the Uninsured, October 2004.

[4] ***Medicaid Cost Containment: A Legislator's Tool Kit, Chapter 3: Intergovernmental Transfers and Other Alternative Funding Mechanisms***, National Conference of State Legislatures, March 2002.

[5] Under current rules, if the taxes returned to a provider are less than 6 percent of the provider's revenues, the return of taxes does not violate the prohibition on a guarantee for returning provider taxes to providers. As a result, a state could impose a provider tax of 6 percent of revenues, receive a federal match for the funds, and then return the tax monies back to the provider. The President's Budget proposes to phase down this allowable tax rate from six percent to three percent. **Source: CRS Report to Congress: Medicaid and SCHIP: The President's FY2006 Budget Proposals, February 15, 2005.**

[6] ***The Cost and Financing of Long Term Care Services***, testimony of Douglas Holtz-Eakin, Director of the Congressional Budget Office before the Subcommittee on Health, Committee on Ways and Means, April 19, 2005.

[7] Congressional Budget Office (CBO) March 2005 Baseline estimate of Medicaid enrollment for 2005.

[8] ***Long Term Care: What Direction for Public Policy?*** Carol O'Shaughnessy, Congressional Research Service, testimony before the House Committee on Energy and Commerce, April 27, 2005 and ***Long Term Care Financing: Growing Demand and Cost of Services are Straining Federal and State Budgets***, Kathryn G. Allen, U.S. Government Accountability Office, testimony before the Subcommittee on Health, Committee on Energy and Commerce, April 27, 2005