Testimony

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The Special Committee on Aging hearing
"Mandatory or Optional? The Truth About Medicaid"

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As the Senate Special Committee on Aging convenes to explore Medicaid reform, I am pleased to provide testimony on behalf of the Catholic Health Association of the United States (CHA). CHA is the national leadership organization representing the Catholic health care ministry. With over 2,000 members, CHA is the nation's largest group of not-for-profit health care sponsors, systems, facilities, health plans, and related organizations. CHA's members provide care to at least one in every six Americans in the health care system, either in an acute care or long-term care setting, in communities across the country. We have been caring for the nation's most vulnerable and disenfranchised individuals for more than 275 years and remain committed to accessible and affordable health care for all.

CHA does believe the time has arrived for a serious, careful discussion about the modernization of the Medicaid program. We also believe, however, that it is important that the process not be driven by cost-savings targets, and that modernizations be developed and implemented with primary consideration of the impact on beneficiaries and a goal of ensuring coverage, access, and quality.

The Catholic health care community provides care and services to Medicaid beneficiaries throughout the continuum of care. Our hospitals deliver babies, take care of premature infants in some of the nation's most advanced neonatal intensive care units, and care for adults and children who are sick or injured. Our clinics in schools and elsewhere in the community keep children well and manage chronic conditions such as asthma and diabetes. Our long-term care facilities provide assisted living and nursing home care for frail and chronically ill elders, and our home care and hospice programs serve persons of all ages who are recovering from or living with serious and disabling illness or are in the end stages of life.

We also know, both from direct experience and through our partners in Catholic Charities agencies and diocesan service programs, that many Medicaid beneficiaries also depend on other federal and state programs. These low-income individuals and families are facing cuts or challenges not only in their health care benefits but also in other essential services including housing and social service programs. The cumulative effect of program reductions on these individuals and families could be devastating. We urge Congress to take a broad look at the overall welfare of those in this country with the greatest needs and the least resources, and offer solutions that will address their needs.

We know from first hand experience that Medicaid is vital to the health and well-being of persons in this country who are materially poor. As policy makers from states and the federal government strive to make improvements in the Medicaid program, we believe it is important to keep in mind the primary oath of medicine: *first do no harm*. There is too much at stake if we get it wrong. The well being of persons who need Medicaid and the entire health care system is in the balance.

Our concern for Medicaid beneficiaries is rooted not only in our experience as service providers but as faith-based organizations committed to the common good and compelled by biblical mandate to offer special protections for poor and vulnerable persons. We consider access to adequate health care to be a basic human right, necessary for the development and maintenance of life and for the ability of human beings to realize the

fullness of their dignity and fully contribute to society. Justice requires us to protect and promote the fundamental rights of people with special attention to meeting the basic needs of the poor and underserved, including the need for safe and affordable health care.

As a member of the Sisters of Providence religious community and Vice President of Mission Leadership for Providence Health System, I would like to tell you about my experience in care for vulnerable Medicaid beneficiaries. Providence Health System is a not-for-profit organization extending across a four-state area – from Alaska through Washington, Oregon, and into Southern California. Providence Health System operates 17 acute care hospitals (181,800 admissions), 20 long-term care facilities (1,741 beds), two PACE programs, and 20 low-income supportive housing and assisted living facilities (1,050 units). We operate comprehensive home care, hospice and palliative care services, primary care clinics, and educational facilities. Providence also sponsors health plans covering more than 850,000 members and other eligible enrollees in Oregon and Southwest Washington. In 2004, almost 34,000 people were employed by Providence Health System.

CHA supports providing states with flexibility to operate their Medicaid programs more efficiently. However, two components of increased flexibility—cost sharing and benefit package design—have not achieved the desired goals of more appropriate utilization, reduced program costs, or significantly increasing the number of persons covered.

Financial Implications of Cost Sharing

Our hospitals in Oregon have experienced first hand the results of increased Medicaid beneficiary cost sharing similar to proposals currently being discussed in Congress. In 2003, under a Medicaid waiver, Oregon established a new Medicaid premium payment policy under which poor adults pay a $6-$20 monthly premium based on income. Oregon also tightened premium payment policies by implementing a new lock-out period for non-payment and removing the ability of low-income and homeless beneficiaries to obtain waivers. Under the new lock-out rule, one missed payment results in disenrollment from the program for a period of six months. Previously, if a beneficiary missed a payment, they could pay the overdue premium and immediately reapply to the program. The state also required co-payments for various areas of care.

Following these state changes, the seven Providence hospitals in Oregon have experienced a steady increase in the percentage of uninsured patient activity in the emergency departments, from 16% in 2003, to 18% in 2004, to 20% to date in 2005. There is a continued dramatic increase in emergency room utilization for ambulatory sensitive conditions (conditions that could be treated appropriately in an outpatient setting) and a behavioral health crisis due to lack of medications. Our uncompensated care overall doubled over a two year period, costing $17,388,179 in 2002 and increasing to $34,994,443 in 2004.

Increases in cost sharing not only impose barriers for beneficiaries needing Medicaid coverage and services but also shift costs to hospitals and other safety net providers already absorbing Medicaid funding shortfalls. In the vast majority of states and for most services, Medicaid does not reimburse providers at a rate that meets their costs, which is only worsened when beneficiaries are unable to afford co-pays.

CHA is very concerned about proposals to increase the cost sharing requirements on Medicaid beneficiaries. Our experience has shown that imposing mandatory cost sharing has severely reduced Medicaid coverage and limited the beneficiary's financial ability to access care. When this occurs the impact on patients and safety net providers alike is dramatic.

Optional Beneficiaries and Optional Services

We cannot stress enough the importance of coverage provided through state-optional categories. While categories of beneficiaries and services may be deemed "optional," the health care coverage and services provided are critical to many individuals and families.

Sally George, aged 70 (whose name has been changed for privacy), a double amputee who suffers from Crohn's disease, was living in low-income housing when her health deteriorated. With the help of Medicaid, she was able to move into Providence ElderPlace in Portland, OR. This innovative program serves frail elderly in a community-based setting that is less expensive than traditional nursing facilities. Sally, a caretaker herself who looked after her own mother until her death at age 97, is grateful for the services she receives and the independence she enjoys at ElderPlace. As she told us at Providence, "Medicaid is so important. Without it, we wouldn't have any of this." Sally is dually eligible for Medicare and Medicaid and receives services through the state-option PACE program at ElderPlace.

Fifteen-year-old Taiviet Nguyen (whose name has been changed for privacy) suffers from a rare from of cancer. Taiviet is too sick to go to school, and his family is occupied with running the family business. With the help of Medicaid, Taiviet is being cared for at home by a team of hospice caregivers. While the value of treating a 15 year-old boy at his home rather than in an emergency room never can be measured in dollars alone, the fact is that Taiviet's home care is less costly than the care he would receive in a hospital. Hospice services are a state-option offered under Washington's Medicaid program.

L.C., a 54-year-old woman in Thurston County, WA, suffers from gastro paresis. This condition causes her stomach not to contract as often as it should and is symptomized by discomfort, nausea, vomiting, and uncontrolled weight loss. L.C. receives home care and Total Parenteral Nutrition (TPN) from Providence Senior and Community Services, a program reimbursed by the State of Washington as a state-option benefit under Medicaid. If Washington State had to scale back or eliminate this benefit due to federal Medicaid cuts, L.C. would not receive the home care she needs and would end up being hospitalized. Providence clinicians estimate her life expectancy would be two to four months without receiving TPN and nurse monitoring. This state option is critical for L.C.'s continued health.

These are some examples of "optional" beneficiaries or "optional services" under Medicaid. For the Medicaid beneficiaries we serve, optional categories certainly do not seem like an option, nor does meeting their health care needs. Reducing Medicaid access or services only increases the likelihood of hospitalization, the cost of uncompensated care borne by hospitals and providers, and ultimately affects employers through increases in insurance premiums due to the higher cost of health care. It becomes an endless cycle that will not be solved by simply cutting Medicaid expenditures. Changes to the Medicaid program must be considered in a broader context of modernizing the program and recognizing the erosive impact of the ever-growing number of uninsured on the health care system.

Mr. Chairman, we applaud your efforts to establish a Medicaid Commission to examine modernization of the program absent Medicaid budget cuts. We agree that an independent bipartisan review of the program needs to be undertaken and we are willing to work with you and the Members of this Committee in that regard. In the meantime, we believe there are a few things that can be done to improve the Medicaid program. Through our experience, the Medicaid program needs to place more emphasis on prevention, care management of chronic conditions, and on home and community-based care.

Securing the Safety Net

Health care services are not consumer goods. We do not know when, if, or how someone will get sick. We cannot predict illness, nor can we anticipate exactly which services an individual will need. Insurance policies exist for this very purpose—to protect someone or something from the unexpected. Without insurance, low-income people are far more likely to delay or even avoid needed care. They are often in poorer health and have a higher rate of illness than the general population. Several factors contribute to this phenomenon, including the inability of low-income people to obtain regular checkups or have access to appropriate nutritional options. Compounding these problems, low-income populations are unable to afford the high cost of health care and insurance. This is where Medicaid steps in. It is ultimately more cost effective for individuals to have coverage and receive preventative and early care when needed. The more costly alternative is for people who could not afford or obtain treatment to reach a point where their only option for acute illness is a hospital emergency room. We currently have some 45 million uninsured persons who may come to the nation's emergency rooms because they have nowhere else to turn for care. They rely on America's hospitals to address their health care needs. Creating barriers to beneficiary access to Medicaid, or scaling back on optional beneficiaries or services, will simply worsen an already bad situation.

Providence Health System in Oregon Responds
The total amount of charity care (uncompensated care) Providence provides to the uninsured and others who cannot pay for their health care continues to rise.

Year	Total Cost of Charity Care	Total Community Benefit*
2001	$10,657,671	$ 58,793,216
2002	$17,388,179	71,042,023
2003	$26,934,018	76,177,057
2004	$34,994,443	94,502,058

*Community benefits are health care and other services underwritten by Providence Health System, such as mission clinics, unpaid costs of Medicaid, education and research. Does not include Medicare shortfall.

Medicaid is a primary source of revenue for America's safety net institutions, including many Catholic hospitals, which serve a disproportionate share of the low-income uninsured and underinsured in their communities every day. In order to ensure continued access to services, attention must be paid to Medicaid payment rates for all providers. When Medicaid payment rates fail to keep pace with the cost of providing care, access to care for Medicaid beneficiaries is affected and the quality of care in departments serving large numbers of beneficiaries, such as obstetrics and trauma, could be jeopardized. Provider reimbursement under Medicaid must be sufficient to foster access to care and to promote quality.

Through its commitment to matching federal funds, Medicaid provides a safety net not only for beneficiaries and providers but for the states as well. The fundamental structure of the Medicaid program as an entitlement must be preserved and strengthened. American communities have long been committed to meeting the basic health care and long-term services needs of low-income Americans through a system of shared federal and state responsibility. We believe this shared responsibility should continue.

Measures to Improve Long-term Care
As people in our communities live longer, the Catholic health ministry is committed to providing a compassionate continuum of care that addresses the physical, social, psychological, and spiritual needs of persons. Making this continuum effective for patients—and for the system itself—requires that we focus more attention on helping people maintain health and independence while treating chronic illnesses in the most appropriate setting. The essential challenge for policy makers and providers alike is to design a system aligned to encourage the highest possible quality along the entire continuum of care.

We strongly support the growing movement of encouraging the delivery of services in the setting that is the least costly and most preferable to older and disabled persons - their homes. Home and community-based services are proving to be cost-effective means for keeping frail and disabled persons as independent as possible and avoiding or delaying the need for costly institutional care. However, it is important to realize that to

be effective a broad range of supportive services must be available. This includes home health and homemaker services, adult day care, caregiver support, and case management. In addition, supportive housing must be available and affordable for these vulnerable persons to be able to remain in their communities. We strongly support policies that coordinate federal and state-supported health and housing services and allow older and disabled persons to be discharged from, postpone or avoid nursing home care.

CHA believes that innovations like Programs for All-inclusive Care for the Elderly (PACE) and other programs aimed at keeping frail, disabled and chronically ill persons at home through creative and flexible uses of Medicare and Medicaid funds should be an even greater part of a modernized Medicaid program. As such, we support S. 1067, the CORE (Community Options for Rural Elders) Act, to facilitate the development of PACE programs in rural areas.

CHA also believes that there needs to be a more rational mechanism for financing and structuring a long-term care system. We need to create alternatives for financing LTC services through such methods as public-private partnerships and tax credits to assist and encourage the purchase of long-term care. But for now, the bottom line is that the need for long-term care services is growing every year and Medicaid nursing home care is consuming 34 percent of all Medicaid costs and serving 60 percent of all nursing home patients. As the baby boom begins to retire over the next 10 years, sustaining or increasing such percentages will present formidable challenges to the Medicaid program.

Conclusion

Congress faces a daunting challenge to ensure that the Medicaid program continues to be both financially viable and responsive to the most needy in our communities. CHA agrees that Medicaid needs a comprehensive review and modernization. However, we believe it is important that such changes are developed and implemented with primary consideration of the impact on beneficiaries and with a goal of ensuring the provision of necessary care, optimizing coverage, enhancing quality and recognizing how changes in Medicaid will impact the entire health care system. This is less likely to be the result of a reform process driven by cost-savings targets.

We also know, from both direct experience and through our partners, that Medicaid beneficiaries are facing cuts or challenges in other essential services for low-income families. The cumulative effect of program reductions on these individuals and families could be devastating. We hope that Congress takes a broad look at the overall welfare of those in this country with the greatest needs and the least resources.

Members of CHA remain concerned about the potential Medicaid funding reductions included in the Congressional budget resolution. We do not believe cutting Medicaid spending is really a means of containing health care costs. It simply shifts the costs to other parts of a health care system already struggling to provide care to underinsured and uninsured persons and to those individuals who are least able to afford it. No program is without flaw, and we are very willing to work with you to identify ways to improve Medicaid while protecting the health and well-being of the people it serves.

Medicaid represents a measure of how we, as a just society and the wealthiest nation in the world, treat the poorest and most vulnerable among us. In the absence of accessible

and affordable health care for all, Medicaid is a critical and important part of our nation's safety net. CHA urges Congress at this critical juncture to make decisions that will preserve and strengthen this vital program.