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U.S. GOVERNMENT
INFORMATION
GPO

H.R. 5613, THE PROTECTING THE MEDICAID SAFETY NET ACT OF 2008

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

APRIL 3, 2008

Serial No. 110–104

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE
51–385 PDF WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
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H.R. 5613, PROTECTING THE MEDICAID SAFETY NET ACT OF 2008

THURSDAY, APRIL 3, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123 of the Rayburn House Office Building, Hon. Frank Pallone (chairman) presiding.

Members present: Representatives Pallone, Waxman, Towns, Green, DeGette, Capps, Baldwin, Solis, Dingell (ex officio), Deal, Wilson, Pitts, Myrick, Murphy, Burgess, and Blackburn.

Staff present: Bridgett Taylor, Amy Hall, Purvee Kempf, Jodi Seth, Brin Frazier, Lauren Bloomberg, Hasan Sarsour, Ryan Long, Brandon Clark, and Chad Grant.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. The subcommittee hearing is called to order.

And today we are having a hearing on H.R. 5613, Protecting the Medicaid Safety Net Act of 2008.

I will first recognize myself for an opening statement, and say that I am very proud to be a cosponsor of this legislation that was introduced by Chairman Dingell and Representative Murphy in order to protect Medicaid beneficiaries from an onslaught of harmful regulations issued by the Bush Administration. Medicaid, as you know, has been a reliable source of medical care, as well as specialized support and services for our most vulnerable population. Medicaid has also assisted millions of American children in receiving the healthcare services necessary to allow them to grow into productive and active members of society. Thanks to the medical program, children have access to services such as early screenings for medical and developmental problems, dental care, vision services, and physical, speech and occupational therapy. All of which enable children who formerly would have been incapable of attending schools to participate in the public education system and receive a good education. Now, in spite of these successes the Bush Administration has launched an all out attack on Medicaid, issuing a constant stream of regulations that seeks to reduce the scope and breath of this vital program. I believe that the goals of these regulations are entirely at odds with the mission of the Medicaid program. And while these regulations may provide instant gratifi-

cation in CMS's estimated cost savings of $15 billion over 5 years, in the long run states will be forced to bear the burden of an even larger healthcare crisis. And as the House Committee on Government Reform and Oversight estimates, this is on the order of nearly $50 billion over 5 years.

For example, I can't understand the logic in limiting hospital outpatient services. The cost of rehospitalization is exponentially more expensive than the cost of providing preventative outpatient care. It is for this regulation the Bush Administration would in effect force people to forego vital preventative services and they would end up in the hospital sicker than they were before. The regulation pertaining to targeted case management services, particularly infuriating to me, as it misuses congressional intent under the guise of improving the Medicaid program. This rule goes far beyond the authority afforded to CMS. And in my State of New Jersey alone would result in a reduction of payments of nearly $100 million over 5 years. More individuals would be forced to remain in institutions without vital case management support to assist them in tasks such as finding jobs and managing numerous chronic diseases, and the medical complexities that are associated with chronic conditions. This regulation will undoubtedly lower the overall quality and quantity of service case managers can provide.

Also, narrowing the definition of rehab services is another obvious step backward by limited access to services necessary to remain out of institutional living. In 2004, some 1.5 million people received rehabilitative services through Medicaid, and it is estimated that three-fourths of these people suffer from mental illness. Under this regulation, states would be restricted from providing these individuals with rehab services, leading to potentially explosive numbers of reinstitutionalized individuals. Another harmful regulation seeks to eliminate funding for administrative activities performed by schools to assist children with disabilities in accessing specialized transportation. They need to get to school and receive specialized medical services, including occupational therapy, physical therapy, speech and language therapy. All of which are absolutely crucial in helping these children become active, working members of society.

Last month the subcommittee invited five governors to talk about their SCHIP, their State Child Health Insurance Programs. And each of them made a point of voicing their concerns on the damaging effects of these regulations on each of their states, and those governors were both Republican and Democrat. In particular, limitations to graduate medical education dollars were of grave concern. GME funding is essential for the operation of teaching hospitals, which not only serve many Medicaid recipients, but which also are vital players in the training of future professionals. By slashing billions of dollars from state Medicaid programs, shifting costs to the states, many of which are strapped for cash as is, these regulations could seriously jeopardize the health care of millions of low-income and disabled Americans. In fact, I, along with my colleagues Mr. Dingell, Mr. King, and Mr. Reynolds, introduced a bill to temporarily increase the FMAP funds to states during this time of recession, so that states may continue to offer critical services

instead of being forced to cut them as the Bush Administration is proposing.

Now, it gives me hope that we will be able to successfully stop this attack on our Nation's safety net, as just a few days ago all 50 governors signed a letter of support for this bill that we have before us. I would like to thank each of our witnesses for being here today to talk about the ways in which these regulations will affect your communities. I look forward to hearing stories, not just about the individuals that would be affected by the regulations, but also any success stories that speak to the power of the Medicaid program to keep citizens active and productive in our society.

Mr. PALLONE. And I will now recognize Mr. Deal for an opening statement.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman. I thank you for holding the hearing today.

We should all concentrate our efforts, I think, today on the bigger picture, which is to try to keep the Medicaid program solvent and fulfilling its original obligations. However, if Medicaid is going to be able to continue its mission to service the poor and disabled, we must be willing to address the financial sustainability of the current program. As the Congressional Budget Office has stated in its most recent budget and economic outlook, the future rates of growth for the government's major health care programs, Medicare and Medicaid, will be the primary determinant of the Nation's long-term fiscal balance. Under current projections, the Medicaid program alone will cost the federal taxpayers $3.34 trillion over the next 10 years. Because Medicaid is a Federal-state matching program, the states will be responsible for an additional $2.44 trillion in payments for the Medicaid program. These numbers are alarming to me and they should be to every member of this committee. When states and the Federal Government are already struggling to meet their obligations under this program, it is hard to entertain ideas of expansion or simply ignore potential reforms.

In fact, in the last Congress, the then Democrat Governor of the State of Virginia testified before this committee on behalf of the National Governor's Association that unless Congress took some drastic action that Medicaid was unsustainable and was in a meltdown posture. That has not changed in my opinion. Instead, we should be focusing our efforts today on addressing the rapid fraud and abuse in Medicaid. At a time of tight budgets we should not be taking money away from those in need in order to pay for program abuses. In regard to these regulations that we are looking at today, I believe it is important for us to keep them in the proper context.

First, they should be seen in a proper financial context. Some supporters of the legislation have given the impression that these regulations would represent a devastating cut to the Medicaid program. Reducing the rate of growth of the Medicaid program by $1.65 billion is not a cut. Medicaid is projected to grow at a rate of well over seven percent during the next year alone, meaning that federal spending would increase by about $20 billion over the

next year. If the Administration rule reduces the spending increase from 20 billion to 18 billion, the Medicaid program is still growing at an unsustainable rate several times larger than inflation. Simply put, if these rules were ever implemented they would only reduce federal and Medicaid spending by less than one percent.

Secondly, these rules were crafted in response to well documented cases of abuses in the Medicaid program. The Department of Health and Human Services Office of the inspector general has provided numerous examples of improper payments, which these rules are designed to address. Of course, like any other product produced by a Federal bureaucracy, these rules are not perfect. And I am confident in the ability of Congress to work cooperatively with the Administration and the states in order to produce policies that are both more effective and easier for states to implement that addresses these abuses. However, this bill does not do anything to facilitate to improve or improve Medicaid policies. To me it is irresponsible for the Committee of jurisdiction for the Medicaid program to simply ignore documented cases of improper payments. Instead, we should be trying to amend these regulations to improve the Medicaid program to the extent underfunding and other areas like IDEA, or Medicaid reimbursement for services, have contributed to the activities that these rules seek to address. We should be examining those underlying problems. As the Committee of jurisdiction it is our responsibility to fix the Medicaid program when it fails Medicaid beneficiaries. However, overlooking these issues until the next Administration simply prolongs a broken system.

I look forward to the testimony of our witnesses about substantive ways to amend these regulations while still addressing some of the real abuses in the Medicaid program. I hope that this committee will be able to pursue reforms which ensure our limited resources as being spent in those most in need, rather than simply continuing to ignore these issues through annual moratoria.

If the object of the regulations is to keep the program solvent, simply putting a hold on the regulations doesn't solve the financial motivation behind them. We can all, perhaps, find reasons to object as to the way they go about it. But if you object to the way these regulations go about it, then you ought to suggest to us, and we all ought to work cooperatively, to achieve reasonable and sufficient goals in a different format. Now, I am afraid that what I have heard thus far is simply criticism of the existing proposed regulations, and no suggestion as to how we can solve the underlying financial issue that is the motivation for those regulations. Hopefully, this hearing will provide those for us today.

Thank you.

Mr. PALLONE. Thank you, Mr. Deal.

I have recognized for an opening statement——

Mr. DEAL. Can I make one other request?

Mr. PALLONE. Sure.

Mr. DEAL. Unanimous consent request that, for the record, we include the regulations that are the subject of this proposed piece of legislation in the record. I think that would be appropriate.

Mr. PALLONE. Without objections so ordered.

[The information follows:]

I

110TH CONGRESS
2D SESSION

H. R. 5613

To extend certain moratoria and impose additional moratoria on certain Medicaid regulations through April 1, 2009.

IN THE HOUSE OF REPRESENTATIVES

MARCH 13, 2008

Mr. DINGELL (for himself and Mr. TIM MURPHY of Pennsylvania) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To extend certain moratoria and impose additional moratoria on certain Medicaid regulations through April 1, 2009.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Protecting the Medicaid Safety Net Act of 2008".

SEC. 2. MORATORIA ON CERTAIN MEDICAID REGULATIONS.

(a) EXTENSION OF CERTAIN MORATORIA IN PUBLIC LAW 110–28.—Section 7002(a)(1) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq

1 Accountability Appropriations Act, 2007 (Public Law
2 110–28) is amended—
3 (1) by striking "prior to the date that is 1 year
4 after the date of enactment of this Act" and insert-
5 ing "prior to April 1, 2009";
6 (2) in subparagraph (A), by inserting after
7 "Federal Regulations)" the following: "or in the
8 final regulation, relating to such parts, published on
9 May 29, 2007 (72 Federal Register 29748)"; and
10 (3) in subparagraph (C), by adding at the end
11 the following: ", including the proposed regulation
12 published on May 23, 2007 (72 Federal Register
13 28930)".
14 (b) EXTENSION OF CERTAIN MORATORIA IN PUBLIC
15 LAW 110–173.—Section 206 of the Medicare, Medicaid,
16 and SCHIP Extension Act of 2007 (Public Law 110–173)
17 is amended—
18 (1) by striking "June 30, 2008" and inserting
19 "April 1, 2009";
20 (2) by inserting ", including the proposed regu-
21 lation published on August 13, 2007 (72 Federal
22 Register 45201)," after "rehabilitation services";
23 and

1 (3) by inserting ", including the final regulation
2 published on December 28, 2007 (72 Federal Reg-
3 ister 73635)," after "school-based transportation".
4 (c) ADDITIONAL MORATORIA.—
5 (1) IN GENERAL.—The Secretary of Health and
6 Human Services may not, prior to April 1, 2009, im-
7 pose (or continue in effect) any requirement, prevent
8 the implementation of any provision, or condition the
9 approval of any provision under any State plan
10 under title XIX or XXI of the Social Security Act,
11 any amendment of such a plan, or demonstration
12 project request relating to such plan or title, on the
13 basis of any policy or interpretation relating to a
14 provision described in paragraph (2) or to any rule,
15 provision, policy, or interpretation similar to such a
16 provision.
17 (2) PROVISIONS DESCRIBED.—The provisions
18 described in this paragraph are the following:
19 (A) PORTION OF INTERIM FINAL REGULA-
20 TION RELATING TO MEDICAID TREATMENT OF
21 OPTIONAL CASE MANAGEMENT SERVICES.—
22 (i) The interim final regulation relat-
23 ing to optional State plan case manage-
24 ment services under the Medicaid program
25 published on December 4, 2007 (72 Fed-

1 eral Register 68007) in its entirety, except
2 as provided in clause (ii).
3 (ii) Clause (i) shall not apply to the
4 portion of such regulation as relates di-
5 rectly to implementing section
6 1915(g)(2)(A)(ii) of the Social Security
7 Act, as amended by section 6052 of the
8 Deficit Reduction Act of 2005 (Public Law
9 109–171), through the definition of case
10 management services and targeted case
11 management services contained in pro-
12 posed section 440.169 of title 42, Code of
13 Federal Regulations, but only to the extent
14 that such portion is not more restrictive
15 than the policies set forth in the Dear
16 State Medicaid Director letter on case
17 management issued on January 19, 2001
18 (SMDL #01–013), and with respect to
19 community transition case management,
20 the Dear State Medicaid Director letter
21 issued on July 25, 2000 (Olmstead Update
22 3).
23 (B) PROPOSED REGULATION RELATING TO
24 REDEFINITION OF MEDICAID OUTPATIENT HOS-
25 PITAL SERVICES.—The proposed regulation re-

1 lating to clarification of outpatient clinic and
2 hospital facility services definition and upper
3 payment limit under the Medicaid program
4 published on September 28, 2007 (72 Federal
5 Register 55158) in its entirety.

6 (C) PORTION OF PROPOSED REGULATION
7 RELATING TO MEDICAID ALLOWABLE PROVIDER
8 TAXES.—The final regulation relating to health-
9 care-related taxes under the Medicaid program
10 published on February 22, 2008 (73 Federal
11 Register 9685) in its entirety, other than the
12 portion of such regulation as relates to the fol-
13 lowing:

14 (i) REDUCTION IN THRESHOLD.—The
15 reduction from 6 percent to 5.5 percent in
16 the threshold applied under section
17 433.68(f)(3)(i) of title 42, Code of Federal
18 Regulations, for determining whether or
19 not there is an indirect guarantee to hold
20 a taxpayer harmless, as required to carry
21 out section 1903(w)(4)(C)(ii) of the Social
22 Security Act, as added by section 403 of
23 the Medicare Improvement and Extension
24 Act of 2006 (division B of Public Law
25 109–432).

1 (ii) CHANGE IN DEFINITION OF MAN-
2 AGED CARE.—The change in the definition
3 of managed care as proposed in the revi-
4 sion of section 433.56(a)(8) of title 42,
5 Code of Federal Regulations, as required
6 to carry out section 1903(w)(7)(A)(viii) of
7 the Social Security Act, as amended by
8 section 6051 of the Deficit Reduction Act
9 of 2005 (Public Law 109–171).

○

Mr. DEAL. Thank you.

Mr. PALLONE. Mr. Waxman, for an opening statement. Oh, Mr. Dingell is here. I apologize—Chairman Dingell is recognized for an opening statement.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Mr. Chairman, I thank you. Mr. Chairman, I commend you for holding this hearing on H.R. 5613.

This is a very valuable event, and the legislation introduced by our good friend and colleague, Mr. Murphy, and I is, I believe, an important piece of legislation. And I want to commend it to my colleagues as being a good piece of legislation much in the public interest. And I want to commend my colleague from Pennsylvania for his willingness to work in a bipartisan fashion on this very important issue.

I would observe that yesterday the Committee had a rather remarkable day in which we passed a very fine piece of legislation in a very carefully thought out and bipartisan fashion. It is my hope that we will be able to continue that kind of undertaking as the session goes forward.

The Protecting the Medicaid Safety Net Act of 2008 is a very simple, straightforward bill. It would place a temporary moratorium on seven regulations recently issued by the Centers for Medicare and Medicaid services, CMS. These regulations would reduce or eliminate payments for services provided to extremely vulnerable Americans and the institutions that serve them. Children with disabilities, people with mental illnesses, those with multiple care needs, people attempting to transition from an institution to a community living environment, and people with disabilities who need these critical services, such as rehabilitation services and case management in order to remain in their community. The regulations would also eliminate funding for school-based outreach and enrollment, and funding that helps safety net providers care for indigent and uninsured patients in our communities.

In my home State of Michigan, the rehabilitation rule would cut rehabilitation services for 15,000 children with special needs, eliminate habilitation services for another 29,000 developmentally disabled adults and children living in the community, and eliminate access to critical community services and resources for 23,600 adults and 5,100 children who are in support independent living arrangements or in group homes. The Administration's argument for supporting these regulations does not hold water. These regulations go well beyond any justifiable point to curb any abuses in the system. And instead, would shift costs to the states and prohibit support for legitimate expenditures on behalf of Medicaid beneficiaries. It is the Administration's thesis that the regulations are going to curb fraud and abuse. A careful examination of these matters will indicate that nothing of the kind will occur, and that the regulations are totally unrelated to that kind of a desirable goal which is not to be found, as I have said, in the regulations. When one finally reviews how CMS dealt with the comments submitted on regulation, it appears that we have some more curious events

to scrutinize. It appears that there was no intention of working with the states or other beneficiary groups to find any kind of common ground. For example, according to CMS's own analysis, only one of the 1,000 comments submitted to CMS on the rule limiting payments to public providers "contained a positive comment." Most remarkable statement. With respect to the rule limiting payments for hospital outpatients there were 91 pieces of correspondence received, containing more than 300 comments of which only one piece of correspondence "contained a positive comment." And in the case of the rehabilitation rule, of the 1,845 comments received, "no comments were in support of the regulation." Those are quotes from the Department of HHS and from CMS. The Protecting the Medicare Safety Net Act will delay a permutation of these seven regulations for a year. It will allow time to examine the regulations more thoughtfully, carefully, and sympathetically. Something which was not done by the Department or by CMS. And I think the public is entitled to ask that a better job of this kind of scrutiny takes place.

I look forward very much to the testimony of our witnesses on this legislation. It is, as we all agree, very important. I hope the Committee will continue its vigorous efforts and will move H.R. 5613 forward quickly and speedily to both protect Medicaid beneficiaries and to protect the integrity of the program. And to see to it, quite frankly, that finally CMS begins to address its responsibilities in rulemaking and doing so in a thoughtful and a careful way, with proper attention to the comments and the testimony received. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Chairman Dingell.

Next, I recognize the gentlewoman from North Carolina, Ms. Myrick.

OPENING STATEMENT OF HON. SUE WILKENS MYRICK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Ms. MYRICK. Thank you, Mr. Chairman, and thanks to all of our witnesses who have agreed to speak with us on this topic today. We appreciate you being here.

Like many of my colleagues, I am concerned about several aspects of the CMS rules that we are discussing today in the context of H.R. 5613. To that end I have co-sponsored a different bill with Mr. Engel, which addresses a critical regulation that concerned my constituents in North Carolina. The rule that limits the types of entities authorized to provide the non-Federal Medicaid chair.

While I fully support the ability of CMS to make regulatory changes to protect the integrity of the Federal State Medicare program, my concerns about the manner in which this provision was implanted and its potential impact on my district lead me to support a moratorium. This decision was made after I and many of my colleagues expressed concerns to CMS and to OMB about the history of the public hospital system in North Carolina. We stressed a desire to delay the effective date to accommodate changes that states and counties would need to make in order to properly fund hospitals. Alternative language proposed it would take into consideration the fact that so few of our state's hospitals are owned by local government. Unfortunately, no agreement was reached. We

are all aware of instances where states and other entities have gained the Medicare system to artificially enhance the Federal match. And we should not encourage systems that promote such activity. We must not, however, paint with too broad a brush, and dismiss systems that are not necessary bad actors.

I have long supported efforts to provide more funding for fraud and abuse crackdowns. In the Deficit Reduction Act I strongly supported the creation of the Medicaid integrity program to provide additional funding through HHS, the office of the inspector general to address fraud and abuse in the Medicaid program. It is clear that tough decisions must be made when it comes to financing systems, and their aspect of these seven regulations that I support. CMS should not provide a blank check to states that use their Medicaid program improperly, or providers who bill for services that are clearly not medical in nature. I am open to efforts that will address some of the most problematic aspects of these CMS regulations head-on, beyond the mere application of moratorium. Some of the logistical problems that states face at the moment are due to the fact that congressional moratorium means that no work can be done with states and localities in preparation for the impact of final regulations.

That said, I realize that we are facing a tight deadline with several of these provisions, and it is not clear that alternative solutions are on the horizon.

I look forward to hearing the testimony of our witnesses this morning. And I yield back the balance of my time, Mr. Chairman.

Mr. PALLONE. Thank you.

I recognize the gentleman from California, Mr. Waxman, and thank him for the work that he did on this issue with his Government Reform Committee.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman, for holding this hearing. And I want to commend Chairman Dingell and Representative Murphy for introducing the bipartisan legislation this hearing will consider, and I am proud to be a cosponsor.

This hearing should not be necessary. The Congress has not directed CMS to make fundamental changes in the way Medicaid pays public and teaching hospitals. The Congress has not directed CMS to make fundamental changes in the scope of services that Medicaid covers for children or adults with disabilities or mental illness. The Congress has not directed CMS to shift billions of dollars in costs of treating Medicaid patients from the Federal Government to the states, the counties, school districts, and providers. Yet, that is precisely what CMS is trying to do by regulatory fiat.

Medicaid is a program that allows states broad flexibility in designing and operating their own programs. As a result, it is famous for its variation from state to state, so it was very odd when CMS told the Oversight Committee several months ago that it had done no state-by-state analysis of the impact of any of these regulations, and it had no intentions of doing such an analysis. Medicaid is by far the largest program of Federal financial assistance in the

states, dwarfing education and highways. But CMS does not seem to want to know what the impact of the regulations would be. Since CMS couldn't tell us,we went to the source. The Oversight Committee asked each of the state Medicaid directors what the impact of each of these regulations would be on their states. The Medicaid directors told us, among other things, that these regulations combined would result in a loss of nearly $50 billion in Federal funds over the next 5 years. Shifting nearly $50 billion in Medicaid costs to the states does not sound like a good idea under any economic circumstance. But it seems particularly misguided at a time when many state economies are clearly in trouble because of the credit and housing markets.

It is pretty clear that states like California, with its 16 billion—that is b, with billion, budget shortfall are not going to make up the loss in Federal funds with their own. In short, what we have here is an unprovoked regulatory assault on Medicaid that is without precedent in scope or destructiveness.

I am looking forward to the testimony from the states, the hospitals, nursing homes, physicians, school administrators who will bear the brunt of this assault. Even though facts don't matter to CMS, they do matter to us.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Waxman.

The gentleman from Pennsylvania, Mr. Murphy.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you, Mr. Chairman, for holding this hearing. And I thank Chairman Dingell for introducing this bill and I am pleased to be the prime cosponsor of it.

In part, from the time that I first came to Congress, a mission I consider most important was to reform our healthcare system. A $2 trillion-a-year system that has $400 or $500 billion worth of inefficiency and waste and, unfortunately, the government pays for much of that. Some 45 percent of Federal mandatory spending is healthcare, much of that in Medicare and Medicaid, and much of that has problems in terms of efficiencies—or shall I say inefficiencies.

Mr. Deal pointed out that one of our concerns is waste fraud and abuse, and that is a huge issue that we have to address. And we need to amend these regulations to make sure we are addressing the waste. Part of this, however, is to make sure that while we are addressing this we do two things. One is focus on moving forward so they do really deal with the waste and efficiency in patient safety and patient quality. And two, in the meantime make sure that those who are in need, the disabled and the infirm, are not the ones bearing the burdens of these cuts.

There are thousands of Medicaid waivers. It is a system that I know in my career as a psychologist working with many physicians. I am not sure any of us understand the system, let alone people in government. Those who are providing care to children and adults—none of us understand how this works. And that alone,

and the massive amount of paperwork needed for waivers, is a huge waste. We need to address that.

Another very important thing is to look. We can find a great deal of savings. I have spoken many times about the $50 billion worth of waste every year when people pick up an infection in the hospital—the 90,000 lives. And how 70 to 80 percent of people that are using up our healthcare dollars have chronic diseases, oftentimes very complex cases. It is important we do not cut case management.

It is also important that Medicaid stops paying for what we call never events. If somebody gets the wrong medication, the wrong amputation, or the wrong therapy and they end up with more time in the hospital, Medicaid shouldn't pay for that. That is a waste. And I hope that as we move forward on this hearing, and subsequently, on our markup for this bill, we include plenty other ways we can come up with $1.65 billion of savings. It is essential we do that. But overall, let us keep this in mind. Those who are the recipients of Medicaid help, many of them young children with disabilities, many of them adults who cannot pay for their care, they should not be the ones bearing the burden of what Congress needs to do. This is an opportunity for both sides. We ought to work together to come up with amendments to Medicaid to stop the waste and to saves lives, and to save money.

I yield back.

Mr. PALLONE. Thank you, Mr. Murphy.

I recognize now the gentlewoman from California, Ms. Capps, for an opening statement.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. CAPPS. Chairman Pallone, thank you for holding this important hearing. And I thank both Committee Chairman Dingel and Mr. Dingell, for introducing this important legislation.

I am proud to be a cosponsor of H.R. 5613, because it is imperative that we protect the Medicaid safety net. The harmful Bush Administration regulations will affect our ability to properly serve the Medicaid population in the most egregious ways. In particular, I am worried about the impact of the regulation regarding school-based health services, because I know about them. This will have a terribly negative effect on the special needs students in my district and countless other districts across the country.

As a school nurse before I came to Congress, these were the students I dealt with. I know these regulations and how they affect the families for whom this is so important. These students are only able to attend school with their peers because of critical services provided to them by their school district. Without reimbursement for transportation and administrative costs, school districts will have to scramble for ways to provide children with necessary services. As the Children's Health Initiative of Santa Barbara put it, schools are, for many students and families, the only gateway to health services. Furthermore, schools are an integral part of conducting outreach in order to enroll eligible students for Medicaid services. And it is hard to see this directive as any other than an attempt to shut these children out.

I am also concerned about the rule concerning targeted case management, which is so critical for individuals transitioning from institutions to community-based care. A few months ago I received an e-mail from the program manager of the Linkages Care Management program of the Life Staff Foundation in San Luis Obispo county. She wrote, "right now we serve 125 seniors and disabled adults with 2.75 care managers and have almost 80 people on our waiting list. There is such a huge need and our resources are truly stretched to the max. Imagine what will happen to those 205 people in San Luis Obispo county alone if this rule went into effect."

Finally, I would like to mention my deep concern for the IGT rule. I am especially concerned of the effect of this rule on public hospitals in California, including those at our prestigious University of California system. So I join my colleagues in supporting H.R. 5613 and applaud the Committee's swift action to address all of these harmful regulations.

My grandchildren from California have joined me to spend the weekend here. And as they arrived last evening I thought about how important their education is to them. And what if their needs were special, and what if they required services like this? And here we are in the process of threatening those very services so important to our next generation. I know there is strong bipartisan support for a moratorium, and I look forward to working with the members of this committee to prevent such drastic cuts from ever going into effect.

I yield back the balance of my time, Mr. Chairman.

Mr. PALLONE. Thank you, Ms. Capps.

Next, I recognize the gentleman from Pennsylvania, Mr. Pitts, for an opening statement. You will waive.

The gentleman from Texas, Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

In the interest of time I think I will submit my statement for the record as well, but I would ask unanimous consent.

I have a copy of a letter submitted by Gene Green and myself to Secretary Leavitt on this issue, and I would like to submit that as part of the record.

[The information was not available at the time of printing.]

Mr. PALLONE. Without objections, so ordered.

Let me also mention that we have a number of letters of support for H.R. 5613 from the National Governor's Association, American Academy of Pediatrics, ARP. I am not going to go through them all—that I would ask unanimous consent to be submitted for the record as well. Without objections, so ordered.

[The information was not available at the time of printing.]

Mr. PALLONE. Next, I recognize the gentlewoman from California, Ms. Solis.

OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Thank you, Mr. Chairman, and I thank the witnesses that are going to be speaking to us at this particular hearing. I want to thank also Chairman Dingell for his leadership on this important issue.

I am proud to be a cosponsor of H.R. 5613, but I am disappointed also that we even have to have a bill like this to address concerns in our communities.

Medicaid, as you know, is an essential safety net for the most vulnerable populations in American. The health of many children, seniors, and people with disabilities relies on the continued funding and existence of Medicaid. However, rather than increasing coverage and funding, the Administration continues to issue misguided policies that will result in the overall reduction of access to care for vulnerable populations enrolled in Medicaid, and the loss of insurance for millions. I am extremely concerned that CMS's ill-advised rules will drastically impact 6.7 million individuals enrolled in California's Medicaid program known as Medi-Cal. More than 170,000 individuals in my district are currently Medi-Cal beneficiaries. And in East Los Angeles alone, in my district, at least one of every four persons received health coverage through the Medi-Cal program. CMS's regulations will reverse any progress that we have made in coverage and will prevent these children and vulnerable populations from receiving care. This is troublesome for communities of color. Sixty-nine percent of Medi-Cal beneficiaries in my district alone happen to be Latino and another 18 percent are Asian.

We have to protect Medicaid. We must also increase outreach and enrollment efforts to ensure that we extend coverage to every child who is eligible for these public programs. Seven in 10 uninsured Latino children are eligible for these programs, such as Medi-Cal and Healthy Families. But sometimes language and cultural barriers delay or block their enrollment in these programs that they deserve to be a part of.

In Los Angeles, the Los Angeles Unified School District will lose at least $7 million in funding for outreach and enrollment activities and referral to Medi-Cal eligible services. The funding for L.A. Unified School District resulted in enrolling more than 1.4 million low-income children into health insurance programs in 2006 alone.

We must also protect the safety net hospitals and providers of CMS's cuts. They provide essential care to individuals who have few options, and train our future health professionals. The government provider cap in graduate medical education restrictions may result in an estimated $240 million lost to L.A. county's already struggling hospital system. And unfortunately, with its regulations and directives, CMS is denying the wishes of states in barring families from health care. The Federal Government is placing further burdens on our states, our counties, our hospitals, and our doctors.

And I look forward to addressing these issues with you, and will yield back the balance of my time.

Mr. PALLONE. Thank you.

I recognize the gentlewoman from Tennessee, Ms. Blackburn, for an opening statement.

Ms. BLACKBURN. Mr. Chairman, I wanted to welcome our guests, and I want to waive my opening and reserve my time for questions. Thank you.

Mr. PALLONE. Thank you.

Next is Mr. Towns of New York recognized for an opening statement.

OPENING STATEMENT OF HON. EDOLPHUS TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me begin by first thanking the witnesses for being here. And I also want to thank Chairman Dingell and Congressman Murphy for the legislation they put forth.

There is widespread agreement about the need to ensure that Medicaid remains a strong and physically secure program. Unfortunately, the regulations released by the senators for Medicare and Medicaid under consideration do not further that aim.

The Administration argues that these regulations are intended to reduce fraud and abuse. It is important that states comply and that we limit fraud and abuse with the established rules and regulations regarding Medicaid payment. But it is equally important that the Federal Government honor its commitment to these states to be a trustworthy partner in funding Medicaid services.

The regulations released by CMS do not honor the commitment, rather they reverse long-standing Medicaid policy at a time when the states are struggling to balance their budgets. Seven, even—I would say even without the significant physical burden that these regulations would impose.

New York alone estimates that it would lose $7.3 billion. That is b as in boy, over the course of 5 years if these regulations were allowed to stand regardless of the objectives behind these regulations. This result in unacceptable, and leaves not only our state governments, but many of our most vulnerable citizens, at risk.

I strongly support the moratorium on these regulations until it can be determined more clearly what the financial impact of these regulations on the states would be. And until an agreement can be reached that addresses the need to clarify existing stature without shifting responsibility for funding Medicaid from the Federal Government to the states.

I want you to know I look forward to reforming our health care system, but let us do it in a positive way, and not a negative way. You know, we have a tendency around here to just use the word reform, and people think it is something positive. But reform is neither positive or negative. It depends on what we do, whether it is positive or negative. There are a lot of terms and phrases that we use like that around here, and this happens to be one. So I am hoping that we pause for a moment and really, really reform this in a positive way. And I am happy that we have many experts at the table and I am looking forward to hearing from you and getting some information as to what we need to do next.

Thank you so much for being here.

On that note I yield back, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Towns.

Ms. Baldwin from Wisconsin recognized for an opening statement.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman, and thank you for holding this very important hearing this morning.

We are in the midst of a health care coverage crisis in the United States. We all probably know the statistics by heart. That the census bureau figures that 47 million Americans are uninsured, and millions more are underinsured, meaning that even though they technically have health insurance they still face barriers to receiving the health care that they need.

This crisis of the uninsured and underinsured is unacceptable. And I am deeply disappointed that instead of working with Congress to address this crisis and improve the situation, the Administration is seeking to undermine the Medicaid program and institute regulations that, in my view, harm Medicaid beneficiaries. Medicaid is a program of last resorts that prevents millions of Americans from joining the ranks of the uninsured. Medicaid is a safety net. Medicaid provides health insurance to groups of people that private insurance would otherwise not cover. The poor, the near poor, people with disabilities, people with extreme medical needs. And unfortunately, in these times of economic hardship we are seeing more of a need for Medicaid. Now is not the time to erode this vital program, but is the time to secure it and make sure that Medicaid continues to provide needed care to millions of Americans. So I am very disappointed by the Administration's actions, and I strongly support H.R. 5613 in putting a 1-year moratorium on these regulations.

Lastly, Mr. Chairman, I want to respond to a few comments that I have heard from those who support these regulations, and I think we need to be very clear on this point. We are all in favor of fiscal integrity, and we support closing loopholes in the Medicaid program, but cutting needed services and reducing access to health care is simply not closing a loophole. These regulations have very real effects on very real people who rely on Medicaid for their health needs. And our states should not have to bear the burden of the $50 billion that these regulations will shift to the states. So I strongly support H.R. 5613, and I am proud to cosponsor it. And I thank our witnesses today for joining us to discuss this important topic.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

I recognize our Vice Chair, Mr. Green, for an opening statement.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman.

As a cosponsor to the bill, I want to thank you for having this hearing on H.R. 5613, the Protecting the Medicaid Safety Net Act of 2008.

Medicaid supports over 60 million people, including sick children, seniors, and low-income families. In 2005, nearly 4 million were enrolled in Medicaid, and 65 percent of those enrolled were children.

Every day Medicaid assists the most vulnerable members of our population.

Under the current administration, CMS has started a trend of issuing rules that we in Congress have not agreed with. There are seven regulations we would be discussing today that CMS wants to makes cuts to the Federal budget funding. My home State of Texas would be most affected by all seven cuts, but most affected would be the payments for graduate education, targeted case management rule, cost limits to public providers, and coverage for rehab services.

According to the OMB, these rules issued by CMS would save the Federal Government $15 billion over 5 years by ending so-called waste, fraud, and abuse. However, upon further congressional investigating it appears that these cuts reduce funding by almost double that amount and leave the states in a significant crisis. In January, my colleague, Mr. Waxman, and the Committee on Oversight and Government Reform asked each state to submit an analysis of the impact of the seven Medicaid regulations issued by CMS over the next 5 years. According to the information submitted by Chris Taylor, the Texas State Medicaid director, Texas stands to lose $3.4 billion in Federal Medicaid funds over the next 5 years. The funding being cut in Medicaid by the Federal Government would not be replaced, and the need for the services has not been reduced, which leaves states in a terrible position of deciding whether they will no longer pay for services, or adjust their budget to pay for the services with only state funds.

In response to the Committee, Mr. Taylor goes on to say, "In Texas, Medicaid accounts for 26 percent of the state's total budget, provides health care for one out of three children, pays for more than half of all births, and covers two-thirds of all nursing home residents."

These Medicaid funds account for more than $21 billion of the annual state budget. It is clear that if these regulations are not delayed, the State of Texas will be in a budget crisis with no way to pay for these services. Even Governor Perry, who I don't often agree with, sent a letter to House Leadership, urging him to extend the moratorium on these Medicaid cuts, so Texas could continue to provide health care services to low-income citizens.

These Medicaid cuts are yet another example of the cavalier attitude CMS has taken under this Administration. It is hard for me to imagine anyone supporting the regulations. We need to extend the 1-year moratorium on these seven cuts and urge the Committee to act quickly on the piece of legislation, because the current moratorium on these cuts ends in July.

And again, I want to thank our witnesses, and welcome our witness from Uvalde, Texas. Obviously, I have a district in Houston, but having a deer lease near Uvalde for many years I would definitely like to have the hospital there if I had some problems out there on that deer lease.

So I yield back my time.

Mr. PALLONE. Thank you, Mr. Green.

I believe that concludes our opening statements by members of the subcommittee, so we will now turn to our witnesses. And I

want to welcome the first panel. We have a large panel here today. I thank you for all being with us.

The way we operate, we have 5-minute opening statements and they are made part of the hearing record. And each witness may, in the discretion of the Committee, submit additional statements or brief or pertinent statements in writing for inclusion in the record.

So let me go through the panel and introduce everyone. Let us see. On my left is Ms. Marsha—or Dr. Marsha Raulerson, who is testifying on behalf of the American Academy of Pediatrics. And then we have Mr. Randy Mohundro, who is superintendent of the DeLeon Independent School District in DeLeon—DeLeon or DeLeon?

Mr. MOHUNDRO. DeLeon.

Mr. PALLONE. DeLeon, Texas. And then we have Ms. Grace-Marie Turner, who is the president of the Galen Institute in Alexandria, Virginia. And Dr. Stuart Shapiro, who is president and CEO of the Pennsylvania Health Care Association. And next to him is Mr. James Cosgrove, who is acting director for Health Care Issues of the GAO. And then is, next to Dr. Cosgrove, is Mr. James Buckner, who is administrator for Uvalde Memorial Hospital in Uvalde, Texas. And then we have Mr. Joseph Antos, who is the Wilson Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. And last is Ms. Barbara Coulter Edwards, who is interim director of the National Association of State Medicaid Directors.

So again, welcome all of you for being here today. And we will just go from my left to right, and start with Dr. Raulerson, recognized for 5 minutes.

STATEMENT OF MARSHA RAULERSON, M.D., FAAP, AMERICAN ACADEMY OF PEDIATRICS

Dr. RAULERSON. Thank you very much, Mr. Chairman, and members of the Committee. I am honored today to represent the American Academy of Pediatrics and its 60,000 primary care physicians, pediatricians, pediatrics sub-specialists, and pediatric surgeons. The Academy is committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults.

I am Marsha Raulerson. I am a pediatrician in private practice in Brewton, Alabama since 1981. In the census, Brewton was 5,498 people, but actually there is an East Brewton, so the two towns together are over 10,000.

Mr. PALLONE. Dr. Raulerson, could—sorry to interrupt. Could you just move a little closer? Move that mic up a little closer to you.

Dr. RAULERSON. OK.

Mr. PALLONE. Thank you.

Dr. RAULERSON. The closest large city to me is Pensacola, Florida. However, when I have a very sick child,the closest children's hospital is in Mobile, Alabama, 90 miles to my west. Brewton is located in the piney woods of Alabama, and our major industry is in pulpwood. My practice is appropriately called Lower Alabama Pediatrics or L.A. Seventy percent of the children I care for receive their medical care through Medicaid. Seventy percent. In the year

2006, for the first time, my practice did not break even. My overhead was over 100 percent, and I had to dip into my own savings to keep my office open. Nevertheless, I believe that I have a calling to provide services to these children, and plan to stay there as long as I can to be their pediatrician.

The Academy has endorsed H.R. 5613 because the neediest children will benefit from a delay in these regulations. The timing is very poor. We have an economic downturn, and more costs to our state will be prohibitive. Every child, regardless of health status, requires health insurance. Research consistently shows that if a child has a medical home he will get the services that he needs, including immunizations and preventive care that will make him a healthier adult. Medicaid is a vital component of our American health care system. Medicaid benefits should be protected to ensure the health and well-being of millions of children.

I want to tell you a little bit about my own office, and put a face on what these regulations will do to my patients. One of the things that will happen with these regulations is that case management will not be paid for in the way that it is now. I had a patient in my practice for over 15 years named Cozzia. Right after she started to kindergarten, when she was five years old, her dad was putting down a new linoleum floor in their mobile home. The glue from the linoleum ignited their gas stove and it blew up, and she was playing right next to it. She sustained burns over 80 to 90 percent of her body, and spent the next 6 months in a burn unit in Mobile. When she was discharged, the surgeon caring for her called me and said this little girl lives in a rural area just north of you, and we want you to care for her. It was my privilege to care for Cozzia until she was 20 years old.

During that time she needed many services. She had skin grafting after skin grafting. She still has a tracheostomy that she got after the burns. But the good news about Cozzia is she has a great spirit, she went back to school, she graduated. And even though she has contractures of her hands from her burns she learned to use a computer, and she can work and she will be a very productive and wonderful citizen for our country.

Another group of children I would like to tell you about who would be impacted are foster children. I presently serve on Alabama's Quality Assurance Committee for the Escambia County Department of Human Resources. Every month we review the management of a child in foster care. These children need services in home care, mental health services, and after school programs. They are at risk for long-term physical and mental illness as a result of their disruptive lives. They may not have their immunizations when I first see them. Never had a vision test. They may be depressed or extremely anxious. Anxiety in children is rampant in the foster care system, because they are afraid someone may come in and remove them from their home again.

I cared for two young boys in my practice who were in foster care years ago. One of them suffered from severe physical punishment for bedwetting, would go hungry for days, and frequently miss school because there was no one home to get him ready for school. In spite of this, while he and his younger brother were in foster care, they would run away to try to return to the abusive family.

Twenty years ago we did not have the services that this child needed. As a result, he has grown to be an adult with a serious mental illness. The good news is that his younger brother went to trade school, works as a brick mason, is married, and has a child and pays taxes.

Finally, I would like to tell you about a child who is only 4 months old. Her name is Shakira. Two weeks ago she came into our office for her EPSDT screening. That was 2 weeks ago. If you don't know that, EPSDT is early periodic screening diagnosis and treatment. It is a very intricate part of the Medicaid program that you pick up things early and you treat them. My physician's assistant, Ms. Guthrie, asked the mom, do you have any concerns about your baby? And she said, well, her belly sticks out funny. And then she kind of laughed, because babies' bellies do stick out. But then when she felt her abdomen she felt something strange, and she immediately came down the hall and got me from another patient, and said you have got to come here. I went in and what I found was very worrisome. She had a mass on the right side of her abdomen extending to the mid-line.

Mr. PALLONE. Dr. Raulerson, I hate to interrupt but, you know, we have got I think eight witnesses and——

Dr. RAULERSON. Oh.

Mr. PALLONE. You are about a minute over, so you have to wrap up.

Dr. RAULERSON. I am sorry. Can I tell you about two more patients real quick?

Mr. PALLONE. Quickly.

Dr. RAULERSON. Anyway, this child, because she came in for a screening, went to Children's Hospital. She has a hepato blastoma. Saturday of this past week she started chemotherapy.

I want to tell you about—quickly about the mental health program that I would with the——

Mr. PALLONE. Very quickly, because you are almost 2 minutes over.

Dr. RAULERSON. Two hundred miles away through telemedicine we bring psychiatric service to children in rural Alabama. But our case manager's the most important part of our service.

And finally, Rebecca Ann was born with a tumor in her face. It grew very rapidly. By 4 weeks of age she had to have a tracheostomy. She could not speak for the first 2 years of her life. She got early intervention. She learned to sign. She is now in pre-kindergarten and speaks as well as the other children, and she actually performed a year ahead of others, because she got early intervention.

We are the adults. We are the ones who have to protect these children.

[The prepared statement of Dr. Raulerson follows:]

American Academy of Pediatrics

STATEMENT

Marsha Raulerson, MD, FAAP

Practicing Pediatrician

Representing the

AMERICAN ACADEMY OF PEDIATRICS

Submitted for the Record of the Hearing Before the
United States House Energy and Commerce Committee

April 3, 2008

The Medicaid Safety Net

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Thank you very much, Mr. Chairman and Members of the Committee. I am honored to represent the American Academy of Pediatrics and its 60,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists before you today. The Academy is committed to the attainment of optimal physical, mental and social health and well-being for all infants, children, adolescents, and young adults.

I am Marsha Raulerson, MD, FAAP, and I have been a practicing pediatrician in Brewton, AL, since 1981. In the 2000 census, Brewton had a population of 5,498. The largest close city is Pensacola, FL and the closest Alabama hospital specializing in children is 90 miles away in Mobile. Brewton is located in the piney woods of Alabama and its major industry is pulp wood.

My practice, Lower Alabama Pediatrics, is 70% Medicaid and we do our best to provide a medical home to all of the children we can reach. Last year, I did not break even in my practice because Medicaid patients require so many services and payments are so low. I had to dip into my own savings to keep my practice afloat. Nevertheless, I believe that I have a calling to provide these services to this population, many of whom are children who have severe and long lasting health needs.

The Academy has endorsed HR 5613, because the neediest children will benefit from a delay in these regulations. The timing of these regulations could not be worse – just as the country tries to weather the storm of a significant economic downturn, the Executive Branch is trying to cut its federal support to states. Children, and especially the most vulnerable children with special health care needs, must not be thrown overboard.

Medicaid

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. 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. Medicaid benefits should be protected to ensure the health and well-being of millions of children.

The Academy 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. On average, 30% of a pediatrician's patients are covered by Medicaid, illustrating the commitment of pediatricians to ensure that Medicaid-insured children have access to a medical home. However, due to low reimbursement levels of Medicaid and high overhead costs of pediatricians' offices, that percentage is decreasing. Mr. Chairman, there's a saying among pediatricians -- when the going gets tough, Medicaid kids get decapitated. By this we mean that "above the neck" services Medicaid enrollees are entitled to – like vision, hearing, speech therapy and dental - become less and less accessible.

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. During this downturn, children are very likely to be affected by state Medicaid budget shortfalls

During the last economic downturn, you addressed states' Medicaid challenges through an increase in the Federal Medical Assistance Percentage (FMAP). Congress has not been successful in passing another FMAP increase, even though it is highly warranted in the opinion of the Academy. Medicaid has also been changed recently at the federal level by the implementation of major program reforms that will make it harder for needy children to access care. These rules, implemented through passage of the Deficit Reduction Act, grant states more flexibility in changing Medicaid programs without waivers, allow states to alter eligibility requirements, cut benefits to optional Medicaid eligibility groups, and implement cost sharing.

These actions and others taken by CMS have done significant damage to children in states. But predictably, the Centers for Medicare and Medicaid Services has taken the instructions you gave them under the DRA and significantly expanded their negative impact on children, often in direct contravention of Congress's express guidance. CMS continues to exceed its authority and I urge you, on behalf of the Academy, to remind them of their role as an implementer of the statutes that you pass, not a loose cannon which may not make law on its own.

Case Management at Lower Alabama Pediatrics

One of the regulations you are considering would deny Medicaid payment for multiple case managers. I have seen the benefits that multiple case managers have brought to my patients. In my practice, I care for many special needs children and some foster children who need multiple case management services. Children on Medicaid are entitled to these services, and they aren't just statistics, but are like the patients that I care for back in Brewton. One such child is named Consia. Consia was playing in her parents' mobile home while her father installed new linoleum flooring in its kitchen. Unfortunately, the stove was not disconnected and the new flooring materials blew up. Consia survived, but had burns over much of her body.

Her parents could not pay for her health needs. Thanks to the multiple case managers paid for by Medicaid, Consia is now attending college. She has also learned how to use a computer even though she has permanent contractures of both hands.

It is almost certain that Consia would not have been able to have a job and get an education except for the case management services she received under Medicaid. Thanks to Medicaid's Early and Periodic Screening, Diagnostic and Treatment Program, Consia will receive an education, and become a taxpaying member of society.

Foster Care Children

Children in foster care also require comprehensive case management services. I presently serve on Alabama's Quality Assurance Committee for the Escambia County Department of Human Resources. We review an individual service plan for one child touched by the foster care system every month. Usually these children are in need of significant services including home care, mental health services, and after-school programs. They are at risk for long-term physical and mental illness as a result of their disrupted lives. They may not have their immunizations, they may not have ever had a vision test, or they may be depressed or extremely anxious. Anxiety in

children is rampant in the foster care system because they are afraid someone may come in and remove them from their home again. While in the care of his family, one of the foster children that I cared for suffered from severe physical punishment for bed- wetting, would go hungry for days and frequently missed school because no one was home. In spite of this, while he was in Foster care he and his younger brother would run away to try to return to his abusive family. Twenty years ago we did not have the services that this child needed, and as a result he has grown up to have a serious mental illness. His younger brother, however, benefited from early intervention, and is doing well working as a brick mason.

Finally, I would like to tell you about a child who is only four months old. Her name is Shakira. Two weeks ago she came to our office for her EPSDT screening and immunizations. She was smiling and cooing and seemed to be a healthy infant. My Physician's Assistant asked the mom if she had any concerns about her baby. The mom stated that Shakira's tummy seemed big. After palpating what seemed to be a large liver, the PA, Ms. Guthrie, called me to the exam room. What I found was a very worrisome mass on the right side of her abdomen extending to the midline. Liver function tests were normal but an ultrasound confirmed a tumor in the liver. I immediately called the pediatric surgeon on call at The Children's Hospital of Alabama in Birmingham. He did not ask me what kind of insurance she had---he arranged to see her then. Saturday March 30th little Shakira had her first chemotherapy for an hepatoblastoma—a rare cancer in her liver. This child is going to need many services from Medicaid including chemotherapy, surgery, transportation (she is 200 miles from home), and case management to see that she gets the care she so desperately needs.

The CMS interim rule curtailing federal financial participation for targeted case management could potentially derail a program I have worked with to provide psychiatric services to children in rural Alabama. Four years ago with the help of the AAP CATCH (Community Access to Child Health) Program, I received a small grant to work with the local schools, juvenile court, the Mental Health Center and Dr. Tom Vaughan, a child psychiatrist in Birmingham. Using telemedicine, we have provided care for more than 100 children with mental illness .An integral service as part of this program has been utilizing a case manager who can see the child at school, go to the home, and arrange for emergency in-patient care which is rarely needed.

I also have many special-needs children in my practice who are attending public schools and are making progress. While at school they may need a variety of health services including use of a feeding tube, physical therapy, medications, in-and-out catherization, and monitoring for seizures. The CMS regulations prohibit Medicaid from paying school employees for administering these services.

Rehabilitative Services at Lower Alabama Pediatrics

Another regulation you are considering would limit access to rehabilitation services for vulnerable children who are enrolled in Medicaid. One patient of mine has benefited tremendously from the rehabilitative services provided by Medicaid. Rebecca Ann is now four and a half years old, but was born with a strawberry patch on her face. This hemangioma grew so large that it abruptly closed her windpipe. She had to be lifeflighted to Mobile where she had an emergency tracheostomy. As a result, she needed round the clock care seven days a week for most of her first two years. Her mother quit her job as an engineer to provide much of this care,

and eventually Rebecca Ann's care required that she go to Boston Children's Hospital on two occasions to receive services. Rebecca Ann also required intensive rehabilitation for the most critical first year of her life, and without these services, she would not have become the wonderful kindergartner that she is today.

I believe that Rebecca Ann's progress was due to the fact that she learned sign language while she had a tracheostomy. Very quickly after the tracheostomy was removed, she started speaking and she has no significant developmental delays. Her progress has been a real miracle. In fact, she recently scored one year ahead of other children her age in verbal skills. Her mother is back at work.

Please delay these regulations for Consia , Rebecca Ann, Shakira, and all the other children in Brewton who depend on us, the adults. I challenge you to stand up to the Administration on behalf of these children.

Conclusion

The Academy strongly supports HR 5613. We commend the courageous wisdom of Chairman Dingell and Congressman Murphy in calling a halt to the implementation of these regulations. Congress must ensure that no child who is currently covered under Medicaid loses his or her access to care as a result of these administrative actions. Support for HR 5613, introduced by Chairman Dingell and Congressman Murphy is needed to place a moratorium on these proposed regulations.

Mr. PALLONE. Thank you. Thank you very much.

Dr. RAULERSON. Thank you.

Mr. PALLONE. I appreciate it.

And let me just—I am going—if you start to go over I am going to ask you to wrap up in each case from now. I hate to do that, but we just have so many witnesses.

Next is Superintendent Mohundro.

STATEMENT OF RANDY MOHUNDRO, SUPERINTENDENT, DELEON INDEPENDENT SCHOOL DISTRICT, EXECUTIVE COMMITTEE DIRECTOR, AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS

Mr. MOHUNDRO. Mr. Chairman, thank you for allowing me to be here today.

The job of the public schools in the United States has historically been to provide children with an education that would allow them to become productive members of a democratic society by attaining basic skills and rudimentary learning. While this basic tenet has held true from the beginnings of our Nation's history to the middle of the 20th century, a major change developed with the passage of Public Law, 94–142, the Individuals with Disabilities Education Act, IDEA. This law mandated that all of the public schools in the United States would accept and educate all children. All children meant accepting those children that had previously been kept at home because no applicable public schools setting was available. IDEA was the key that unlocked the door for those children to enter the same public schools as those children who were "normal." The difference is that schools now became responsible for providing the special needs students the services that they needed to become successful, including medical services. The services provided to these students range from speech therapy, to physical therapy, to providing on-site skilled nursing care to enable these children to attend public schools.

An example of the public school systems and their acceptance of children with special needs would be a student by the name of Eduardo. Eduardo began school as a 3 year old. He came from a single-parent, Spanish-speaking household. He had one younger sibling. Eduardo was born with spina bifida, showing in a typical distribution of paralysis in his right leg. His only method of mobility at 3 was crawling on hands and knees. Early childhood intervention under IDEA, the program that serves children under the age of three before they can enter the public school systems, had plans to obtain a wheelchair for the child, but this was never accomplished. Upon initial evaluation by his school physical therapist, it was discovered that Eduardo had enough muscle function in his right hip to possibly allow ambulation with a long leg brace. The wheelchair was ordered, along with a walker, to be used to teach Eduardo to walk. Referrals were made to the proper medical professionals to obtain the medical care and equipment that Eduardo needed to have functional mobility in a school setting. The school physical therapist has worked with Eduardo on functional skills, consulted with school personnel regarding his function and skill and mobility and other areas, and worked closely with

orthotists for the manufacture of the long leg braces that Eduardo has used.

The issue today faced by schools across the country is the possible loss of Medicaid funding that make such interventions possible. Medicaid funding to schools comes only when schools provide eligible services by qualified providers to those students that are entitled to such services. These services that many children would never be able to utilize or realize the benefit of without the public schools.

The reason for this can include parents not knowing what to do or where to go for the services to be assessed, parents not being financially able to leave work to access these services from another provider away from school, the plight of the working poor that we now see in our country, or the distance being too far and the services being needed so frequently that it is cost prohibitive for parents to go to a medical provider for the services.

Schools are appropriate providers for health care services. We can provide them with minimal educational disruption. Medicaid reimbursement has made it possible for school districts to provide these services for high poverty students. The reality of school-based services receiving Medicaid reimbursement is that there has been an attempt over the last several years to make the process so arduous and tedious that schools would simply throw up their hands and give up. It is simply not worth the hassle or effort. As a school superintendent from a rural community, and as the fiscal agent that works with six other small rural districts I do not have the luxury of saying that it is not worth the effort to receive a certain source of funding. I need every dollar that I can find to assist the learning process of each student that is entrusted into my care.

The common thread that has been seen over the past two to three years is to put up so many hurdles as possible to end the assistance that has been realized in the past for Medicaid for those students that qualify and receive these necessary services. Time logs, service logs, coding of services, coding of personnel, are only the beginning of the paperwork that is now faced by those districts that seek to be reimbursed. The level of paperwork work has increased so substantially that additional clerical resources are now allocated strictly to complete the Medicaid reimbursement process. The time is quickly approaching that the amount of paperwork and requirements to receive the funding will prohibit schools from seeking the funds. It is then that the covert goal of ending the program will fully be realized. Not dying through a lack of need or the lack of children that would benefit from the program, but rather because the bureaucracy has succeeded in making the process so cost-prohibitive.

The additional services that are provided to these students are critical to their success in schools. These services are not luxuries, but rather are educationally and medically necessary for these students to be successful in learning their curriculum that has been established by our state and through the state's individual—excuse me—the students' individualized education program. Will schools cease to provide such programs if the funding is lost? The reality is that public schools have sought to do the one thing that no other institution in our country, either today or in its entire history, has

sought to do. Public schools take whoever walks through the door, regardless of their abilities, and seek to provide the most appropriate education as is allowed. That means that frequently we are educating children that have suffered a traumatic brain injury, and who are not able to neither speak, nor show any signs of recognizing an individual, to those students that also must have feeding tubes to exist. Currently children that look like my 10-year-old daughter, Katelyn, and 14-year-old son, Ben, are served in regular classrooms and are in the regular curriculum. The system that we love would love to have all children be a part of that system, so that they could experience public education and the benefits that can be experienced nowhere else.

Mr. PALLONE. Mr. Mohundro, again, I am sorry, but you are over by a minute. So if you could wrap up I would appreciate it.

Mr. MOHUNDRO. Yes, sir. As the Centers for Medicare and Medicaid services has taken steps this year to eliminate school-based administrative transportation services, I fear our ability to provide these services. My community and my national association, AASA, applaud the steps that are being taken by Congress to apply a moratorium on any changes until June 30, 2008. We are even more pleased to see the introduction of H.R. 5613, the Protecting Medicaid Safety Act of 2008, introduced by Chairman Dingell and Representative Murphy. This bill will provide us the peace of mind and allow us to serve children in an effective manner.

Thank you.

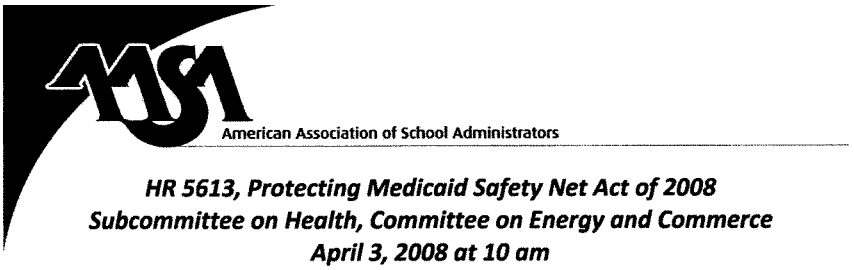
[The prepared statement of Mr. Mohundro follows:]

American Association of School Administrators

HR 5613, Protecting Medicaid Safety Net Act of 2008
Subcommittee on Health, Committee on Energy and Commerce
April 3, 2008 at 10 am

Summary of Testimony by Dr. Randy Mohundro, Superintendent
DeLeon Independent School District, DeLeon, TX
American Association of School Administrators, Executive Committee Member

- Since the inception of the Individuals with Disabilities Education Act, schools have been required to serve children with disabilities and ensure a free and appropriate public education. This has included providing medical services to students and early intervention services.
- Providing medical services through schools is critical because parents often have little knowledge of the various services that could be offered. The reason for this can include parents not knowing what to do or where to go for the services to be accessed, parents not being financially able to leave work to access these services from another provider away from the school (the plight of the working poor), or the distance being too far and the services being needed so frequently that it is cost prohibitive for parents to go to a medical provider for the services. Schools are appropriate and efficient providers of health care services to students in need.
- Schools have been permitted to claim Medicaid reimbursement for eligible services provided to Medicaid eligible students with disabilities. These reimbursements have improved the quality of services that are provided to impacted students. However, the proposed elimination of school-based Medicaid claiming threatens schools ability to provide these funds. We support Congressional efforts to extend the moratorium against any such changes in school based reimbursement including the introduction and passage of HR 5613, the Protecting the Medicaid Safety Net Act of 2008.



HR 5613, Protecting Medicaid Safety Net Act of 2008
Subcommittee on Health, Committee on Energy and Commerce
April 3, 2008 at 10 am

Testimony by Dr. Randy Mohundro, Superintendent
DeLeon Independent School District, DeLeon, TX
American Association of School Administrators, Executive Committee Member

The job of the public school systems in the United States has historically been to provide children with an education that would allow them to become productive members of a democratic society while attaining basic skills in rudimentary learning. While this basic tenet has held true from the beginnings of our nation's history to the middle of the twentieth century, a major change developed with the passage of Public Law 94-142, the Individuals with Disabilities Education Act. This law mandated that all of the public schools in the United States would accept and educate all children. All children meant accepting those children that had previously been kept at home because no applicable public school setting was available. For you see, until the passage of this law, children with special needs and handicaps were simply left at home and it was up to their parents to provide any form of education. While those parents who had the financial means placed their children in special schools and other placements, the majority of those children were left to become dependent on their family for support and eventually dependent on the support of the social welfare system.

IDEA was the key that unlocked the door for those children to enter the same public schools as the children who were "normal". The difference is that schools now became

responsible for providing to special need students the services that they needed to become successful, including medical services. The services provided to these students ranged from speech therapy, to physical therapy, to providing on-site skilled nursing care to enable these children to attend public school.

An example of the success of public school systems and their acceptance of children with special needs would be a student by the name of Eduardo. Eduardo began school as a 3-year old. He came from a single parent, Spanish speaking household. He had one younger sibling. Eduardo was born with spina bifida, showing an atypical distribution of paralysis in his right leg. His only method of mobility at three was crawling on hands and knees. Early Childhood Intervention under IDEA, the program that serves children under that age of 3 before they can enter the public school systems, had plans to obtain a wheelchair for the child, but this was never accomplished.

Upon initial evaluation by the school physical therapist, it was discovered that Eduardo had enough muscle function in his right hip to possibly allow ambulation with a long-leg brace. The wheelchair was ordered, along with a walker to be used to teach Eduardo to walk. Referrals were made to the proper medical professionals to obtain the medical care and equipment that Eduardo needed to have functional mobility in a school setting. The school physical therapist has worked with Eduardo on functional skills, consulted with school personnel regarding his function and skill in mobility and other areas, and worked closely with orthotists for the manufacture of the long leg braces Eduardo has used.

Eduardo is now in the third grade in regular education classroom. He receives no special education services other than physical therapy. Using forearm crutches he is able to walk in all

areas of the school including the stairs, playground and he can even carry his own tray in the lunch room. He can board regular school buses and participates in regular PE with only minor modifications. He even had his name in the paper for being included in the 'Miler-club" with other elementary school children. Eduardo is still progressing in his mobility skills. He can walk short distances with one crutch and the long leg brace. With increased strength in both the right hip and left leg, he has the potential to walk regular distances using only one crutch and his brace.

The benefits of Eduardo being able to access these services in the public school are numerous. Because he came from a home that had little knowledge of the various services that could be offered, it was crucial that the school was there at the earliest stage possible. Without it, Eduardo would not have received the services that he needed to become a functional child. It is true that he was getting some medical care, but when it came to providing the needed services to enable Eduardo to become a productive member of society, those services were not made available to him until the appropriate professionals at his public school began providing them and insure his access to the proper programs and necessary equipment.

The issue today faced by schools across the country is the possible loss of Medicaid funding that makes such interventions possible. Medicaid funding to schools comes only when schools provide eligible services by qualified providers to those students that are entitled to such services. These are services that many children would never be able to utilize or realize the benefit of without the public schools. The reason for this can include parents not knowing what to do or where to go for the services to be accessed, parents not being financially able to leave work to access these services from another provider away from the school (the plight of the

working poor), or the distance being too far and the services being needed so frequently that it is cost prohibitive for parents to go to a medical provider for the services. Schools are appropriate providers of health care services. We can provide them with minimal educational disruption. Medicaid reimbursement has made it possible for school districts to provide these services for high poverty students.

The reality of school based services receiving Medicaid reimbursement is that there has been an attempt over the last several years to make the process so arduous and tedious that schools would simply throw up their hands and give up. It is simply not worth the hassle or effort. As a school superintendent from a rural community and as the fiscal agent that works with six other small rural districts, I do not have the luxury of saying that it is not worth the effort to receive a certain source of funding. I need of every dollar that I can find to assist the learning process of each student that is entrusted into my care. The common thread that has been seen over the past two to three years is to put up as many hurdles as possible to end the assistance that has been realized in the past from Medicaid for those students that qualify and receive these necessary services.

Time logs, service logs, coding of services, coding of personnel, are only the beginning of the paperwork that is now faced by those districts that seek to be reimbursed. The level of paperwork has increased so substantially that additional clerical resources are now allocated strictly to complete the Medicaid reimbursement process. The allocation of such resources is strictly monitored to determine the cost-benefit from seeking such dollars. The time is quickly approaching when the amount of paperwork and requirements to receive the funding will prohibit schools from seeking the funds. It is then that the covert goal of ending the program

will be fully realized. Not dying due to lack of need or the lack of children that would benefit from the program, but rather because of the bureaucracy has succeeded in making the process cost prohibitive.

It is then that students like Treyton who began school at age three will no longer realize the benefits that have been offered to them in the past. Treyton had been born at 26 weeks gestation and had multiple medical problems. Treyton's gross motor skills consisted of sitting and rolling from stomach to back. Treyton could not move into or out of any other position, and he had no method of mobility. Treyton is now 8 years old, and because of the intervention of therapy in school, he is able to crawl on his hands and knees, walk and climb stairs with guarded assistance, negotiate turns, and walk on the playground and all other areas of school and home. He is showing beginning skills in opening doors, stepping up and down curbs, and moving from hands and knees to standing.

Or, students like Judy will be left farther and farther behind because of the inability to access the services that she needs. Judy is a girl born with Down's syndrome. Her mother began bringing Judy to speech therapy at the school when she was 3 years old. Judy spoke in "gibberish" at the time. She could not label items and could not make her thoughts or needs known. Judy has attended speech therapy twice a week for the last 5 years. Judy is now very intelligible in conversational speech. She speaks in complete sentences and answers simple questions. Speech and language is definitely her strength and when she is re-evaluated at the end of this year, it is highly probable that she will be dismissed from speech therapy.

The additional services that are provided to these students are critical to their success in schools. These services are not luxuries, but rather are educational and medically necessary for

these students to be successful in learning the curriculum that has been established by our state and through the student's Individualized Education Program.

Will schools cease to provide such programs if the funding is lost? The reality is that public schools have sought to do the one thing that no other institution in our country either today or in its entire history has sought to do. Public schools take whoever walks through the door, regardless of their abilities, and seek to provide the most appropriate education as is allowed. That means that frequently we are educating children that have suffered a traumatic brain injury and who are not able to neither speak nor show any signs of recognizing any individual, to those students that must have feeding tubes to exist. Currently, children that look like my ten year old daughter Kaitlyn and fourteen year old son Ben are served in regular classrooms and are in the regular curriculum. That system that we would love to have all children be a part of and to be successful in for their public education experience and the benefits that can be offered no where else.

But the reality of the world is that for whatever reason and by whatever power, there have been children with special needs, and there are those children today and there will continue to be those children in the future that need additional services. Because there are children that cannot run, laugh, play, and learn like a "normal" child, we must provide these important services. It is a duty I feel I must in all good conscience and responsibility strive to provide. It is my job and I take it very seriously.

As the Center for Medicare and Medicaid Services has taken the steps this year to eliminate school based administrative and transportation services, I fear for our ability to provide these services. My community and my national association, AASA, are grateful for the

steps taken by Congress in December to apply a moratorium on any changes to school based services until June 30, 2008. We were even more pleased to see the introduction of HR 5613, the Protecting the Medicaid Safety Net Act of 2008, introduced by Chairman Dingell and Representative Murphy. This bill will provide us peace of mind until April 1, 2009 that we can continue to provide our services uninterrupted.

As a school administrator I will not walk away from my responsibility of educating any child that enters one of my schools. I will continue to seek resources where ever available to educate children. The reality of the public education system is that mandates come down regularly from the federal and state level with inadequate funding; but somehow and from somewhere, school administrators across this country are committed to the children they serve and will find the resources necessary to make sure that the Eduardors, Treytons, and Judys of this country have the same quality of education and end up with a quality of life that is comparable to my own children.

As a parent I want to know that if something tragic were to happen to either one of my children that they would receive the quality of services that they need to be successful in the classroom.

I have sat with parents in meetings where they struggle with understanding why their child has to endure the suffering that has been placed on them. These parents are not looking for miracles, but rather they are looking for whatever assistance that they can find. In the rural area that I serve the school is often the only social agency that parents know to turn to for their children. Without the schools these children will have to be served by our society and governmental agencies. The question to ask is whether we want those services provided to

them at the earliest and most beneficial moment in time, or do we wait until the need is so severe that intensive intervention is necessary.

I leave you with the story of Bob. Bob has been enrolled in pre-kindergarten for one and half years. He is unable to verbalize. Augmentative communication and sign language through speech therapy have been implemented. Bob is beginning to be able to communicate his wants and needs. He is beginning to smile and laugh at school, and participate in activities. Bob should enter kindergarten this coming fall. Are you ready to end the funding that allows Bob to be the success that he is today? Or do we strive to allow the funds that Bob and other children like Bob are entitled to flow in the manner in which they are the most efficient and effective.

Mr. PALLONE. Thank you very much.

And I hesitate to stop you all, but we just have too many witnesses. I don't think we have too many. I am glad we have so many, but we have to keep it to 5 minutes.

Ms. Turner.

STATEMENT OF GRACE MARIE TURNER, PRESIDENT, GALEN INSTITUTE

Ms. TURNER. Thank you, Chairman Pallone, for holding the hearing today, and Chairman Dingell, and Ranking Member Deal and members of the Committee for inviting me to testify today.

To introduce myself, I am Grace-Marie Turner, president of the Galen Institute, we're a think tank focusing on free market ideas for health reform. I also was a member of the Medicaid Commission between 2005 and 2006, and we held numerous hearings both in Washington and around the country to gather testimony from experts and citizens about this program.

We heard from hundreds of witnesses about the importance of Medicaid to the millions of people it serves. It is truly the safety net for our health care system, and a lifeline for people with low incomes and disabilities. It is vital to recipients such as those that Dr. Raulerson and Mr. Mohundro have described, as well as to tax payers that Medicaid is sustainable. The CMS rules addressed by the legislation being considered by the Committee today were intended to make Medicaid—to make sure that Medicaid is spending taxpayer dollars appropriately to protect and preserve the program. The GAO and the Inspector General of Health and Human Services have identified important areas where waste and even misuse of Medicaid funds taking place. The GAO found that many states are actually gaming the system to boost their Federal Medicaid reimbursement, yet there is no assurance that these funds are being used for Medicaid services. One state used the funds to help finance education, and others for other non-Medicaid purposes. It doesn't help and it even can harm the beneficiaries for this kind of abuse to take place. The OIG found that medical facilities such as nursing homes, for example, have been forced to rebate tens of millions of dollars of payments back to the states, compromising the quality of care for residents.

One example, one nursing home had total operating costs over a 3-year period of $70 million. Creative state billing using the upper payment limit resulted in $132 million in payments to the facility. But the nursing home was required to rebate to the state all but $50 million. Did I say billion? I mean million. $50 million, meaning that it operated at a $20 million loss and was seriously understaffed. It is difficult to see how this kind of use of Medicaid is helping Medicaid patients.

In the interest of making sure that Medicaid dollars are paying for patient care, it makes sense to require that providers receive and retain the total amount of Medicaid payments that are due them. The provider tax provides similar challenges. The Office of the Inspector General has found numerous cases in which Medicaid claims were being filed that did not involve patient care, or allowable rehabilitation services. It found, for example, cases in which taxpayer—the taxpayer was being billed for non-rehabilitative serv-

ices, such as transporting beneficiaries to grocery stores, restaurants, or even bingo games. Unless a check is placed on these kinds of expenditures, states could undermine Medicaid's ability to provide needed and allowed medical services to the millions of Medicaid recipients who often have no other alternative for care.

The CMS rules certainly are not perfect, but rather than block them completely, a better strategy would be for Congress to work with the Administration, should produce policies that address this financial abuse. The great majority of providers, such as Dr. Raulerson, serving Medicaid patients work to provide the best care possible, often at considerable sacrifice, even when payment means that they are taking a financial loss.

But when states are gaming the system, patient care is not helped. The OIG has reported in testimony before this committee that its goal is to make sure that Medicaid funds are used to provide intended health care services in the intended facility to intended beneficiaries. If there are additional services that Congress believes are the responsibility of the Federal Government but not allowed under current Medicaid rules, such as graduate medical education, this should be done and could be done through more explicit appropriation. Many of the abuses in the Medicaid program are brooded in the way that it is financed through the FMAP provisions.

While I don't have the time to go into that today, I do refer to it in my written testimony. That is the kind of—these kinds of abuses really are part of the system in which we finance health care and finance Medicaid. And looking at the more serious and more—the underlying ways that Medicaid is financed giving states more authority to make sure that they can provide the care the people need is really, I think, the ultimate goal. And would avoid having to spend so much time looking at specific rules, allowing states that are closer to the patient to have more authority to make decisions about their care. We heard that over and over in our Medicaid Commission.

Thank you, Mr. Chairman, for the opportunity to testify.

[The prepared statement of Ms. Turner follows:]

A not-for-profit health and tax policy research organization

Hearing before the House Energy and Commerce Committee

Subcommittee on Health

Hearing on

H.R. 5613
Protecting the Medicaid Safety Net Act of 2008

The Honorable Frank Pallone, Jr.
Chairman

By Grace-Marie Turner
President, Galen Institute

April 3, 2008

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House Energy and Commerce Committee

Subcommittee on Health
Hearing on

H.R. 5613. Protecting the Medicaid Safety Net Act of 2008

Mr. Chairman and members of the committee, thank you for inviting me to testify before your committee today about the important issue of Medicaid integrity. To introduce myself, I am Grace-Marie Turner, president and founder of the Galen Institute. Galen is a non-profit research organization devoted to developing and furthering public understanding of solutions to problems in our health sector. I recently completed a three-year term as a member of the Advisory Council to the Agency for Healthcare Research and Quality in the Department of Health and Human Services, and I served as a member of the Medicaid Commission from 2005 to 2006.

One issue on which there is little or no disagreement is the importance of the Medicaid program to the millions of people it serves. It is vital to recipients as well as to taxpayers that Medicaid funds are spent wisely to provide the best care to this vulnerable population, especially as demands increase. Medicaid expenditures and enrollment are projected to grow significantly, with enrollment projected to increase from about 54 million today to 65 million by 2015, a 21 percent increase. In 2015, the program will be spending $685 billion a year, a 145 percent increase over today.

Our Medicaid Commission held numerous hearings in Washington and around the country to gather testimony from experts and citizens about the program.

We heard a great deal about the strengths of Medicaid:

- Medicaid truly is the safety net for our health care system and can be a lifeline for millions of people with low incomes and disabilities.

- Medicaid fills gaps in our private health sector that is dominated by employment-based health insurance, covering millions of people for whom job-based coverage is not an option.

- Because Medicaid is a joint federal-state program, it benefits to some extent from the principles of federalism, allowing Medicaid to be more flexible than Medicare. States have used this flexibility to experiment with programs to better meet the needs of their citizens.

But we also heard about many of the problems with Medicaid:

- Medicaid offers a rich benefits package, but recipients often have trouble finding private physicians who will see them. Patients are often relegated to crowded hospital emergency rooms to receive medical care.

- The care of Medicaid recipients is often uncoordinated among the physicians, clinics, and hospitals where they receive treatment.

- The focus often is how much money Medicaid is spending rather than on whether the money is being spent wisely to produce the best outcomes.

- And while the federal-state partnership provides Medicaid with some limited benefits of federalism, states' flexibility is constrained by extensive rules and regulations which force them to go through long, complex, and time-consuming appeals to request program changes to better meet the needs of their citizens.

One of the most important lessons I learned from our work on the Medicaid Commission is that changes are needed so the program will have the resources to meet its mission in the future.

Medicaid is the biggest item in many state budgets. Governors from both parties told us they don't see how they will pay for Medicaid's escalating costs and also pay for roads, schools, and public safety, and they pleaded for more flexibility and control. Changes need to be made to the program so it can be more responsive to our 21st century health sector, but even small steps toward injecting some spending discipline create a great deal of fear and opposition.

The proposals addressed by the legislation being considered by the committee today were intended to bring more fiscal stability to the Medicaid program. These changes would result in an estimated $13 billion reduction in federal Medicaid spending over the next five years, out of the $1.2 trillion in federal dollars that Medicaid will spend over that time. So these changes represent only about 1 percent of spending, but they could demonstrate a federal will to bring greater integrity into the program.

One example is the proposal to limit states' ability to use intergovernmental transfers, or IGTs. The Government Accountability Office wrote in a study entitled "Intergovernmental transfers have facilitated state financing schemes"[1] about problems that persist:

> For many years states have used varied financing schemes, sometimes involving IGTs, to inappropriately increase federal Medicaid matching payments. Some states, for example, receive federal matching funds on the basis of large Medicaid payments to certain providers, such as nursing homes operated by local governments, which greatly exceed established Medicaid rates. In reality, the large payments are often temporary, since states can require the local-government providers to return all or most of the money to the

states. States can use these funds—which essentially make a round-trip from the states to providers and back to the states—at their own discretion.

States' financing schemes undermine the federal-state Medicaid partnership, as well as the program's fiscal integrity, in at least three ways.

• The schemes effectively increase the federal matching rate established under federal law by increasing federal expenditures while state contributions remain unchanged or even decrease. GAO estimated that one state effectively increased the federal matching share of its total Medicaid expenditures from 59 percent to 68 percent in state fiscal year 2001, by obtaining excessive federal funds and using these as the state's share of other Medicaid expenditures.

• There is no assurance that these increased federal matching payments are used for Medicaid services, since states use funds returned to them via these schemes at their own discretion. In examining how six states with large schemes used the federal funds they generated, GAO found that one state used the funds to help finance its education programs, and others deposited the funds into state general funds or other special state accounts that could be used for non-Medicaid purposes or to supplant the states' share of other Medicaid expenditures.

• The schemes enable states to pay a few public providers amounts that well exceed the costs of services provided, which is inconsistent with the statutory requirement that states ensure economical and efficient Medicaid payments. In one state, GAO found that the state's proposed scheme increased the daily federal payment per Medicaid resident from $53 to $670 in six local-government-operated nursing homes.

Although Congress and the Centers for Medicare & Medicaid Services have acted to curtail financing schemes when detected, problems persist. States can still claim excessive federal matching funds for payments exceeding public facilities' actual costs. GAO suggests that Congress consider a recommendation open from prior work, that is, to prohibit Medicaid payments that exceed actual costs for any government-owned facility.

A CMS rule that would address this problem has been delayed since the final rule was published on May 29, 2007, and would be further delayed by H.R. 5613. Regarding other provisions, such as limiting payments through Medicaid for graduate medical education (GME), CMS is saying that the federal government should exercise its role to make sure that Medicaid funds are being used for Medicaid services. GME is not an allowed Medicaid service. If there are additional services that Congress believes are the responsibility of the federal government, this should be done through an explicit appropriation.

That is the case with many other provisions addressed by the legislation. The Office of the Inspector General for the Centers for Medicare and Medicaid Services (CMS) has reported in testimony before this committee that it is working to "ensure that Medicaid expenditures are in fact used for medical care to Medicaid beneficiaries…Our overarching concern is to ensure that

Federal matching payments are in the proper proportion to States' shares and that the funds are used to provide the intended health care services in the intended facility to the intended beneficiaries. Changes are still needed to enable the Congress and the Department to be responsible stewards of Federal funds and measure the true cost and benefits of the Medicaid program."[2] These payments may draw down a disproportionate share of Federal matching funds but without providing any corresponding benefit to intended beneficiaries.

I would offer a few specific comments about the seven rules that H.R. 5613 would delay:

- Many members of Congress have expressed concern about the CMS rule placing new and lower limits on federal financial participation for state Medicaid payments to government health care providers. However, the HHS Office of the Inspector General has documented numerous instances in which medical facilities, such as nursing homes, have been forced by the states to rebate tens of millions of dollars of these enhanced payments. These extra payments can, in many cases, cause the facilities to operate in the red and compromise patient care. The OIG reported one instance in which a nursing home did not retain enough Medicaid funding to fill all of its nursing positions. The nursing home was significantly understaffed considering the minimum number of nursing positions specified in its budget and recommended for similar-sized nursing homes. The OIG reported that this condition may have affected the quality of care provided to its residents.[3] The CMS rule would require that these providers receive and retain the total amount of the Medicaid payments they are due, without being forced to rebate a portion of the payments back to the states, payments that often are used to help the states offset their share of the Medicaid program or to pay for non-Medicaid services.

- The provider tax provides similar challenges. Health care providers need to be protected from states that are using these taxes to extract revenues from providers to fill state coffers.

- Again, regarding Medicaid payments for graduate medical education: The costs and payments associated with GME are not expenditures which are federally reimbursable under the Medicaid program. The core mission of the Medicaid program is to pay for medical and medically-related services for Medicaid enrollees. If Congress decides to provide additional funds for GME, the appropriation should be explicit and authorized by statute, which is not currently the case.

- The Office of the Inspector General has found numerous cases in which Medicaid claims were being filed that did not involve patient care or allowable rehabilitation services. It found, for example, cases in which the taxpayer was being billed for nonrehabilitative services such as transporting beneficiaries to the grocery store, restaurants, or even bingo games.[4] The government has a responsibility to assure that taxpayers' dollars are being spent legally and for the appropriate and allowed care and services.[5] The same principle holds true for targeted case management and school-based administration and transportation. Many of these services may be needed but are not legal Medicaid expenditures. Unless a check is placed on these expenditures, states could undermine

> Medicaid's ability to provide the needed and allowed medical services that millions of Medicaid recipients rely on.

The GAO and the OIG have identified important areas where this waste and even misuse of Medicaid funds is taking place. The CMS rules may not be ideal, but rather than block the rules completely, a better strategy would be for the Congress to work with the administration and the states to produce policies to address this financial abuse.

The great majority of providers serving Medicaid patients are working to provide the best care possible, often at considerable sacrifice, such as physicians who treat Medicaid patients even if the Medicaid payment means they are taking a financial loss. But there are people who are using the rules to game the system. And even the states, enabled by clever lawyers, have learned how to game the system by drawing as many federal dollars as possible and forcing providers to operate on tight or even non-existent margins. Patient care can suffer.

Many of the abuses in the Medicaid program are rooted in FMAP, or Federal Medical Assistance Percentage, as my Medicaid Commission colleague Bob Helms of the American Enterprise Institute has documented[6]:

> The FMAP procedure of Medicaid financing has been criticized by policy analysts and government agencies for decades.[7] This criticism comes from analysts representing a wide spectrum of policy-oriented and philosophical approaches to health policy, proving that this debate is not just a matter of government budgets. The perverse incentives created by this method of financing would be present at any level of spending. In addition to the AARP report, a recent report from the National Academy of State Health Plans refers to the Medicaid "tug of war" and calls for steps to improve the fiscal integrity of federal financing.[8] The authors of the report point out that the FMAP procedure creates strong incentives for states to engage in accounting schemes that enhance federal funding, and for the federal bureaucracy to attempt to control these schemes--hence the "tug of war." Numerous analysts have pointed out that we have created a situation in which each governor and state Congressional delegation has a strong incentive to increase federal funding under the FMAP procedures rather than consider reforms that would be in the best interest of those Medicaid is intended to serve.

The most important goal, I believe, is to preserve the Medicaid program for the most vulnerable members of our society, those who have few if any other alternatives to support their needs for medical care. If states are allowed to continue to use Medicaid dollars to support other state services and to rob the providers of the resources they need to provide the best care for patients, the program and its recipients will be harmed. Additionally, while many of the functions that states have undertaken with Medicaid dollars may represent legitimate needs, it is important for the integrity of the program and for the legitimate expenditure of federal taxpayer dollars that Medicaid spending follow congressional directives.

The president and CEO of the Mayo Clinic, Dr. Denis Cortese, spoke in Washington recently about health reform. Mayo is renowned worldwide for its expertise in medical diagnosis, and Dr.

Cortese drew on these capabilities to help policymakers think more strategically about health reform. He said in medical care and in public policy, change must focus on putting the needs of the patient first. Patients want personal, high-value health care, and we need to provide better incentives for programs and providers to provide that care.

Micromanagement of the system through rules and regulations is not putting the patient first. Instead, we need to focus on new financial incentives to encourage patients, providers, program administrators, and the states to make sure they are getting the best value in health spending. Rethinking Medicaid's financial structure, I believe, is needed.

Our commission heard many, many witnesses testify that patients want a medical home. The worst place to get routine medical care is in a crowded hospital emergency room, but too many Medicaid recipients have no other choice. Having a medical home would mean that someone is working on their behalf to coordinate care. Medicaid doesn't support the kind of coordination that would lead to better care and more efficient spending.

After hearing hours and hours of testimony during my service on the Medicaid Commission, I believe we must begin the process of transforming this fragmented, procedure-oriented program to one that is focused on coordinated care, results, and outcomes. Quality of care for Medicaid recipients will be improved when health care providers are responding to patients' needs and not to bureaucratic program rules and regulations.

For Medicaid to become more patient-focused and to more effectively meet the distinctive needs of populations with different needs, Medicaid programs must begin funding health care in a new way. Achieving better quality of care is integrally connected to creating new incentives to achieve better outcomes. This means that new funding mechanisms should be tied to the success of providers and health plans in coordinating patient care, gathering sharable information on the patient's medical care, and giving patients more information and responsibility to be partners in managing their health.

Focusing on these goals and on putting patients first would assure taxpayers, states, and most importantly, patients, that the system is supporting quality care.

Thank you for the opportunity to testify today and I welcome any questions.

ENDNOTES

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[3] "Adequacy of Medicaid Payments to Albany County Nursing Home," U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), June 2004, at http://oig.hhs.gov/oas/reports/region2/20201020.pdf.

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[5] "Audit of Medicaid Claims for Iowa Rehabilitation Treatment Services Family-Centered Program," U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), July 2004, at http://oig.hhs.gov/oas/reports/region7/70203023.pdf.

[6] Robert B. Helms, "The Medicaid Commission Report: A Dissent," American Enterprise Institute, January 11, 2007, at http://www.aei.org/publications/pubID.25434/pub_detail.asp.

[7] Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs*. Vic Miller and Andy Schneider ("The Medicaid Matching Formula: Policy Considerations and Options for Modification") list the following Government Accounting Office (GAO) studies: GAO, *Changing Medicaid Formula Can Improve Distribution of Funds to States*, GAO/GGD-83-27, March 9, 1983; GAO, *Medicaid Matching Formula's Performance and Potential Modifications*, GAO/T-HEHS-95-226, July 27, 1995; GAO, "Medicaid Formula: Effects of Proposed Formula on Federal Shares of State Spending," memo to Senator Daniel Patrick Moynihan (D-N.Y.), GAO-HEHS-99-29R, February 19, 1999; and GAO, "Medicaid Formula: Differences in Funding Ability among States Often Are Widened," GAO-03-620, July 2003. For more recent criticisms, see John R. Graham, "Taming the Medicaid Monster," *Health Policy Prescriptions* 4, no. 8 (August 2006); Tommy G. Thompson, *Medicaid Makeover: Four Challenges and Potential Solutions on the Road to Reform*, (Washington, DC: Medicaid Makeover, 2006), available at http://www.medicaidmakeover.org/MedicaidMakeoverPlan.pdf (accessed December 29, 2006); and Pamela Villarreal, "Federal Medicaid Funding Reform" (brief analysis 566, National Center for Policy Analysis, Dallas, TX, July 31, 2006, available at http://www.ncpa.org/pub/ba/ba566/ (accessed December 29, 2006).

[8] Sonya Schwartz, Shelly Gehshan, Alan Weil, and Alice Lam, *Moving beyond the Tug of War: Improving Medicaid Fiscal Integrity* (Portland, ME: National Academy for State Health Policy, 2006), available at http://www.nashp.org/Files/Medicaid_Fiscal_Integrity.pdf (accessed December 29, 2006).

Mr. PALLONE. Thank you, and thank you for keeping within the time limit as well.

Dr. Shapiro.

STATEMENT OF STUART SHAPIRO, M.D., PRESIDENT AND CEO, PENNSYLVANIA HEALTH CARE ASSOCIATION

Dr. SHAPIRO. Good morning, Chairman Pallone, Ranking Member Deal, and members of the Committee.

I am Stuart Shapiro, and I am president and CEO of the Pennsylvania Health Care Association, and I am here on behalf of the American Health Care Association and the National Center for Assisted Living.

We in Pennsylvania are grateful to Chairman Deal and our own representative, Tim Murphy, for introducing this bipartisan legislation, which we fully endorse. The quick passage of this bill is essential, as it stops an end run by the Bush Administration to implement seven Medicaid regulations that would dramatically change policy and payment without congressional input or oversight if they are allowed to go forward.

As a physician I am deeply worried that these regulations would cause harm to our greatest generation of Americans by limiting access to key Medicaid programs. And that the loss of Federal Medicaid dollars will cause further havoc in states that already face serious budget deficits. I assure you that in my own State of Pennsylvania, these regulations have the ability to disrupt an already fragile system of care.

The Administration claims that its Medicaid changes would save the Federal Government $15 billion over 5 years. But a recent report by the House Oversight Committee puts that number not at $15, but at nearly $50 billion over 5 years. Cost estimates of this magnitude and this variation offer prudence and further study. It just makes common sense to step back, take a breath and then take the time to accurately assess what the real impact will be on Medicaid beneficiaries.

I dare say, that our government can better afford to live without these regulations than Americans, frail seniors, and people with disabilities can live with these regulations and the abrupt changes they would bring to their Medicaid-funded long-term care system. I was raised in a do-no-harm culture. These regulations will do harm. Let me discuss only three of them. My written testimony is much longer.

First, the case management services regulation has the potential to undercut the congressional intent in the Supreme Court decision that individuals should be cared for in the least restrictive setting. Transition planning under this bill is cut by two-thirds of time.

Second, the regulation for cost limits on public providers has the potential to instantly, and I mean instantly, remove millions of dollars from fragile Medicaid systems and states across America. Pennsylvania has over 30 county nursing homes, which depend on IGT dollars. If these Federal dollars are removed from the system, our state will simply not be able to find the dollars necessary to continue to provide the level of care for these citizens. This regulation is both hard-hearted and short-sighted.

The third regulation I will discuss concerns the provider assessment, which is in place in 34 states. So our state's represented not only in Pennsylvania, but 34 other states and by three quarters of the members of this committee. The proposed regulation is so convoluted—and we have had lots of lawyers looking at it—and gives CMS such unfettered flexibility that with the snap of a finger, yes, a snap of the finger, CMS will have the unfettered ability to pull Federal dollars from this program in any state. Clearly not ongressional intent.

In Pennsylvania, we depend on the almost $400 million this assessment generates for the Commonwealth, which is helping cushion the double whammy of cuts in Medicare and in Medicaid.

Mr. Chairman, I want to leave this committee with three brief thoughts. First, future budget savings should not come at the expense of quality long-term care for the poor and the frail elderly. These individuals have paid their dues to America. Many of them fought in World War II. They should be at the front of the line for resources, and not shoved to the back.

Second, in these difficult economic times, all states are desperate for supplementary Federal Medicaid funding to meet the needs of their most vulnerable citizens. States must retain the latitude necessary to ensure that quality care and access are maintained.

And finally, I encourage this committee to focus on addressing the looming fiscal tsunami of long-term care costs that this country is facing as 77 million baby boomers begin to turn 65. The Dingell-Murphy legislation is the right bill at the right time, asking the right questions. It is among our profession's highest priorities, and we are working for passage this year. We stand ready to work with this committee on this issue, as well as on ways to solve the broader, long-term financing crisis.

Thank you, and I look forward to your questions.

[The prepared statement of Mr. Shapiro follows:]

American Health Care Association

National Center For Assisted Living

STATEMENT
Of
STUART H. SHAPIRO, MD

On Behalf Of The
AMERICAN HEALTH CARE ASSOCIATION
&
NATIONAL CENTER FOR ASSISTED LIVING

Before The
House Energy & Commerce Subcommittee on Health
On
"H.R. 5613, Protecting the Medicaid Safety Net Act of 2008"

April 3, 2008

On behalf of the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL), I thank Chairman Frank Pallone, Ranking Member Nathan Deal, and Members of the Energy and Commerce Health Subcommittee for taking the time to closely examine our nation's Medicaid policies.

My name is Dr. Stuart H. Shapiro, and I am President and CEO of the Pennsylvania Health Care Association (PHCA) and its companion organization, the Center for Assisted Living Management (CALM). We advocate for compassionate, quality, long term care for Pennsylvania's elderly and disabled citizens. Our 300-plus members are predominantly long term care providers who operate nursing homes, personal care homes, and assisted living residences and whose top priority is providing quality of care and quality of life for those entrusted to their charge.

Today's hearing provides an ideal forum to discuss how "so-called policy clarifications" and changes in Medicaid regulations are, unfortunately, a unilateral attempt by the executive branch to cut Medicaid funding without adequate congressional oversight, without a complete understanding about how these changes impact our most vulnerable seniors, and without the public policy transparency clearly needed considering the sweeping nature of the proposed changes.

Equally important, Mr. Chairman, the Medicaid changes being proposed here in Washington, DC, are completely antithetical and divorced from the budgetary and economic realities that we face in Harrisburg, Pennsylvania and in state capitals from coast to coast.

As the *Wall Street Journal* recently reported, "Slower growth in tax revenues, the result of a weakening economy, are prompting governors from New Jersey to California to consider an array of belt-tightening measures to balance their budgets for this year and next." According to the National Governors Association (NGA), three-fourths of our states anticipate budget deficits in the year ahead. In my own state, we are facing a $184 million budget hole in long term care alone should changes to the "Cost Limits for Public Providers" regulation proposed by the Bush Administration take effect.

Beyond just contending with the negative budgetary implications at the state level caused by the economic downturn, seniors and the providers who care for them have struggled with the fact that Medicaid, the largest single payer of nursing home care, fails to cover the cost of care for every Medicaid patient receiving care in a nursing home.

An annual study from BDO Seidman/ Eljay LLC shows that nursing homes receive an average of $13.15 less than the cost of care for every day of care provided to a Medicaid patient – a shortfall of $4.4 billion nationwide. Since 1999, the funding gap has grown by 45 percent. In Pennsylvania alone, Medicaid underfunding for the cost of that care in 2007 was estimated at more than $223.6 million—a shortfall that has occurred, every year for the last five years.

These are more than just abstract numbers. These funding shortfalls have a major impact on the front lines of care and negatively impacts staffing, jeopardizes intra-facility quality improvement efforts, and even costs the jobs of the very staff that make a key difference in the quality of care and quality outcomes.

This crisis is far more than just an inconsequential gap between care costs and reimbursement levels – it is a widening chasm that threatens patients, and undermines providers' ability to sustain hard-won quality gains on behalf of our patients.

Our profession commends Chairman Henry Waxman (D-CA) and the U.S. House of Representatives' Committee on Oversight & Government Reform for issuing a report that looks at the state-by-state impact of the seven Medicaid regulations issued by the Centers for Medicare & Medicaid Services (CMS). *The Administration's Medicaid Regulations: State-by-State Impacts* report reflects concerns that our profession has raised about how these regulations impact the long term care of America's most vulnerable seniors.

From our perspective, the Committee's report offers documented proof of the considerable blow these regulations would have on our states, our providers and those we care for, and we share the concerns expressed by the Committee that these seven regulations reduce federal Medicaid funds

not through greater efficiency, but through what the report calls, "...unilateral actions by CMS neither directed nor authorized by Congress."

Especially in the context of the economic downturn and concomitant strain on state budgets, we worry that these regulations will limit seniors' access to key Medicaid programs and resources, and that the loss of federal Medicaid funds will shift costs to the states and disrupt existing systems of care for fragile populations.

We in Pennsylvania are grateful to Chairman Dingell and our own Representative Tim Murphy for pursuing the bipartisan bill being discussed today – *The Protecting the Medicaid Safety Net Act of 2008 (H.R. 5613)* – that would impose one-year moratoria on seven Medicaid regulations issued by CMS. It is simply common sense, and good public policy to pause implementation of these regulations in order to take the necessary time to accurately assess the ultimate impact that these changes would have on the people we serve in the Medicaid program—frail seniors and people with physical and developmental disabilities. I am here on behalf of Pennsylvania providers and nearly 11,000 providers nationwide represented by the American Health Care Association and National Center for Assisted Living, and I am proud to say that we endorse this important legislation that is the subject of today's hearing.

The Bush Administration claims that its Medicaid policy changes would save the federal government $15 billion over five years, but the House Oversight and Investigations Committee report shows that the impact on states would be more than three times that amount – as much as $49.7 billion. Certainly, with cost estimates of this magnitude and variation, prudence and further study is in order.

The Dingell-Murphy legislation is the right bill, at the right time, asking the right questions—it is among our profession's highest priorities, and we are working for its passage this year.

While we and a host of other providers are still analyzing the proposed regulatory changes and how they would impact different states in different ways, four of the seven regulations – case management services, cost limits for public providers, provider tax, and rehabilitation services – most directly impact seniors and people with physical and developmental disabilities who need long term care. Specifically:

Case Management Services
The proposed changes to this Medicaid regulation would shorten planning time available for seniors and people with disabilities that need help transitioning from a facility to the community. Also, the administrative complexities in this rule would likely decrease both participation by case managers and beneficiaries' quality of care; meanwhile, states' costs would likely increase. When preparing to leave a nursing home after a lengthy stay, an individual may no longer own a home or have appropriate housing, or even transportation for follow up doctor visits. Reasonable time is needed to help put these services in place and ensure that necessary services are maintained so that the fragile senior or person with physical or developmental disabilities makes

a successful transition from facility to home.

While the regulation does not prevent provision of these services, it appears to constrict funds to pay for them. It would be wrong to constrict services to the point that the person being discharged does not receive the case management necessary to put new services in place or ensure their continuation. Patients should not risk ending up worse off, and requiring re-admission to a nursing home, which is what we fear could happen if this regulation implements these kinds of constraints.

Cost Limits for Public Providers
The proposed regulation would reduce much-needed Medicaid payments to county nursing homes and other public providers, and also restrict states' use of this legal mechanism to generate funding for states' share of Medicaid costs that would send states scrambling to replace funds previously committed to long term care.

States will be hard-pressed to replace lost federal funds with state dollars. States' use of inter-governmental transfers (IGTs) to enhance the federal funds received from CMS, for example, is a symptom of a greater Medicaid funding crisis. States desperate for more Medicaid funding to meet the needs of seniors and people with disabilities in their states have turned toward programs such as IGTs to access the resources needed to care for a growing patient population who require more complex care.

Data collected by AHCA/NCAL finds thirteen states utilize IGT funds for nursing home costs. CMS documents show that as many as 30 states use funds generated from IGTs to help fund long term care costs. States such as California utilize upwards of $26.2 billion from IGTs for nursing homes and hospitals, and approximately $50 million is directed to nursing home care. In Illinois, $71 million from IGTs goes to nursing home care.

In the Commonwealth of Pennsylvania, we continue to rely on an IGT to help fund long term care. If the Cost Limits for Public Providers regulation takes effect on May 25, Pennsylvania will have a $184 million hole to fill – that is $184 million less to fund care of more than 80,000 nursing home residents by the more than 101,000 nursing home employees statewide. If CMS continues to restrict critical funding, then we must find another way to fund long term care. It is not fair to the seniors and people with disabilities who rely on us to care for them to have this funding, in essence, cut by changing a regulation with no apparent regard for how their care will otherwise be funded.

Provider Taxes
The changes to this regulation could alter states' ability to assess a provider tax – sometimes referred to as a quality fee – to raise additional, critical funds for patient care. To assess a provider tax, a state must first pass legislation authorizing the use of a quality fee and then apply for approval of the state's provider tax plan from the Centers for Medicare & Medicaid Services (CMS). More than 30 states currently have obtained CMS approval for a provider tax, including

CMS approval of a complex statistical model that states must build to illustrate that the state has met all of the tests required by the federal statute regarding provider tax.

States struggling with their Medicaid budget have relied increasingly on the use of quality fees. Funds generated help pay for care of seniors and people with disabilities in nursing homes, assisted living residences, intermediate care facilities for the mentally retarded or developmentally disabled (ICFs/MRDD) and other Medicaid-funded long term care settings, including home- and community-based services.

Long term care is often the largest piece of a state's Medicaid pie, and governors and legislatures labor over how to adequately fund it. AHCA/NCAL agrees that the quality fee or provider tax does not represent a long term funding solution. AHCA/NCAL supports major reform of the long term care funding system, focusing on individual responsibility to plan for one's long term care needs. Until we have more comprehensive reform and properly fund the long term care system our nation demands, AHCA/NCAL maintains that the quality fee program should remain to generate important funding to pay for long term care for seniors and people with disabilities.

States with a nursing home provider tax include: Alabama, Arkansas, California, Connecticut, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and the District of Columbia.

In Pennsylvania, we depend on this provider tax. The almost $400 million dollars this tax generates for the Commonwealth is helping to cushion the "double whammy" of federal cuts to Medicare and Medicaid as well as the cuts being proposed by our own Governor.

Rehabilitative Services

AHCA/NCAL is particularly concerned that this regulation's reduction in expenditures could significantly impact services to individuals with developmental disabilities (DD). Specifically, individuals who may be receiving essential services, such as training to improve physical and mental functioning, under a state plan's rehabilitation option, might lose those longstanding and vital services because the services no longer match the proposed rule's definition of "rehabilitation." Notably, unlike the other provider types and public programs mentioned in the rule, intermediate care facilities for people with mental retardation or developmental disabilities (ICFs/MRDD) and group homes for people with developmental disabilities have no funding source beyond Medicaid, and the services required by DD clients are not included in other government programs.

Further, we are concerned about other impacts of the rehabilitation regulation on the broader population of vulnerable Medicaid beneficiaries. The State of Maine has built a system of private non-medical institutions to care for people who would be considered nursing home eligible any where else in the country. This system has reduced state and federal costs as well as the number

of nursing home beds in the state by 3,000—no small feat given Maine providers care for some of the highest acuity patients in the nation. I understand from my colleagues in Maine that providers in the state stand to lose $100 million in critical funding—a significant loss for such a small state and for Maine's state plan, which was built on good faith and with CMS' approval.

Even though the rehabilitation services regulation is expected to have a greater impact on care of Maine's frail and elderly citizens than the case management services regulation, the state Medicaid agency in Maine has yet to focus on it simply because the agency is still trying to sort through the impact of changes that took effect on March 1 regarding Medicaid case management. The happenstance of this timing that places changes to Medicaid case management ahead of rehabilitation services underscores the need for the moratoria that this Committee is considering today, which would allow states more time to analyze and understand the real impact these regulations will have and to begin planning on behalf of Medicaid beneficiaries.

Mr. Chairman, as we move forward with reforming our nation's Medicaid program – reform that we acknowledge is not just necessary, but vital – we want to offer several principles that form the basis of AHCA/NCAL's policy objectives:

- Finding future budget savings should not come at the expense of today's quality long term care provided for poor and frail elderly;
- Particularly in difficult economic times, states are desperate for supplementary Medicaid funding to meet the needs of their most vulnerable citizens, and must retain the latitude necessary to ensure care quality and access are maintained;
- Instead of focusing on legal mechanisms such as the provider tax, which has been used for nearly two decades, we should focus on why these dollars are needed, and how we can meet the financial challenges ahead.

We appreciate the leadership of Chairman Dingell and Representative Murphy in proposing *H.R. 5613, Protecting the Medicaid Safety Net Act of 2008* and this Committee's review of the impact these seven regulations would have—an impact that seeks to reduce federal Medicaid funding not through greater efficiency, but through administrative action.

We also look forward to working with this Committee and other leaders in Congress to forge more comprehensive long term care financing reforms for Medicaid as well as our nation's entire long term care structure.

Important hearings such as this provide a springboard to assess the bigger, broader long term care financing crisis – and how to solve it.

Now, more than ever, we need a bipartisan, serious, open-minded discussion in the 2008 presidential election about financing what amounts to America's largest unfunded mandate:

paying for nearly 80 million Americans' long term care needs. The impending 'perfect storm' of aging boomers, coupled with advances in healthcare and medical technology, will allow vast numbers of Americans to live longer. That's the good news.

But over the next two decades, nearly 80 million baby boomers – about 10,000 per day – will enter retirement. As the U.S. Department of Health & Human Services (HHS) estimates that nearly 40 percent of all Americans will require the care and services provided in a nursing facility at some point during their lives, the time to invest to protect the future of this critical healthcare infrastructure is now – before the wave of boomers requires these critical services.

Beyond the sheer starkness of these statistics is the disturbing corollary fact that eighty-five percent of Americans believe, mistakenly, their long term care needs will be met by Medicare, Medicaid or their existing health insurance. I am proud to say that our profession is taking an active role in encouraging Senators Obama, Clinton and McCain – and all candidates for federal office in 2008 – to outline proposals to meet this challenge. We are interested in generating ideas and discussion beyond that found in 15-second sound bites and photo opportunities.

Our profession is advancing a plan to help address the long term care financing challenges we face, and our *Long Term and Post-Acute Care Financing Reform Proposal* will not just allow federal and state lawmakers to seize control of eldercare financing issues, but offers welcome help to the nation's Governors by dramatically restructuring the Medicaid program. This is directly applicable to today's hearing.

More broadly, the plan, available at www.ahca.org, would reorganize the Medicaid long term care and Medicare post-acute care systems by centralizing and streamlining government services – and making more private resources available to pay for care that would benefit consumers, providers, and taxpayers alike.

This plan represents but one approach towards solving a looming national crisis, and we hope to see others put a plan on the table for discussion. Now is that time.

Every American's retirement years should be something to look forward to, not to fear. We intend to continue being a positive voice in the long term care reform debate, and to help pass laws and policies that will help ensure every American, from every walk of life, has access to the quality long term care they need and deserve – whenever that may arise, and in the setting most appropriate for them.

Working together with the power of ideas and conviction, we are convinced we can meet this challenge in a manner that makes us proud to be Americans, and proud to be entrusted with the care of our most vulnerable frail, elderly and disabled.

Thank you.

Mr. GREEN. [Presiding] Thank you.

I now recognize Dr. Cosgrove for his opening statement.

STATEMENT OF JAMES COSGROVE, PH.D., ACTING DIRECTOR, HEALTH CARE ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

Mr. COSGROVE. Good morning, Mr. Chairman, Ranking Member Deal, members of the subcommittee.

I am pleased to be here today as you explore CMS's recent Medicaid regulatory actions, and the potential effects of these actions on beneficiaries, providers, and states.

Medicaid fulfills a crucial role in providing health coverage for our Nation's most vulnerable populations, therefore ensuring the program's long-term sustainability is vitally important. Starting in the early 1990s and as recently as 2004, we and others identified inappropriate Medicaid financing arrangements in some states. These arrangements often involved supplemental payments made to government providers that were separate from, and in addition to, those made of the state's typical payment rates.

About a year ago we reported on a CMS initiative that was started in 2003 to end these inappropriate arrangements. My remarks today will focus on Medicaid financing arrangements involving supplemental payments to government providers. I will discuss our findings on these financial arrangements, including their implications for Medicaid's fiscal integrity, and CMS's 2003 initiative to end these arrangements. These findings help provide context for the important issues being discussed today.

In summary, for more than a decade we and others have reported on financing arrangements that inappropriately increased Federal Medicaid matching payments. In these arrangements, states received Federal matching payments by paying certain government providers, such as county owned nursing homes, amounts that greatly exceeded Medicaid rates. In reality, the large payments were often temporary, since states could require the government providers to return all or most of the money back to the states. Under these arrangements, Federal matching funds essentially made a round trip from the state to the provider, and back to the state. States could then use these funds at their own discretion. The exact amount of the additional Federal Medicaid funds generated through these arrangements is unknown, but it is estimated that it was in the billions of dollars.

Despite congressional and CMS action taken to limit such arrangements we have found, even in recent years, that improved Federal oversight was still needed. By effectively increasing the Federal Medicaid share above what is established by law, these types of arrangements threaten the fiscal integrity of Medicaid's Federal and state partnership. They inappropriately shifted costs from the state to the Federal Government. And moreover, these arrangements take funding intended to cover Medicaid costs away from providers. The consequences of these types of arrangements are illustrated by one state that in 2004 increased Federal expenditures without an increase in state spending. That state made a $41 million supplemental payment to a local government hospital. Under its Medicaid matching formula the state paid $10.5 million,

the Federal Government paid $30.5 million of the supplemental payment. Shortly after receiving the payment, however, the hospital transferred back to the state approximately $39 million of the $41 million payment, retaining just $2 million.

In March of 2007, we reported on CMS's 2003 initiative to more closely review state financing arrangements. From August 2003 to August 2006, 29 states ended one or more supplemental payment arrangements, because providers were not retaining the Medicaid payment for which states had received Federal matching funds. We found CMS's action to be consistent with Medicaid payment principals that call for economy and efficiency. However, we also found that CMS's initiative lacked transparency, and that the Agency had not issued any written guidance about the specific approval standards. When we contacted the 29 states, only 8 reported receiving any written guidance or clarification from CMS regarding appropriate and inappropriate financing arrangements. State officials told us it was not always clear what financing arrangements were allowed and why arrangements were approved or not approved. This lack of transparency raised questions about the consistency with which states have been treated and ending their financial arrangements. We recommended that CMS issue guidance about allowable financial arrangements.

In conclusion, as the Nation's health care safety net, the Medicaid program is of critical importance to beneficiaries. The Federal Government and states have a responsibility to administer Medicaid in a manner that ensures both that expenditures benefit those individuals for whom benefits were intended. And that providers are paid appropriately for the Medicaid services they provides. Congress and CMS have taken important steps to address the financial management of Medicaid over the years. Yet, more can be done to ensure accountability and the program's fiscal integrity.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions. Thank you.

[The prepared statement of Mr. Cosgrove follows:]

United States Government Accountability Office

GAO

Testimony
Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Thursday, April 3, 2008

MEDICAID FINANCING

Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight

Statement of James Cosgrove, Acting Director
Health Care

GAO-08-650T

April 3, 2008

GAO
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Highlights

Highlights of GAO-08-650T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

MEDICAID FINANCING

Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight

Why GAO Did This Study

Medicaid, a joint federal-state program, financed the health care for about 59 million low-income people in fiscal year 2006. States have considerable flexibility in deciding what medical services and individuals to cover and the amount to pay providers, and the federal government reimburses a portion of states' expenditures according to a formula established by law. The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for overseeing Medicaid.

Growing pressures on federal and state budgets have increased tensions between the federal government and states regarding this program, including concerns about whether states were appropriately financing their share of the program. GAO's testimony describes findings from prior work conducted from 1994 through March 2007 on (1) certain inappropriate state Medicaid financing arrangements and their implications for Medicaid's fiscal integrity and (2) outcomes and transparency of a CMS oversight initiative begun in 2003 to end such inappropriate arrangements.

What GAO Found

GAO has reported for more than a decade on varied financing arrangements that inappropriately increase federal Medicaid matching payments. In reports issued from 1994 through 2005, GAO found that some states had received federal matching funds by paying certain government providers, such as county-operated nursing homes, amounts that greatly exceeded established Medicaid rates. States would then bill CMS for the federal share of the payment. However, these large payments were often temporary, since some states required the providers to return most or all of the amount. States used the federal matching funds obtained in making these payments as they wished. Such financing arrangements had significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is unknown, but was in the billions of dollars. Because such financing arrangements effectively increase the federal Medicaid share above what is established by law, they threaten the fiscal integrity of Medicaid's federal and state partnership. They shift costs inappropriately from the states to the federal government, and take funding intended for covered Medicaid costs from providers, who do not under these arrangements retain the full payments.

In 2003, CMS began an oversight initiative that by August 2006 resulted in 29 states ending one or more inappropriate financing arrangements. Under the initiative, CMS sought satisfactory assurances that a state was ending financing arrangements that the agency found to be inappropriate. According to CMS, the arrangements had to be ended because the providers did not retain all payments made to them but returned all or a portion to the states. GAO reported in 2007 that although CMS's initiative was consistent with Medicaid payment principles, it was not transparent in implementation. CMS had not used any of the means by which it normally provides states with information about Medicaid program requirements, such as the published state Medicaid manual, standard letters issued to all state Medicaid directors, or technical guidance manuals. Such guidance could be helpful by informing states about the specific standards used for reviewing and approving states' financing arrangements. In May 2007, CMS issued a final rule that, if implemented, would, among other things, limit Medicaid payments to government providers' costs. We have not reviewed the substance of the May 2007 rule. The extent to which the May 2007 rule would respond to GAO's concerns about the transparency of CMS's initiative and review standards will depend on how CMS implements it.

To view the full product, including the scope and methodology, click on GAO-08-650T. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you explore recent regulatory actions of the administration related to the Medicaid program and the potential impacts of these actions on beneficiaries, providers, and states. Medicaid, a joint federal and state program that covered over 59 million people in fiscal year 2006, fulfills a crucial role in providing health coverage for a variety of vulnerable populations, including certain low-income children, families, and individuals who are aged or disabled. Ensuring the program's long-term sustainability is therefore very important.

The federal government and the states share responsibilities for financing and administering Medicaid. Within broad federal requirements, states have considerable flexibility in deciding what medical services and individuals to cover and the amount to pay providers, and the federal government reimburses a portion of states' expenditures according to a formula established by law.[1] The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for overseeing states' Medicaid programs and ensuring the propriety of expenditures for which states seek federal reimbursement. Total Medicaid expenditures are significant, totaling an estimated $317 billion in fiscal year 2006.[2]

Growing pressures on federal and state budgets have increased tensions between the federal government and the states regarding Medicaid. In recent years, tensions have arisen regarding CMS's actions in overseeing the appropriateness of provider payments for which states have sought federal reimbursement, including whether states were appropriately financing their share, that is, the nonfederal share of these payments. Starting in the early 1990s and as recently as 2004, we and others have reviewed aspects of inappropriate Medicaid financing arrangements in some states, often involving supplemental payments made to government providers that were beyond states' typical Medicaid payment rates. We have also reviewed CMS's oversight of such arrangements, most recently reporting in March 2007 on an initiative started in 2003 to end inappropriate arrangements. Since 2007, CMS has issued a series of proposed or final rules related to payments for certain Medicaid services.

[1]States and the federal government share in Medicaid expenditures. The federal share of expenditures for Medicaid services can range from 50 to 83 percent.

[2]This figure includes estimated federal and state Medicaid program expenditures for provider services and administration in fiscal year 2006.

These rules are the subject of H.R. 5613[3]—which would place a moratorium on the rules—and of today's hearing. One of those rules, issued as a final rule in May 2007,[4] relates to a body of work GAO has conducted since the early 1990s on state Medicaid financing arrangements. In my testimony today, I will summarize and describe our findings on (1) past inappropriate state Medicaid financing arrangements, including their implications for the fiscal integrity of the Medicaid program, and (2) the outcomes and transparency of CMS's 2003 initiative, which provides context for considering the effect of the May rule on various stakeholders. My testimony is based on our previous work assessing various Medicaid financing arrangements and federal oversight of these arrangements. We conducted this body of work from June 1993 through March 2007. We have not reported on the proposed and final rules that are addressed in H.R. 5613, with respect to the operation of the Medicaid program. We conducted our work in accordance with generally accepted government auditing standards.

In summary, we have reported for more than a decade on varied financing arrangements that inappropriately increase federal Medicaid matching payments. In reports issued from 1994 through 2005, we reported on various arrangements whereby states received federal matching funds by paying certain government providers, such as county-owned or county-operated nursing homes, amounts that greatly exceeded standard Medicaid rates.[5] The large payments were often temporary, since some states could require the government providers to return all or most of the money to the states. States used the federal matching funds received for these payments—which essentially made a round-trip from the states to providers and back to the states—at their own discretion. Such financing arrangements had significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is not known, but was in the billions of dollars. Despite congressional and CMS action taken during those years to limit such arrangements, we found even in recent years that

[3]Protecting the Medicaid Safety Net Act of 2008, H.R. 5613, 110th Cong. (2008). This legislation would place a moratorium until April 1, 2009 on seven Medicaid regulations issued by CMS in 2007.

[4]See 72 Fed. Reg. 29748 (May 29, 2007).

[5]See related GAO products at the end of this statement.

improved federal oversight of such arrangements was still needed.[6] Because such financing arrangements effectively increase the federal Medicaid share above what is established by law, they threaten the fiscal integrity of Medicaid's federal and state partnership. They shift costs inappropriately from the states to the federal government, and take funding intended for Medicaid beneficiaries and covered Medicaid costs from providers, who do not under these arrangements retain the full payments.

CMS's oversight initiative, started in 2003 to end inappropriate state financing arrangements, by August 2006 had resulted in 29 states ending one or more financing arrangements in which providers did not retain the supplemental payments they received. Although we found that CMS's initiative was consistent with Medicaid payment principles, we also found that more transparency was needed regarding the way in which CMS was implementing its initiative and the review standards it was using to end certain financing arrangements. For example, to inform states about the specific standards it used for reviewing and approving states' financing arrangements under its new initiative, CMS had not used any of the means by which it typically provides information to states about new or revised Medicaid program requirements, such as proposed rule making, its published state Medicaid manual, standard letters issued to all state Medicaid directors, and technical guidance manuals. Consequently, states were concerned about standards that were applied in CMS's review of their arrangements and the consistency with which states were treated. These observations provide some context for the controversy surrounding CMS's May 2007 rule. We have not assessed this rule, or others addressed by H.R. 5613, with respect to the operation of the Medicaid program. . The extent to which the May 2007 rule would respond to concerns about the transparency of CMS's initiative and review standards will depend on how CMS implements it.

[6]Since identifying problems with inappropriate financing arrangements involving certain government providers in 1994, we have suggested that the Congress consider limiting payments to government providers to their costs of providing Medicaid services to Medicaid beneficiaries. See GAO, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, GAO/HEHS-94-133 (Washington, D.C.: Aug. 1, 1994).

Background

Title XIX of the Social Security Act establishes Medicaid as a joint federal-state program to finance health care for certain low-income, aged, or disabled individuals.[7] Medicaid is an open-ended entitlement program, under which the federal government is obligated to pay its share of expenditures for covered services provided to eligible individuals under each state's federally approved Medicaid plan. States operate their Medicaid programs by paying qualified health care providers for a range of covered services provided to eligible beneficiaries and then seeking reimbursement for the federal share of those payments.[8]

CMS has an important role in ensuring that states comply with certain statutory Medicaid payment principles when claiming federal reimbursements for payments made to institutional and other providers who serve Medicaid beneficiaries. For example, Medicaid payments by law must be "consistent with efficiency, economy, and quality care,"[9] and states must share in Medicaid costs in proportions established according to a statutory formula.[10]

Within broad federal requirements, each state administers and operates its Medicaid program in accordance with a state Medicaid plan, which must be approved by CMS. A state Medicaid plan details the populations a state's program serves, the services the program covers (such as physicians' services, nursing home care, and inpatient hospital care), and the rates of and methods for calculating payments to providers. State Medicaid plans generally do not detail the specific arrangements a state uses to finance the nonfederal share of program spending. Title XIX of the Social Security Act allows states to derive up to 60 percent of the

[7]42 U.S.C. §§ 1396 et seq. (2000).

[8]Throughout this statement, we refer to funds used by state Medicaid programs to pay providers for rendering Medicaid services as payments. We refer to federal funds received by states from CMS for the federal share of states' Medicaid payments as reimbursements.

[9]See 42 U.S.C § 1396a(a)(30)(A) (2000).

[10]Under the formula, the federal government may pay from 50 to 83 percent of a state's Medicaid expenditures for services. States with lower per capita incomes receive higher federal matching rates. 42 U.S.C § 1396d(b) (2000).

nonfederal share from local governments, as long as the state itself contributes at least 40 percent.[11]

Over the last several years, CMS has taken a number of steps to help ensure the fiscal integrity of the Medicaid program. These include making internal organizational changes that centralize the review of states' Medicaid financing arrangements and hiring additional staff to review each state's Medicaid financing. The agency also published in May 2007 a final rule related to Medicaid payment and financing.[12] This rule would, among other things, limit payments to government providers to their cost of providing Medicaid services. Congress has imposed a moratorium on this rule until May 25, 2008.[13]

Concerns about Certain Medicaid Financing Arrangements That Undermine Medicaid's Fiscal Integrity Are Long-standing

From 1994 through 2005, we have reported numerous times on a number of financing arrangements that create the illusion of a valid state Medicaid expenditure to a health care provider. Payments under these arrangements have enabled states to claim federal matching funds regardless of whether the program services paid for had actually been provided. As various schemes have come to light, the Congress and CMS took several actions from 1987 through 2002, through law and regulation, to curtail them (see table 1).

[11]See 42 U.S.C § 1396a(a)(2) (2000). Local governments and local government providers can contribute to the nonfederal share of Medicaid payments through mechanisms known as intergovernmental transfers, or IGTs. IGTs are a legitimate feature in state finance that enable state and local governments to carry out their shared governmental functions, for example through the transfer of revenues between governmental entities.

[12]See 72 Fed. Reg. 29,748 (May 29, 2007).

[13]See Pub. L. No. 110-28, § 7002, 121 Stat. 112, 187 (2007).

Table 1: Medicaid Financing Schemes Used to Inappropriately Generate Federal Payments and Federal Actions to Address Them, 1987-2002

Financing arrangement	Description	Action taken
Excessive payments to state health facilities	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration (HCFA, now called the Centers for Medicare & Medicaid Services or CMS) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by states.
Provider taxes and donations	Revenues from provider-specific taxes on hospitals and other providers and from provider "donations" were matched with federal funds and paid to the providers. These providers could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 imposed restrictions on provider donations and provider taxes.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped the amount of DSH payments individual hospitals could receive.
Excessive DSH payments to state mental hospitals	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to institutions for mental disease and other mental health facilities.
Upper payment limit (UPL) for local government health facilities	In an effort to ensure that Medicaid payments are reasonable, federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate aggregate payment limit for local government health facilities. HCFA issued its final regulation on January 12, 2001. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.

Source: GAO.

Notes: See GAO, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*, GAO-04-547T (Washington, D.C.: Mar. 18, 2004). Before June 2001, CMS was known as HCFA.

Many of these arrangements involve payment arrangements between the state and government-owned or government-operated providers, such as local government-operated nursing homes. They also involved supplemental payments—payments states made to these providers separate from and in addition to those made at a state's standard Medicaid payment rate. The supplemental payments connected with these

arrangements were illusory, however, because states required these government providers to return part or all of the payments to the states.[14] Because government entities were involved, all or a portion of the supplemental payments could be returned to the state through an IGT.[15] Financing arrangements involving illusory payments to Medicaid providers have significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is not known, but was in the billions of dollars. For example, a 2001 regulation to curtail states' misuse of the UPL for certain provider payments was estimated to have saved the federal government approximately $17 billion from fiscal year 2002 through fiscal year 2006. In 2003, we designated Medicaid to be a program at high risk of mismanagement, waste, and abuse, in part because of concerns about states' use of inappropriate financing arrangements.[16]

Inappropriate Medicaid Financing Arrangements Undermine Medicaid's Fiscal Integrity

States' use of these creative financing mechanisms undermined the federal-state Medicaid partnership as well as the program's fiscal integrity in at least three ways.

First, inappropriate state financing arrangements effectively increased the federal matching rate established under federal law by increasing federal expenditures while state contributions remain unchanged or even decrease. Figure 1 illustrates a state's arrangement in place in 2004 in which the state increased federal expenditures without a commensurate increase in state spending. In this case, the state made a $41 million supplemental payment to a local government hospital. Under its Medicaid matching formula, the state paid $10.5 million and CMS paid $30.5 million

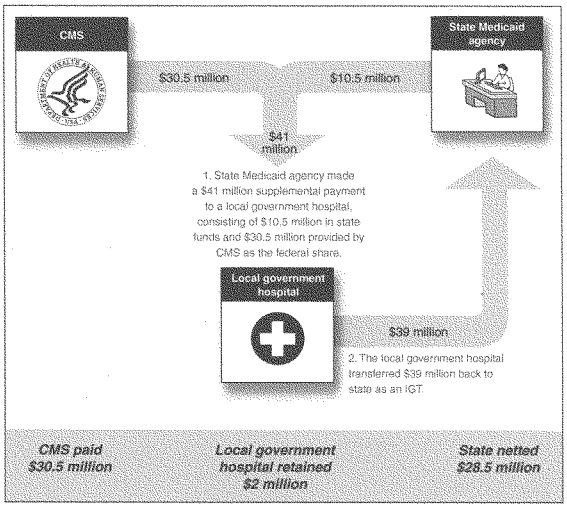
[14]The two most common supplemental payments that involved illusory payments to government providers are UPL payments and DSH payments. Illusory UPL payments are based on the misuse of Medicaid UPL provisions. UPLs are the federal government's way of placing a ceiling on the federal share of a state Medicaid program; they are the upper bound on the amounts the federal government will pay a state for the federal share of state spending on certain services. Some states made supplemental payments up to the UPL but then required the providers to return all or a portion of the payment. Under Medicaid law, states are required to make special hospital payments to supplement standard Medicaid payment rates and help offset costs for hospitals that serve a disproportionate share of low-income or uninsured patients; these payments came to be known as DSH payments.

[15]State and local governments use IGTs to carry out their shared governmental functions, such as collecting and redistributing revenues to provide essential government services.

[16]GAO, *High Risk Series: An Update, Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-07-310 (Washington, D.C.: Jan. 2007).

as the federal share of the supplemental payment. However, after receiving the supplemental payment the hospital transferred back to the state approximately $39 million of the $41 million payment, retaining just $2 million. Creating the illusion of a $41 million hospital payment when only $2 million was actually retained by the provider enabled the state to obtain additional federal reimbursements without effectively contributing a nonfederal share—in this case, the state actually netted $28.5 million as a result of the arrangement.

Figure 1: Example of How One State Increased Federal Medicaid Matching Funds without Increasing State Spending



Source: GAO analysis of one state's financing arrangement for state fiscal year 2004.

Second, CMS had no assurance that these increased federal matching payments were retained by the providers and used to pay for Medicaid services. Federal Medicaid matching funds are intended for Medicaid-covered services for the Medicaid-eligible individuals on whose behalf payments are made. However, under these arrangements payments for such Medicaid-covered services were returned to the states, which could then use the returned funds at their own discretion. In 2004, we examined how six states with large supplemental payment financing arrangements involving nursing homes used the federal funds they generated. As in the past, some states deposited excessive funds from financing arrangements into their general funds, which may or may not be used for Medicaid purposes. Table 2 provides further information on how states used their funds from supplemental payment arrangements, as reported by the six states we reviewed in 2004.

Table 2: Selected States' Use of Funds Generated through UPL Arrangements, as of January 2004

State	Use
Michigan	Funds generated by the state's UPL arrangement were deposited in the state's general fund but were tracked separately as a local fund source. These local funds were earmarked for future Medicaid expenses and used as the state match, effectively recycling federal UPL matching funds to generate additional federal Medicaid matching funds.
New York	Funds generated by the state's UPL arrangement were deposited into its Medical Assistance Account. Proceeds from this account were used to pay for the state share of the cost of Medicaid payments, effectively recycling federal funds to generate additional federal Medicaid matching funds.
Oregon	Funds generated by the state's UPL arrangement were used to finance education programs and other non-Medicaid health programs. UPL matching funds recouped from providers were deposited into a special UPL fund. Facing a large budget deficit, a February 2002 special session of the Oregon legislature allocated the fund balance, about $131 million, to finance kindergarten to 12th grade education programs. According to state budget documents, the UPL funds were used to replace financing from the state's general fund.
Pennsylvania	Funds generated by the state's UPL arrangement were used for a number of Medicaid and non-Medicaid purposes, including long-term care and behavioral health services. In state fiscal years 2001 through 2003 the state generated $2.4 billion in excess federal matching funds, of which 43 percent was used for Medicaid expenses (recycled to generate additional federal matching funds), 6 percent was used for non-Medicaid purposes, and 52 percent was unspent and available for non-Medicaid uses (does not total 100 percent because of rounding).
Washington	Funds generated by the state's UPL arrangement were commingled with a number of other revenue sources in a state fund. The fund was used for various state health programs, including a state-funded basic health plan, public health programs, and health benefits for home care workers. A portion of the fund was also transferred to the state's general fund. The fund was also used for selected Medicaid services and the State Children's Health Insurance Program (SCHIP), which effectively recycled the federal funds to generate additional federal Medicaid matching funds.
Wisconsin	Funds generated by the state's UPL arrangement were deposited in a state fund, which was used to pay for Medicaid-covered services in both public and private nursing homes. Because the state used these payments as the state share, the federal funds were effectively recycled to generate additional federal Medicaid matching funds.

Sources: CMS and states, based on work ending in January 2004.

Note: See GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228 (Washington, D.C.: Feb. 13, 2004).

Third, these state financing arrangements undermined the fiscal integrity of the Medicaid program because they enabled states to make payments to government providers that could significantly exceed their costs. In our view, this practice was inconsistent with the statutory requirement that states ensure that Medicaid payments are economical and efficient.

CMS Oversight Initiative to End State Financing Arrangements Lacked Transparency

Our March 2007 report[17] on a recent CMS oversight initiative to end certain financing arrangements where providers did not retain the payments provides context for CMS's May rule. Responding to concerns about states' continuing use of creative financing arrangements to shift costs to the federal government, CMS has taken steps starting in August 2003 to end inappropriate state financing arrangements by closely reviewing state plan amendments on a state-by-state basis. As a result of the CMS initiative, from August 2003 through August 2006, 29 states ended one or more arrangements for financing supplemental payments, because providers were not retaining the Medicaid payments for which states had received federal matching funds.

We found CMS's actions under its oversight initiative to be consistent with Medicaid payment principles—for example, that payment for services be consistent with efficiency, economy, and quality of care. We also found, however, that CMS's initiative to end inappropriate financing arrangements lacked transparency, in that CMS had not issued written guidance about the specific approval standards for state financing arrangements. CMS's initiative was a departure from the agency's past oversight approach, which did not focus on whether individual providers were retaining the supplemental payments they received. In contacting the 29 states that ended a financing arrangement from August 2003 through August 2006 under the initiative, only 8 states reported that they had received any written guidance or clarification from CMS regarding appropriate and inappropriate financing arrangements. CMS had not used any of the means by which it typically provides information to states about the Medicaid program, such as its published state Medicaid manual, standard letters issued to all state Medicaid directors, or technical guidance manuals, to inform states about the specific standards it used for reviewing and approving states' financing arrangements. State officials told us that it was not always clear what financing arrangements CMS would allow and why arrangements approved in the past would no longer be approved. Twenty-four of 29 states reported that CMS had changed its policy regarding financing arrangements, and 1 state challenged CMS's disapproval of its state plan amendment, in part on the grounds that CMS changed its policy regarding payment arrangements and should have done

[17]GAO, *Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency*, GAO-07-214 (Washington, D.C.: Mar. 30, 2007).

so through rule making.[18] The lack of transparency in CMS's review standards raised questions about the consistency with which states had been treated in ending their financing arrangements. We consequently recommended that CMS issue guidance to clarify allowable financing arrangements.

Our recommendation for CMS to issue guidance for allowable financing arrangements paralleled a recommendation we had made in earlier work reviewing states' use of consultants on a contingency-fee basis to maximize federal Medicaid revenues.[19] Problematic projects where claims for federal matching funds appeared to be inconsistent with CMS's policy or with federal law, or that—as with inappropriate supplemental payment arrangements—undermined Medicaid's fiscal integrity, involved Medicaid payments to government entities and categories of claims where federal requirements had been inconsistently applied, were evolving, or were not specific. We recommended that CMS establish or clarify and communicate its policies in these areas, including supplemental payment arrangements.[20] CMS's responded that clarifying guidance was under development for targeted case management, rehabilitation services, and supplemental payment arrangements.

We have ongoing work to examine the amount and distribution of states' Medicaid supplemental payments, but have not reported on the May 2007 rule or other rules related to Medicaid financing issued this year. Certain elements of the May 2007 rule relate to the concerns our past work has raised. Some aspects of the final rule appear to be responsive to

[18]This state formally requested that the CMS Administrator reconsider the disapproval of the state plan amendment. The Administrator upheld the disapproval, finding the state's argument that CMS was required to use notice-and-comment rule making unsupported. The United State Court of Appeals for the Eighth Circuit denied the state's appeal of this decision. *Minnesota v. Ctrs. for Medicare and Medicaid Servs.*, 495 F.3d 991 (8th Cir. 2007).

[19]See GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, GAO-05-748 (Washington, D.C.: June 28, 2005).

[20]Other areas where our 2005 report identified that federal law and policies had been inconsistently applied, were evolving, or were not specific included targeted case management services and rehabilitation services. We found that states' claims in some of these categories had grown substantially in dollar amounts. For example, during fiscal years 1999 through 2003, combined state and federal spending for targeted case management services increased by 76 percent, from $1.7 billion to $3 billion, across all states.

recommendations from our past work, to the extent that its implementation could help ensure that Medicaid providers, on whose behalf states' receive federal matching funds, retain the payments made by the state. The extent to which the rule would address concerns about the transparency of CMS's initiative and review standards will depend on how CMS implements it.

Concluding Observations

As the nation's health care safety net, the Medicaid program is of critical importance to beneficiaries and the providers that serve them. The federal government and states have a responsibility to administer the program in a manner that ensures that expenditures benefit those low-income people for whom benefits were intended. With annual expenditures totaling more than $300 billion per year accountability for the significant program expenditures is critical to providing those assurances. Ensuring the program's long-term fiscal sustainability is important for beneficiaries, providers, states, and the federal government.

For more than a decade, we have reported on various methods that states have used to inappropriately maximize federal Medicaid reimbursement, and we have made recommendations to end these inappropriate financing arrangements. Supplemental payments involving government providers have resulted in billions of excess federal dollars for states, yet accountability for these payments—assurances that they are retained by providers of Medicaid services to Medicaid beneficiaries—has been lacking. CMS has taken important steps in recent years to improve its financial management of Medicaid, yet more can be done.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or members of the subcommittee may have.

Contact and Acknowledgments

For information regarding this testimony, please contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Katherine Iritani, Assistant Director; Carolyn Yocom, Assistant Director; Ted Burik; Tim Bushfield; Tom Moscovitch; and Terry Saiki also made key contributions to this testimony.

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Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight. GAO-08-255T. Washington, D.C.: November 1, 2007.

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Mr. GREEN. Mr. Buckner, welcome to the Committee.

STATEMENT OF JAMES E. BUCKNER, JR., CHE, ADMINISTRATOR, UVALDE MEMORIAL HOSPITAL

Mr. BUCKNER. Thank you and good morning, Mr. Chairman.

I am Jim Buckner, administrator of Uvalde Memorial Hospital in rural southwest Texas, on behalf of the American Hospital Association, nearly 5,000 member hospitals. I appreciate the opportunity to share the hospital's strong support for the Protecting the Medicaid Safety Net Act of 2008.

More than 57 million children, poor, disabled, and elderly people rely on Medicaid for care. At my hospital in Uvalde, 20 percent of our patients are covered by Medicaid, while 89 percent of our newborns are also covered by the program. Thirty-eight percent of our patients who are Medicare primary beneficiaries also have Medicaid for their supplemental insurance. Another 11 percent of those Medicare beneficiaries are unable to pay their deductibles and co-insurance. Nearly 50 percent of our elderly are indigent. So it is clear that changes in the Medicaid reimbursement program will have a direct impact on our ability to serve the people who need us.

With the ranks of the uninsured growing and the threat of an economic recession looming, the importance of Medicaid to so many people's lives and health is being magnified even as we are—even as it is being jeopardized. CMS has issued seven regulations that would weaken the government's financial support for Medicaid. I will focus on four that directly affect hospitals.

The cost limit rule would restrict payments to financially strapped government-operated hospitals, narrow the definition of public hospitals, and restrict state Medicaid financing through intergovernmental transfers and certified public expenditures. It would also limit reimbursement for government-operated hospitals and restrict the ability of states to make supplemental payments to providers through the Medicaid upper payment limit.

Let me summarize this rule. It cuts funding for public and safety net providers that are in stressed financial circumstances and are most in need of adequate payments, not cuts. The supplemental Medicaid program payments that Uvalde Memorial Hospital has received through the Texas Rural Upper Payment Limit program have been essential to our ability to keep the hospital doors open. If the Medicaid cost limit rule is implemented, Texas hospitals expect an 80 percent reduction to the Texas Rural Upper Payment Limit program. To fill that budget gap, my hospital would be forced to consider deferring acquisitions of technology, especially in areas like electronic health records, and deferring much needed renovations to our 35-year-old hospital.

Also, important services we provide to improve quality of life to our residents could be eliminated, such as our hospice program and diabetic outreach program. The community and the medical staff count on our hospital to recruit primary care physicians and specialists to our community to improve the medical safety net. UPL program helps us make initial support for these physicians possible. Without hospital leadership we struggle with even keeping primary care in a medically underserved area.

The proposed graduate medical education rule would eliminate any Federal Medicaid support for GME. While CMS claims that this rule is a clarification, it is in fact the reversal of more than 40 years of agency policy and practice, and would cut nearly $2 billion in Federal support. Again, the rule puts safety net hospitals in financial jeopardy.

The outpatient rule also substantially departs from long-standing Medicaid policy. The types of services that might not be reimbursed through hospital outpatient programs under the rule include early and periodic screening and diagnostic treatment; dental services for children; physician emergency department services; physica, occupational, and speech therapies; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; and outpatient audiology services. In other words, important cost-efficient services that millions of people rely on. Many of these services my own hospital provides to the rural residents of southwest Texas, and I am very concerned that this rule, if finalized, would make it harder for my hospital to continue to offer these services.

If I may, Mr. Chair, one last rule. The provider tax rule would change Medicaid policy on health care-related taxes that help states support their share of Medicaid spending. And the AHA specifically objects to the rule's hold harmless changes that would make it difficult for states to adopt or implement health care-related tax programs.

Mr. Chair, we have touched on the harm that each of these regulations will do. We certainly ask and beg your support to enact H.R. 5613, as it is absolutely critical to the continued support of hospitals in the safety net areas.

Thank you.

[The prepared statement of Mr. Buckner follows:]

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Testimony
of the
American Hospital Association
before the
Committee on Energy and Commerce
of the
U.S. House of Representatives

"H.R. 5613, Protecting the Medicaid Safety Net Act of 2008"

April 3, 2008

Good morning, Mr. Chairman. I am Jim Buckner, administrator of Uvalde Memorial Hospital (UMH) in Uvalde, Texas. On behalf of the AHA's nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, I appreciate the opportunity to share with you and your colleagues the hospital field's strong support for H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008." This much-needed legislation will prevent, for one year, the Centers for Medicare & Medicaid Services (CMS) from imposing regulations that would do harm to the health care services America's most needy people rely on.

My hospital is located in southwest Texas and serves five counties in the sparsely populated Edwards Plateau/brush country region. UMH has 66 beds with eight intensive care units; 11 maternity rooms with fetal monitoring equipment; surgical suites; an intermediate intensive care unit; and a 24-hour emergency department. We also provide a broad array of services in this rural area of Texas, such as pharmacy, hospice, rehabilitation and case management. The hospital recently added a triage area and four new fast-track emergency treatment areas. Each month we average 179 surgeries, 38 obstetrical deliveries, 1,200 emergency department visits, and 204 inpatient admissions. And, to the subject of today's hearing, 20 percent of our patients are covered by Medicaid. Moreover, 89 percent of our newborns are covered by Medicaid. So it is clear that any changes in Medi[illegible]'l have a direct impact on our ability to serve the people who need us.

For more than 40 years, Medicaid has served as the nation's health care safety net, providing access to health services for millions who cannot afford private insurance. Today, more than 57 million children, poor, disabled and elderly people rely on Medicaid for care. The program now serves more people than Medicare. With the ranks of the uninsured growing, and the threat of an economic recession looming, the importance of Medicaid to so many people's lives and health is being magnified even as it is being jeopardized.

Hospitals like mine are the backbone of America's health care safety net, providing care to all patients who come through their doors, regardless of ability to pay. But, hospitals experience severe payment shortfalls when treating Medicaid patients. In 2006, Medicaid paid hospitals only 86 cents for every dollar it cost them to treat Medicaid patients. That same year, hospitals provided more than $31 billion in care for which no payment was received. Despite these financial pressures, the Administration continues to call for further cuts in federal support for the Medicaid program.

THE FEDERAL BUDGET AND THE CMS REGULATIONS

Since early 2007, CMS has issued seven regulations, in either proposed or final form, that would significantly affect the Medicaid program's financial support for hospitals and Medicaid services provided to children, families, the elderly and the disabled. The Administration estimates that these rules would reduce federal spending by $15 billion over five years. However, a report issued in March 2008 by the House Committee on Oversight and Government Reform estimates the fiscal impact of these rules at nearly $50 billion over five years. CMS asserts that the majority of these regulations are necessary to address problems, particularly with the financing of the program. But, in the written justification for the regulations, CMS failed to identify any significant or widespread problems.

Despite concerns raised by Congress, states and providers, CMS has continued to move toward implementation of the regulations. Implementation would, among other things, limit payments for public hospitals and hospital outpatient services and reduce school-based services for children and case management for the disabled. The AHA has joined a broad-based coalition of 131 organizations, including advocates, labor, physicians and others who oppose these regulations. In addition, the National Governors' Association has called for a moratorium on the rules. The following are the regulations that directly affect hospitals.

REGULATIONS UNDER THE CONGRESSIONAL MORATORIUM

Congress has imposed a year-long moratorium, secured by P.L. 110-28, on two regulations: the proposed and final cost-limit rule; and the proposed graduate medical education (GME) rule. The existing moratorium on implementation of these rules expires May 25, 2008.

Cost-limit Rule. This regulation would restrict payments to financially strapped government-operated hospitals, narrow the definition of "public" hospitals, and restrict state Medicaid financing through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). It would also limit reimbursement for government-operated hospitals to the cost of providing Medicaid services to the program's recipients. In addition, the rule would restrict states' ability

to make supplemental payments to providers with financial need by setting the Medicaid Upper Payment Limit (UPL) for government-operated hospitals at the individual facility's cost.

The rule's restrictive definition of government-operated hospitals would have significant practical implications for public hospitals, particularly those that have restructured to achieve gains in efficiency. This regulation effectively amounts to a cut in funding for those public and safety-net providers that – as CMS recognized – are in stressed financial circumstances and are most in need of enhanced payments. CMS estimates that the rules would reduce federal Medicaid support by $5 billion over five years, cuts that would undermine states' and hospitals' ability to make sure Medicaid beneficiaries get the care they need. The cuts would also hurt states' and hospitals' substantial investments in initiatives to promote the Department of Health and Human Services' policy goals, including adoption of electronic health records, reducing disparities in care provided to minority populations, and enhancing access to primary and preventative care.

The supplemental Medicaid payments that UMH has received through the Texas Rural Upper Payment Limit program have been essential to our ability to keep our hospital's doors open. In 2007, UPL payments provided $1.6 million, or 3.2 percent, of our operating budget. UPL payments have made the difference in being able to invest in new technology and building improvements since the program started in FY 2003.

If the Medicaid cost-limit rule is implemented, Texas hospitals overall expect an 80 percent reduction to the Texas Rural UPL program in which UMH participates. We would struggle to fill that budget gap and would be forced to immediately consider deferring acquisitions of technology, especially in areas like electronic medical records, and deferring renovations to our 35-year-old hospital. Also, a number of services we provide to improve the quality of life for our rural residents could be eliminated. They include our hospice program and a diabetic outreach program. Furthermore, the community and the medical staff count on the hospital to recruit primary care physicians and specialists to our community to improve the medical safety net. UPL dollars help make initial support of these physicians possible.

Intergovernmental transfers have been utilized for at least two decades in Texas. Public hospitals have been putting up the match that our state does not provide because of budget constraints. The Texas Rural UPL program has operated very openly and with no abuse of the system. As best as I can determine, rural Texas public hospitals have only been able to keep from closing their doors thanks to two major funding interventions: the Texas Rural UPL program and the Critical Access Hospital program. As a result, rural, needy, and Medicaid-eligible Texans have retained access to their rural safety net hospitals.

GME Rule. This proposed rule would eliminate any federal Medicaid support for GME. While CMS claims that this rule is a clarification, it is in fact a reversal of more than 40 years of agency policy and practice recognizing GME as medical assistance. This rule would cut nearly $2 billion in federal support for the Medicaid program. The finalization of this new policy would throw many safety-net hospitals into financial jeopardy, ultimately harming the most vulnerable of our citizens.

REGULATIONS NOT CURRENTLY UNDER CONGRESSIONAL MORATORIUM

Outpatient Rule. This proposed rule substantially departs from long-standing Medicaid policy regarding the definition of Medicaid outpatient hospital services and how costs for such services are treated when calculating the hospital outpatient UPL. Under the proposed rule, the types of services that might not be reimbursed through hospital outpatient programs include: early and periodic screening and diagnostic treatment dental services for children; physician emergency department services; physical, occupational and speech therapies; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; and outpatient audiology services.

CMS attempts to justify this dramatic policy shift by citing a need to align Medicaid outpatient policies with Medicare outpatient polices. However, these programs serve very different populations. Medicaid serves a largely pediatric population, while Medicare serves an elderly population. Despite these differences, CMS proposes to narrowly define Medicaid hospital outpatient services in order to achieve its goal of aligning Medicaid with Medicare. The effect of aligning the hospital outpatient policies for these two programs would be to limit Medicaid federal support for hospital outpatient programs and state Medicaid programs overall, and to ultimately limit the services needed by Medicaid patients.

Provider Tax Rule. This final rule would change Medicaid policy on health care-related taxes that are used by states to help support their share of Medicaid expenditures. The AHA specifically objects to CMS' changes to the standards for determining whether an impermissible hold-harmless arrangement exists within a health care-related tax. The rule represents a substantial departure from long-standing Medicaid policy by imposing largely subjective, overly broad standards to determine the existence of hold-harmless arrangements. These policy changes would create great uncertainty for state governments and providers, making it difficult for them to adopt or implement Medicaid health care-related tax programs with reasonable assurance that they are compliant, leaving them unreasonably open to after-the-fact challenges. In addition, the vaguer and broader standards CMS proposes would unduly limit states from implementing legitimate provider tax programs that are consistent with the Medicaid statute and congressional intent.

IN THE COURTS

With the May 25 deadline looming, the AHA and others are also pursuing a litigation strategy. The AHA, National Association of Public Hospitals, Association of American Medical Colleges and the Alameda County (CA) Medical Center, with the support of several other hospitals and the National Association of Children's Hospitals, filed suit in U.S. District Court for the District of Columbia to reject CMS' policies, specifically asking the Court to prevent the administration from implementing the Medicaid regulation that would cut some $5 billion in funding by restricting how states fund their Medicaid programs and pay public hospitals. The grounds of the suit are these:

- CMS has overstepped its authority in dictating to states the governmental status of entities within their jurisdiction;

- Congress has barred the agency from imposing a cost limit on Medicaid payments to governmental providers;
- CMS improperly issued the rule on the very day – May 25, 2007 – that a congressional moratorium took effect to block the rule for one year.

Alameda County (CA) Medical Center, the lead plaintiff in the case, estimated in the court filings that the Medicaid cost-limit rule alone would result in a loss of approximately $85 million in supplemental Medicaid payments. That is a 19 percent loss in the hospital's operating budget, a number that threatens the hospital's very existence. Cutbacks in critical services like trauma care, acute psychiatric care and outpatient specialty clinic services, as well as staff downsizing, might not be enough to make up for the resulting gap in their financial operating budget.

Hurley Medical Center in Flint, Michigan, also joined the lawsuit as a declarant. Hurley noted in court documents that they expect to lose anywhere from $6 million to nearly $13 million in Medicaid supplemental payments because of the rule's policy changes. The hospital, which provides 66 percent of the uncompensated care provided in its region, is already operating at a deficit. It would not be able to sustain this magnitude of payment cuts.

CONCLUSION

Mr. Chairman, we applaud your leadership, and that of your colleague, Rep. Tim Murphy (R-PA), in introducing H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008." By extending until March 31, 2009, the moratorium on several Medicaid regulations and including other regulations as part of the moratorium, your bill would prevent some $20 billion from being stripped from Medicaid. It accomplishes this by delaying implementation of regulations affecting CPEs and IGTs; GME; rehabilitation services for people with disabilities; outreach and enrollment in schools and specialized medical transportation to school for children covered by Medicaid; coverage of hospital outpatient services; case management services that allow people with disabilities to remain in the community; and state provider tax laws.

As you well know, many in Congress have expressed their opposition to the CMS rules. Legislation introduced earlier in the year to extend the moratorium on rules specific to hospitals has strong bipartisan support in the House and Senate.

The weight of these new regulatory policy decisions is hurting hospitals and state Medicaid programs that already are reeling under many other pressures, from a costly workforce shortage to higher demand for services, and from higher costs due to the onset of a recession. Yet, Congress and the general public have been largely excluded from CMS' decision-making process. The agency's regulatory budget-cutting policies will have a devastating effect on America's poor children and mothers, disabled and elderly, and the caregivers who want to help them.

We again thank you for your leadership on this issue, and we urge all of your colleagues to support your legislation to delay implementation of these harmful policy changes.

Mr. GREEN. Our next witness is Dr. Antos. Again, welcome to the Committee, Doctor.

STATEMENT OF JOSEPH R. ANTOS, PH.D., WILSON H. TAYLOR SCHOLAR IN HEALTH, CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE

Mr. ANTOS. Thank you very much, Mr. Chairman.

I am Joseph Antos. I am with the American Enterprise Institute. Before AEI I was at the Congressional Budget Office. I had various positions in the Department of Health and Human Services and CMS.

Medicaid is an important part of our health system, paying for the acute and long-term care needs of millions of low-income and disabled persons. It is also a source of considerable friction between the Federal Government and the states. There is an ongoing disagreement about what the Federal Government should pay for in Medicaid and how much it should pay. The major reason for these disputes is unfortunately quite clear. It has to do with the shared nature of the program.

The Federal Government pays a substantial part of the program's cost through open-ended matching grants, but the states operate Medicaid on a day-to-day basis. It is essential that the Federal Government maintain and strengthen its oversight of this $350 billion program. Numerous reports from GAO and from the Inspector General's Office and HHS attest to the financial and policy risks associated with the current matching rate mechanism. However, payment rules are subject to interpretation and local issues are difficult to resolve from Washington. Consequently, congressional oversight of HHS policies and regulations effecting Medicaid is essential to help ensure that state concerns are fully aired and that regulations are developed in an orderly process that protects the interests of the taxpayers and Medicare beneficiaries.

H.R. 5613 would stop such a process in its tracks. It is difficult to see how any of the objections raised against the seven regulations in question can be resolved by prohibiting further work on them. Whether or not Congress stops HHS's work on the regulations, the tension between the Federal Government and the states over Medicaid will continue unabated. There will continue to be disputes over the appropriateness of state actions to increase the flow of Federal funds. There will continue to be new regulations piled on top of old that attempt to clarify accounting procedures and program rules. Every new regulation will open up yet another avenue of state action, and yet another cause for dispute.

The source of this ongoing problem is not found in a single set of regulations. The problem is the structure of Medicare financing, which splits the costs between the Federal Government and the states in a way that promotes Federal micro-management. People—legislators have considered possible alternatives to the way we now handle Federal contributions to the Medicare program. For example, Federal block grants would solve many of the disputes that now go on. An alternative proposal would cap the Federal Medicaid contribution on a per beneficiary basis without imposing an overall limit on program spending. Under such per capita caps, the Federal Government and the states would share the risks of higher en-

rollment rates, but the states would continue to have very strong financial incentives to manage their programs carefully.

Block grants and per capita caps are certainly not panaceas, but they would raise the Federal focus from the details of accounting to the broader concerns of national policy. States would have greater flexibility to innovate and the Federal Government would have less reason to dictate to states what they could or could not do.

As a number of members of the Committee pointed out in their opening statements, Medicaid is part of a coming financial crisis for the government and for the country. It is certainly no surprise that runaway health spending is contributing to this crisis that is right around the corner. Clearly the Medicaid program is part of that. It is part of the same $2 trillion health system that we have that is rapidly rising without—seemingly without limit. As the cost of health care continues to explode health programs, including Medicare—Medicaid will absorb larger shares of tax revenues, leaving little room for new policy initiatives. I am a member of a group of budget experts, bipartisan group of budget experts, who have been meeting now for some time, that are concerned about this issue. And we recently released a report that suggests an approach that Congress should consider to put itself back on a track to make the kinds of hard decisions that will be necessary to meet this health spending crisis. There is more detail on this in my written testimony. But the bottom line here is that we are not prepared as a Nation, and Congress is not prepared as a body, as a legislative body, to deal with these issues without making very, very difficult decisions. The kind of process reforms that my group recommends will certainly not solve all the problems, but they will put us on a path to sensible decision making.

To wrap up, a major reform to vindicate financing should be placed on the agenda for the next administration that should not absolve HHS in Congress in continuing to be good stewards of taxpayer dollars. And it should not prevent HHS from taking appropriate actions necessary to maintain the fiscal integrity of Medicaid.

Thank you.

[The prepared statement of Mr. Antos follows:]

STATEMENT OF JOSEPH R. ANTOS, PH.D.

Mr. Chairman and members of the Committee, it is a pleasure to appear before you today. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, a Washington-based think tank. I am also part of a bipartisan group of budget experts who believe Congress must address the rapidly growing mismatch between Federal spending and revenues that threatens our ability to finance important policy priorities. In a paper released this week, we argue that the first step toward restoring budget responsibility is to reform the budget decision process so that Social Security, Medicare, and Medicaid-the major drivers of escalating deficits-are no longer on auto-pilot.

Medicaid is an important part of our health system, paying for the acute- and long-term care needs of millions of low-income and disabled persons. It is also a source of considerable friction between the Federal Government and the states. There is ongoing disagreement about what the Federal Government should pay for in Medicaid and how much it should pay. Today's hearing highlights a concern that the states and some members of Congress have over regulatory actions meant by the U.S. Department of Health and Human Services (HHS) to clarify payment rules and reduce spending that it deems unnecessary.

My testimony will highlight the major reason for such intergovernmental disputes: the use of a matching formula to determine a variable federal subsidy rather than a fixed amount. I will also describe the likely path of Medicaid spending over the long term and the need for Congress to directly consider the impact of policies beyond the budget window for Medicaid and the other major entitlement programs.

A Governance Issue

The ongoing debate over regulatory actions proposed by HHS to alter or clarify some of the details of its Medicaid financing policy stems from an important matter of program governance. How should the Medicaid program be managed to ensure that beneficiaries receive appropriate and effective health care while maintaining fiscal discipline? This question naturally arises because Medicaid is a shared responsibility. The Federal Government pays a substantial part of the program's cost through open-ended matching grants but the states operate Medicaid on a day-to-day basis.

It is essential that the Federal Government maintain and strengthen its oversight of this $350 billion program. Numerous investigations conducted by the Government Accountability Office (GAO) and the HHS Office of Inspector General (OIG), as well as decades of experience, demonstrate the financial and policy risks associated with the current matching rate mechanism. However, payment rules are subject to interpretation, and local issues are difficult to resolve from Washington. Consequently, congressional oversight of HHS policies and regulations affecting Medicaid is essential to help ensure that state concerns are fully aired, and that regulations are developed in an orderly process that protects the interests of the taxpayers and Medicaid beneficiaries.

H.R. 5613, Protecting the Medicaid Safety Net Act of 2008, would stop such a process in its tracks by preventing HHS from further developing, refining, and implementing seven proposed or final regulations that have been advanced over the past year. Moreover, the Act does not envision congressional action on these regulations over the next 12 months. It is difficult to see how any of the objections raised against these regulations can be resolved by prohibiting further work on them. Without some clarification, the states will remain uncertain about the program's rules of the road.

There is a further cost of delaying the regulations that directly affects Congress. If H.R. 5613 is enacted, federal spending would increase by $1.65 billion over the next 2 years—not very much money relative to the size of Medicaid. Under the pay-as-you-go rules prudently adopted in this Congress, spending offsets will be needed. To avoid unnecessary controversy, offsets should be identified in an open and bipartisan manner.

Perverse Financial Incentives Breed Conflict

Whether or not Congress stops HHS's work on the seven regulations in question, the tension between the Federal Government and the states over Medicaid will continue unabated. There will continue to be disputes over the appropriateness of state actions to increase the flow of federal funds. There will continue to be new regulations piled on top of old that attempt to clarify accounting procedures and program rules. Every new regulation will open up yet another avenue of state action and another cause for dispute.

The source of this ongoing problem is not found in a single set of regulations. The problem is the structure of Medicare financing, which splits the costs between the Federal Government and the states in a way that promotes federal micromanagement.

As an alternative to the current matching formula, federal block grants would resolve many of the disputes between the two levels of government since many of the financial methods now in use would no longer affect the amount of the federal payment. There is already a tradition of negotiating an aggregate target for state drug expenditures in Medicaid. This allows maximum flexibility for each state to manage its program while assuring HHS that expenditures will remain under control. However, states are concerned that a block grant covering the entire program might not fully account for the growth in Medicaid enrollment in an economic downturn or for unexpected increases in the cost of health care.

An alternative proposal would cap the federal Medicaid contribution on a per-beneficiary basis without imposing an overall limit on program spending. Under such "per capita caps", the Federal Government and the states would share the risk of higher enrollment rates. States would have a strong incentive to manage their programs in a cost-effective manner since they would be liable for per capita spending above the capped amount.

Block grants or per capita caps are not panaceas, but they would raise the federal focus from the details of accounting to the broader concerns of national policy. States would have greater flexibility to innovate, and the Federal Government would have less reason to dictate to states what they could or could not do.

THE COMING FISCAL CRISIS

We are about to meet an enormous fiscal challenge head on, and Medicaid is a major part of that challenge. Some 80 million baby boomers are rapidly reaching the age at which they can draw benefits from Social Security and Medicare, and substantial numbers are already enrolled in Medicaid. These three entitlement programs will experience high spending growth over the next few decades, outrunning growth in the overall economy and threatening to crowd out other policy priorities in federal revenue.

By far the fastest spending growth is expected in the health programs. Not only will many more people become eligible for Medicare and Medicaid, but average health spending per enrollee is likely to continue its upward spiral. If present trends continue, Medicare and Medicaid will rise from 4.1 percent of GDP in 2007 to 8.1 percent in 2030, and 12.0 percent by 2050. 1A[1] By that estimate, health programs will consume an ever increasing share of federal tax revenue, which has averaged 18 percent of GDP over the past 50 years. Moreover, the pressure that Medicaid is already putting on state budgets will increase enormously.

WHAT SHOULD CONGRESS DO?

It is no surprise to policymakers that runaway health spending is contributing to a growing fiscal crisis. The Medicare trustees have been warning about impending imbalances in that program, and the states have made it clear that Medicaid spending is becoming unsustainable for them. As the cost of health care continues to explode, the health programs will absorb a larger share of tax revenues, leaving little room for new policy initiatives.

A significant part of the problem is the automatic nature of spending in Medicare and Medicaid. Except in periods of crisis, entitlement programs are on auto-pilot. As the entitlements grow, there is less money available in the budget for housing, education, energy, transportation, and the other discretionary programs. There is no mechanism in our federal policy process that forces policymakers to look at the broader picture and re-establish some balance across programs competing for scarce resources.

We need to establish the preconditions necessary to encourage elected officials to make the hard choices that will be needed if we hope to regain control of the budget. As a member of a bipartisan group of budget experts who have been working on this issue, I offer the following suggestion for reforming the budget process. 1A[2]

The budget expert group proposes that the Congress and the president adopt explicit, sustainable long-term budgets for Medicare, Medicaid, and Social Security. Periodically, perhaps every 5 years, the CBO would determine whether the programs were remaining on the agreed upon, long-term path of outlays and revenue. If a program was off course fiscally, the Congress and the president would try to come to agreement about an appropriate change in policy. If agreement was not reached, a budget trigger would automatically reduce spending or increase taxes (or some combination) enough to put the program back on course.

This proposal would change the way decisions about long-term spending commitments are made, but they would not automatically solve the fiscal crisis that will soon be precipitated by entitlement programs. That will still require innovative thinking, political risk-taking, and bipartisanship.

A major reform of Medicaid financing should be placed on the agenda for the next administration. That should not absolve HHS and Congress from continuing to be good stewards of taxpayer dollars, and it should not prevent HHS from taking appropriate actions necessary to maintain the fiscal integrity of Medicaid.

Mr. GREEN. Ms. Edwards.

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[1] Congressional Budget Office, The Long-Term Budget Outlook, December 2007. The estimates include only the federal portion of Medicaid spending.

[2] Joseph Antos et al., Taking Back Our Fiscal Future, April 2008, available at http://www.aei.org/publications/filter.all,pubID.27743/pub—detail.asp.

STATEMENT OF BARBARA COULTER EDWARDS, INTERIM DIRECTOR, NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS (NASMD)

Ms. EDWARDS. Mr. Chairman, Mr. Deal, thank you. And to members of the Committee thank you so much for the opportunity to testify this morning on behalf of State Medicaid Directors regarding H.R. 5613.

My name is Barbara Coulter Edwards. I am the interim director of the National Association of State Medicaid Directors, an affiliate of the American Public Human Services Association. NASMD represents the directors of the 50 state Medicaid programs, plus the Medicaid programs administered by the District of Columbia and the U.S. territories.

Medicaid in the states is a program under considerable stress. One major source of that stress is a slowing economy. When state economies slow, people lose jobs, state tax revenues decline, and the demand for Medicaid services increases just when states are least able to afford it. And because states must balance their budgets on an annual basis, the crisis is immediate, not something that can be put off to the future. A compounding source of stress for states is the recent dramatic change in Federal policy as expressed in a series of proposed and enacted Federal Medicaid regulations. The Center for Medicare and Medicaid Services has issued at least 15 proposed regulations over the last 2 years, 10 in the last 6 months alone. Eight of these regulations have been flagged by states as causing significant harm to the ability of states to appropriately serve the Medicaid population. This collection of regulations impacts a broad range of Medicaid services and activities, including reimbursement for safety net providers, the support of the cost of medical residents who provide substantial amounts of care to Medicaid consumers, services to people with mental illness, the design of home and community based long-term care waiver programs, the facilitation of service access for adults and children with the most complex medical, emotional, and social services needs, and the ability of states to support school-based efforts to enroll children into the Medicaid program.

The proposed regulations do not reduce the underlying cost of health care. They represent a shift of billions of dollars in Federal costs to states. The Administration has estimated the regulations will produce $13 to $15 billion in reduced Federal Medicaid spending over the next 5 years. States are predicted losses as high as $50 billion. The reality is that because most states do not have the resources to absorb these costs, whether it is $15 billion or $50 billion, there will be little choice but to restrict services for consumers.

H.R. 5613 would place seven of the proposed regulations under a moratorium until March 2009. State Medicaid directors are strongly supportive of efforts to provide a time-out on these regulations to allow a careful consideration of the impact of proposed policy changed on the vulnerable people served by states. It is important to note that some of the proposed regulations contain provisions that Congress has rejected during debate over the DRA of 2005. In addition, many of the regulations were issued either as interim final regulations or with significantly shortened comment pe-

riods. And there has been inadequate opportunity for public input on the proposals. Perhaps as a result, these proposals appear to have unintended consequences on good programs and will limit legitimate services to vulnerable people.

States have heard the word "schemes" and "abuse" and "fraud" when we have asked why these justifications—these regulations are justified. We have been told that the extreme approach in some instances is the result of a firm intention to guarantee that there are no more "loopholes" that may allow states to draw more Federal matching funds than the Administration believes is proper.

I would urge Congress to look beyond these words that are designed to incite outrage, to consider the actual implications of these proposed regulations. NASMD has been clear in our interactions with CMS that we do not seek to defend inappropriate excesses in Federal claiming. We have not asked CMS to walk away from those issues. Rather NASMD believes that CMS has in many instances already found strategies to successfully identify and remediate areas of clear excess. In recent years CMS has put in place new informal and formal guidance on IGTs, CPEs, and school administrative claiming, just to name a few. Congress has acted to create reforms to targeted case management, clarifying important parameters regarding how Medicaid interfaces with other public programs. Congress has also authorized additional funding for CMS auditors, both to monitor state fiscal arrangements and to increase provider reviews. States would argue that CMS has, in fact, already solved much, if not all, of the problems that were of legitimate concern regarding state claiming of Federal reimbursement.

As just one example, a school nurse who works today to help a child with untreated medical needs enroll in the Medicaid program is not an abuse of the system. It is a critical component of an effective Medicaid program. But under the school services regulations, this legitimate activity would be prohibited from receiving Medicaid support. The fact is that most of these regulations are not really about fiscal integrity. They are about limiting the services that the Federal Government will share in funding through Medicaid. And again, they don not reduce the underlying costs of the health care services needed by the individuals.

And NASMD urges Congress to support H.R. 5613. We need time to find the right balance between Federal clarity and state flexibility, between absolute assurances that Federal funds are never overused and the imperative for states to be able to meet the needs of the elderly, children with special health care needs, and other persons with complex, chronic or disabling conditions. And we should find that balance before we implement changes that will damage critical services to vulnerable populations.

I thank you for your interest in this issue. NASMD and its members stand ready to work with Congress and the Administration to resolve important challenges. And we look forward to your questions.

[The prepared statement of Ms. Edwards follows:]

STATEMENT OF BARBARA COULTER EDWARDS

Thank you for the opportunity to testify today on behalf of state Medicaid directors regarding H.R. 5613. My name is Barbara Coulter Edwards, and I am Interim

Director of the National Association of State Medicaid Directors, an affiliate of the American Public Human Services Association. NASMD represents the directors of the 50 state Medicaid programs, plus the Medicaid programs administered by the District of Columbia and the U.S. territories.

Medicaid provides comprehensive health coverage to 62 million U.S. citizens, including on average one out of every three children in the Nation. Medicaid is the largest payer for long-term care services and provides long term care supports in community-based and in-home settings, as well as in nursing homes, for millions of senior citizens, and adults and children with disabling conditions. Medicaid is the largest insurer of non-aged adults with disabilities, is often a source of support for people with disabilities who can return to the work force, and plays an increasingly important role in offering coverage to low income working Americans, especially parents, as coverage in the employer sector declines. Medicaid is also relied upon to fill the holes in the Medicare program for low-income seniors and people with disabilities: 40 percent of all the spending in the Medicaid program is for the approximately 14 percent of the enrolled population who is already insured by Medicare.

Medicaid in the states is a program under considerable stress. The major source of that stress is a slowing economy. When state economies slow, people lose jobs, state tax revenues decline—and the demand for Medicaid services increases. Because states must balance their budgets every fiscal year, slowing tax revenues and increased demand for public services often triggers efforts by states to reduce Medicaid spending. Unfortunately, cuts to Medicaid are difficult to achieve in the timeframe of a single fiscal year. The rate of growth in the program is already lower on a per person basis that the commercial marketplace, so additional cuts to reimbursement run the risk of reducing access or quality of care. Because states must give up the federal revenue that comes with state Medicaid spending, it requires reducing health care spending by $2.40 to achieve a $1.00 reduction in state spending (in a state with a 60 percent federal matching rate). In addition, because cuts in spending on health care do not reduce the covered population's need for health care, someone else in the system ends up absorbing the cost of unreimbursed care, or individuals who are denied care eventually end up in emergency rooms, often resulting in higher cost and poorer outcomes. While states remained engaged in implementing larger system reforms (e.g., developing health information technology-supported strategies to reduce error and increase information sharing; using managed care to improve access to appropriate services and reduce unnecessary care; and increasing efforts to avoid fraud and abuse), many of these changes require up-front investments that are difficult to make in the midst of an economic downturn and have return-on-investment cycles in excess of twelve months.

A second source of stress for states is the recent, dramatic change in federal policy as expressed in a series of proposed and enacted federal Medicaid regulations. The Center for Medicare and Medicaid Services (CMS) has issued at least 15 proposed regulations over the last 2 years (10 in the last 6 months alone!). Some of the regulations provide guidance for the implementation of major new provisions contained in the Deficit Reduction Act of 2005 (e.g., Section 1915i, use of benchmark benefit plans, cash and counseling, cost sharing, etc.). Others attempt to provide clarification regarding long-standing but perhaps inconsistently applied federal policy. Still others, however, propose to make significant changes in long-standing federal policy, changes that states believe will significantly interfere with achieving the legitimate purposes of the Medicaid program.

Eight of the 17 sets of regulations have been flagged by states as causing potential significant harm to the ability of states to appropriately serve the Medicaid population. This collection of regulations impacts a broad range of Medicaid services and activities, including reimbursement for safety net providers; reimbursement for out-patient services in hospitals; the support of the cost of medical residents who provide substantial amounts of care to Medicaid consumers; services to people with mental illness; the design of home- and community-based waiver programs for the elderly and people with physical and developmental disabilities; the facilitation of service access for adults and children with the most complex medical, emotional and social services needs; and the ability of states to support school-based efforts to enroll needy children into Medicaid coverage. The proposed regulations represent a shift of billions of dollars in federal costs to states. The Administration has estimated that the full implementation of these regulations will produce $13 billion in reduced federal Medicaid spending over the next 5 years; states have estimated a considerably larger potential impact of these regulations, predicting losses as high as $50 billion in federal Medicaid support over the same period. Because most states do not have the resources to absorb these costs, there will be little choice but to restrict services for consumers.

H.R. 5613 would place seven of the proposed regulations under a moratorium until March 2009. (The eighth regulation regards the operation of the U.S. Health and Human Services' Departmental Appeals Board and, while not specifically associated with federal savings, is viewed by most states as seriously undermining the availability of due process for states through an administrative appeal before the federal department.) State Medicaid directors are strongly supportive of efforts to provide a "time out" on these regulations to allow a careful consideration of the impact of proposed policy changes on the vulnerable people served by states. Directors also encourage a more robust public debate on the merits of some of the proposed changes in such a critical program. It's important to note that some of the proposed regulations contain provisions that Congress rejected during debate over the DRA of 2005. In addition, because many of the regulations were issued either as interim final regulations or with significantly shortened comment periods (as few as 30 days), there has been inadequate opportunity for public input on these proposals. As a result, these proposals appear to have unintended consequences on good programs and will limit legitimate services to vulnerable people.

States have heard the words "schemes" and "abuse" and even "fraud" when they've asked why these regulations are justified. We've been told that the extreme approach in some instances is the result of a firm intention to guarantee that there are no more "loopholes" that may allow states to draw more federal matching funds than the Administration believes is proper. I'd like to make two points regarding this justification.

First, I urge Congress to look beyond the words that incite outrage to consider the actual implications of proposed changes. NASMD has been clear in our interactions with CMS that we do not seek to defend inappropriate excesses in federal claiming. While Medicaid directors may sympathize with states that have responded to very real fiscal pressures by, in part, over-reaching in terms of the use of Medicaid funds to support otherwise underfunded programs, directors have not asked CMS to walk away from these issues. Rather, NASMD believes that CMS has, in most instances, already found strategies to successfully identify and remediate areas of clear excess. In recent years, CMS has put in place new informal or formal guidance on IGTs, CPEs, and school administrative claiming, just to name a few. At the Administration's urging, Congress has enacted reforms to targeted case management, clarifying important parameters regarding benefit design and how Medicaid interfaces with other public programs. Congress has authorized additional funding for CMS auditors, both to monitor state fiscal arrangements and to increase provider reviews. States would argue that CMS has, in fact, already solved much if not all of the problems that were of legitimate concern regarding state claiming of federal reimbursement.

Second, the apparent focus of the regulations to assure that "no loopholes" remain has resulted in overly-broad changes and prohibitions that are throwing the figurative baby out with the bath water. For example, some school administrative claiming arrangements in the past may have charged excessive costs to Medicaid. However, a school nurse who works today to help a child with untreated medical needs enroll in the Medicaid program is not an abuse of the system. It is a critical component of an effective Medicaid program. But under the school services regulations, this legitimate activity would be prohibited from receiving Medicaid support.

It may be useful to clarify the definition of rehabilitative services. However, to declare an entire group of individuals to be ineligible for rehabilitation services because CMS has unilaterally decided that people with developmental disabilities cannot ever benefit from rehabilitation appears biased and of uncertain clinical merit.

It was certainly appropriate for CMS to reflect in rule the definition that Congress enacted to define case management as a comprehensive service. However, CMS's decision to reverse years of federal policy by now prohibiting the use of administrative case management, purportedly in order to avoid any "loophole," appears again to have been an over-reaction, well beyond what Congress enacted and with no regard for the consequences for states which have now lost an important option for assuring the quality and effectiveness of services delivered to high cost populations.

NASMD urges Congress to support HR 5613, giving states, federal policy-makers, consumers and providers a period of time to understand and prevent the unintended consequences of these regulations, and to revisit and debate the wisdom of the apparently intended consequences as well. We need an opportunity to find the right balance between federal clarity and state flexibility, between absolute assurances that federal funds are never "overused" and the imperative for states to be able to meet the needs of the elderly, children with special health care needs, and other persons with complex, chronic or disabling conditions. Finally, we need more realistic timeframes for implementation of new regulations, particularly for regulations that change existing federal policy as reflected in years of approved state plans.

Thank you for your interest in this issue. NASMD and its members stand ready to work with Congress and the Administration to resolve this important set of challenges. I look forward to your questions.

Mr. GREEN. Thank you to each of our panelists, and that concludes the opening statements. And the Chair will recognize himself for 5 minutes for questions.

Now, Mr. Buckner, can you give us an idea of the population at Uvalde Memorial Hospital and the typical patient?

Mr. BUCKNER. Uvalde Memorial Hospital serves a population in five counties of about 45,000 people, in which we are the only hospital around.

Mr. GREEN. And you state in your testimony that 20 percent of your patients are covered by Medicaid, and yet 89 percent of your newborns are covered by Medicaid. How much of your yearly budget comes from Medicaid funding related to these proposed cuts? What would it mean actually for your hospital?

Mr. BUCKNER. We are projecting on the UPL program—we take in about a million and five from that program. Eighty percent cut of that takes us down to about 300,000. And that, sir, is largely the margin that we are operating on these days, is that funding from UPL.

Mr. GREEN. OK. If these regulations go into place would the Uvalde Memorial Hospital be able to serve Medicaid patients at all, or the types of patients that you currently serve, particular for the newborns?

Mr. BUCKNER. Our ability to take care of our newborns really gets tougher because, frankly, we are looking at a physician shortage right now. We are trying to recruit primary care physicians who deliver, and we are struggling right now to find those kinds of physicians. Without the extra support to make it possible to bring those and recruit those physicians to town that is really one of the first areas we get hit with. Now, keeping up with the technology—we are just putting an electronic medical record for OB area—is the things that we are doing right now with our—if you want to call it a surplus—a bottom line. That is what we are doing with it, is trying to maintain better services for those folks.

Mr. GREEN. Does your hospital benefit from the Medicaid Graduate Medical Education funding?

Mr. BUCKNER. No, sir. In Texas, GME is not funded, and we do not—we are not a teaching hospital.

Mr. GREEN. OK. Where would those patients go? Would they go to Bear County, San Antonio?

Mr. BUCKNER. Yes, sir.

Mr. GREEN. And that is the closest urban area that would have the hospital facilities?

Mr. BUCKNER. The—it is an hour-and-a-half trip. And that is for—in our town we have trouble just getting people from the west side, which is our lower socioeconomic area, to the east side, where the hospital and the Wal-Mart are located. So getting 90 miles to the next nearest facility that—tertiary facility or even—well, the nearest hospital is 40 miles away, which is a critical access hospital. They can't take on more patients. So what happens is we struggle with transportation and access and, the community is

three-quarters Hispanic and there are first or second generations of immigrancy and assimilation into American society. We have—what is amazing, sir, is the ability that Medicaid provides to these folks. And you would tolerate just one thing. We polled our medical—we polled our hospital employees. They are largely the folks that are homegrown. Many of these folks have grown up on the Medicaid program, and are now taxpaying members of society on the hospital's private insurance program, and are contributing to society. And if you would bear with me, I do have one quote from one of them that represents, really, everybody. One of our health information clerks, Esperonza Zomerepa, says we, meaning she and her husband, have been fortunate to count on the Medicaid program for several years, allowing us to pursue our educational goals. And as a result we are both employed full-time. We are, indeed, grateful for what the Medicaid program has allowed us to accomplish. I speak for both of us in saying that in our case Medicaid was a hand-up, not a handout. That is the sentiment echoed time and time again with members of my hospital staff and others who have worked their way up from the lower socioeconomic branches into a middle class in Uvalde.

Mr. GREEN. OK. Thank you. My time is expired. The Chair will recognize our ranking member from Georgia, Congressman Deal.

Mr. DEAL. Thank you, Mr. Chairman. Let me preface my questions by a statement that I do not in any way intend to mean anybody by virtue of questions that I might ask, because I appreciate the services that all of you provide and the representatives of the groups that you represent to provide. I think we really are all here dealing with the question of how do we address the immediate concerns? How do we keep this program financially solvent, both for the Federal Government and for the states? And maybe we should have a hearing on Dr. Antos' report about looking at other ways that might be a loss incentive to maybe try to gain the system. Because I perceive that many of these regulations are efforts to try to make the system honest in the way that it works. Dr. Raulerson, certainly I appreciate what you do. I think your service is one of those invaluable things. And you mentioned a number of instances where EPSDT provided the ability to find problems early on. I think all of us are firm supporters of that program. I know it was reaffirmed in the recent efforts under the Deficit Reduction Act. Do you have anything in the regulations that you think jeopardizes that program?

Dr. RAULERSON. Yes. Some of the services that children get, that I identify, they need at school. Their teachers cannot provide those services. They need school services and the school has to some way administrate those services.

Mr. DEAL. So you are talking about a follow-up?

Dr. RAULERSON. Well——

Mr. DEAL. Not the initial screening?

Dr. RAULERSON. The reason the overhead got so high in my office is because we spend so much time trying to find services for the problems that we identify. And the school is one of our major sources. And I have to work with school nurses. I write a plan up for each special needs child that goes to the school.

Mr. DEAL. And you do that under IDEA? Which I presume transitions to our next witness representing the school systems. What you are saying is that IDEA, an education program, is the program that has created these needs for the services that you are providing, but we are expecting Medicaid to pay for it, rather than IDEA. Is that pretty much the——

Dr. RAULERSON. I think——

Mr. DEAL. I am talking to Mr. Mohundro.

Dr. RAULERSON. I think it costs more than they can provide, especially now when there is an economic downturn. I don't have enough case management services.

Mr. DEAL. Yes, ma'am, I understand. I apologize for cutting you off, but I have a limited time, and I want to go down the list. Am I pretty much correct on that, that IDEA is not fully funded and therefore these are costs that you have built in because you created the program? And not every state or community has done this school-based program have they?

Mr. MOHUNDRO. That is correct. IDEA is not fully funded. It has never been fully funded. And because we do have access through Medicaid for those students that do qualify we do seek those reimbursements.

Mr. DEAL. OK.

Mr. MOHUNDRO. And if you could fully fund IDEA that would be great.

Mr. DEAL. Yes.

Mr. MOHUNDRO. And we probably wouldn't be in this mess.

Mr. DEAL. And I think that is part of the problem is we are asking here in this instance for Medicaid to pick up an underfunded education initiative, IDEA. Let me keep on going down the list very quickly. Dr. Shapiro. And I guess I really should ask this to everybody, but then I will come back to you, Dr. Shapiro. Do any of you really think that a state should be able to force private non-governmental health care providers to give back to the state part of their Medicaid payments? OK, Dr. Shapiro, let me ask you specifically, because I understand in the state of Pennsylvania there is some $400 million in provider taxes that your nursing homes pay to the state.

Dr. SHAPIRO. Correct.

Mr. DEAL. Do you get that back? Do you have an agreement to get it back from the state?

Dr. SHAPIRO. Let us be very clear. Nursing homes in Pennsylvania who service Medicaid people would go broke without the provider assessment. It takes——

Mr. DEAL. You know that is hard—let me stop you right there. Let me stop you right there. You are saying that unless you paid an extra tax you would go broke? That doesn't make sense to most people.

Dr. SHAPIRO. The provider assessment takes dollars out of nursing homes. It is matched by the Federal Government. It goes entirely back to the nursing homes, 100 percent back to the nursing homes, it pays the providers who care for the most Medicaid——

Mr. DEAL. I understand.

Dr. SHAPIRO. It takes the first dollars and it is a Godsend.

Mr. DEAL. And it counts as the state's portion of the formula?

Dr. SHAPIRO. Now, the state puts in a lot of its own money.

Mr. DEAL. Well, yes, but they count your money too don't they?

Dr. SHAPIRO. Sure, they ante up some, but——

Mr. DEAL. Considered, that is something in the nature of a kickback?

Dr. SHAPIRO. But they get it all back.

Mr. DEAL. Well, yes.

Dr. SHAPIRO. But you are missing, I think, the real issue, and it goes—I spend a lot of time in Georgia. And I know——

Mr. DEAL. I am surprised you went back to Pennsylvania.

Dr. SHAPIRO. Oh, no, Georgia is great. But the real issue here is with many of these regulations is that the analysis of what their sudden impact on the entire long-term care system will be has not been done. I asked staff, who were preparing this testimony, to give me some data. And they went to CMS, and CMS said we just don't have that data. So you and I are both comparable in age, and comparable I suspect in philosophy, and we generally don't want to do any harm. And what these regulations are doing is suddenly coming in, taking a lot of money out of the system, and disrupting it. Maybe provider assessment isn't the best thing. Maybe IGT isn't the best thing, but we can't take those dollars like this out of the system——

Mr. DEAL. I understand your point in that regard, and that is why I think Dr. Cosgrove's comment about GAO making these recommendations—I understand some of these recommendations date back to 1994, do they not, Dr. Cosgrove? I apologize. I am over my time.

Mr. COSGROVE. That is correct.

Mr. DEAL. OK. Thank you all. I apologize I couldn't get to more of you.

Mr. GREEN. The Chair recognizes the Chair of our full committee, Chairman Dingell.

Mr. DINGELL. Mr. Chair, I thank you for your courtesy to me, and I commend you again for the way that you are presiding in this very important hearing. These questions are to Mr. Mohundro and to Mr. Cosgrove, and I will proceed as fast as I can. And I think they will all require, with regard to Dr. Mohundro, a yes or no answer. Doctor, under the proposed CMS regulations isn't it true that you and your colleagues who work in the schools would no longer be paid by Medicaid to find and enroll children who belong in the program, yes or no?

Mr. MOHUNDRO. Yes.

Mr. DINGELL. Is it also true that the schools would no longer be paid for important activities that they do in referring children with health care needs to the appropriate place.

Mr. MOHUNDRO. Yes.

Mr. DINGELL. Isn't it true that GAO wrote the following about outreach and enrollment in the schools, and I quote, "Close to one-third of Medicaid eligible individuals are school-age children, which makes schools an important service, delivery and outreach point for Medicaid. Schools can undertake administrative activities that help identify for first screen and assist in the enrollment of Medicaid eligible children. Outreach and identification activities help ensure

that most vulnerable children receive routine preventive health care and ongoing primary care and treatment."

Mr. MOHUNDRO. Yes, sir.

Mr. DINGELL. Mr.—Dr. Mohundro, if you and your school-employed colleagues no longer provide such services, who will?

Mr. MOHUNDRO. No one.

Mr. DINGELL. Now, I note that local schools do not have the funds to pay for the costs of enrolling eligible children in Medicaid. So even though the schools are the most logical place to find and enroll these children it won't happen without Medicaid. Is that right?

Mr. MOHUNDRO. That is correct.

Mr. DINGELL. Now, Doctor, in the presentations of CMS they are going to defend the proposed rule that we are discussing on grounds there has been improper billing under the Medicaid program by school districts who administer costs through transportation service. Does your school district improperly bill your state's Medicaid program for the cost of your services?

Mr. MOHUNDRO. No, sir.

Mr. DINGELL. Now, just one interesting question. Is there anything in this that you find that would—in these rules that would do anything other than simply terminate the funding of these programs, as opposed to addressing any problems that might exist in reality with regard to misbehavior, waste, fraud, and abuse?

Mr. MOHUNDRO. No, sir. All this is going to do is we are going to cut Medicaid funding totally out of the public school systems.

Mr. DINGELL. Now, Dr. Mohundro, my good friend and colleague, Mr. Deal, asked you if IDEA was fully funded, and would you need Medicaid. Could you elaborate on that question, please?

Mr. MOHUNDRO. Yes, sir. It is true the Federal Government has not funded IDEA. That Congress set a goal in 1975 with its first pass. However, this has nothing to do with whether the Federal matching funds would be available for transportation costs. In 1998, Congress made it clear that Medicaid programs should provide Federal matching funds for Medicaid covered services. They are specified in a child's IEP. We know that Medicaid policies authorize Federal matching funds for transportation to and from if transportation is specified in the child's IEP for days when the child receives health care with health services in school. While this help meets the costs of children in special ed, the fact that IDEA is underfunded is really irrelevant at this point.

Mr. DINGELL. Now, these questions—thank you very much, sir. These questions now to Mr. Cosgrove. And I am going to have to do you the same regrettable discourtesy by asking for questions that are, in fact, going to solicit a yes or no answer. Mr. Cosgrove, as you know, H.R. 5613 would place a 1-year moratorium on seven different regulations. With regards to the CMS regulation prohibiting payment for graduate medical education, has GAO done any specific work or found any specific abuses with regard to Medicaid graduate education—of graduate medical education payments?

Mr. COSGROVE. No, sir, not that I am aware.

Mr. DINGELL. Again, Mr. Cosgrove, with respect to CMS regulation restrictive payment for hospital outpatient department serv-

ices, has GAO done any work or found any abuses with respect to Medicaid hospital outpatient department payments?

Mr. COSGROVE. No.

Mr. DINGELL. Mr. Cosgrove, with respect to CMS regulations defining allowable provider taxes under Medicaid has GAO done any work or found any abuses with respect to Medicaid provider taxes?

Mr. COSGROVE. Not that I am aware.

Mr. DINGELL. Mr. Cosgrove, with respect to CMS regulation eliminating payment for certain Medicaid services provided by schools in 2000, GAO wish you to report recommending CMS clarify policies for such services. In response, CMS issued a guide for appropriate claiming of school-based services in 2003. Has GAO issued any further recommendations?

Mr. COSGROVE. No, not on the matter.

Mr. DINGELL. Again, Mr. Cosgrove, with regard to school services, did GAO ever recommend completely eliminating Medicaid payment for school-based transportation services?

Mr. COSGROVE. No, we did not.

Mr. DINGELL. With respect to school services did GAO ever recommend completely eliminating Medicaid payment for outreach and enrollment activities performed by schools?

Mr. COSGROVE. No, we did not.

Mr. DINGELL. With respect to rehabilitation services did GAO ever recommend eliminating Medicaid coverage for rehabilitation care that helps children with disabilities maintain functional status?

Mr. COSGROVE. No, sir.

Mr. DINGELL. With respect to targeted case management services did GAO ever recommend CMS require billing in 15-minute increments?

Mr. COSGROVE. No.

Mr. DINGELL. With respect to targeted case management did GAO ever recommend that CMS reduce the amount of time case managers could serve people with disabilities who are trying to transition out of an institution into the community?

Mr. COSGROVE. No, we did not.

Mr. DINGELL. With—has GAO done any work evaluating the specific regulations at issue in H.R. 5613?

Mr. COSGROVE. No, not these specific recommendations.

Mr. DINGELL. So, while this is a legislative hearing on H.R. 5613, you do not have any specific work on which to base comments on the bill?

Mr. COSGROVE. Our work over time has called for more guidance, but no, we do not have any specific recommendations on these.

Mr. DINGELL. One further question here, if you please. The regulations would terminate all of the programs that are mentioned in those regulations. Does—is that the ideal way to address questions that might exist with regard to waste, fraud, and abuse, or is it overkill?

Mr. COSGROVE. I think addressing waste, fraud, and abuse in the Medicaid program is vitally important, but we——

Mr. DINGELL. And we agree on that, but that is something that has to be done with very, very specific mechanisms to correct the abuses. Is that not so?

Mr. COSGROVE. That is correct.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy, and I thank you Dr. Mohundro and Mr. Cosgrove. I want to tell you, Mr. Cosgrove, we very much appreciate the work that GOA does. You are a fine group of public servants. Thank you, gentlemen.

Mr. COSGROVE. Thank you, Mr. Dingell.

Mr. DINGELL. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Chairman Dingell.

I recognize Mr. Murphy of Pennsylvania for 5 minutes.

Mr. MURPHY. Thank you, Mr. Chairman. Ms. Turner, you gave some examples of transportation misuses. People driving to bingo games, to grocery stores, et cetera. Do you see those issues addressed in this legislation that would affect those?

Ms. TURNER. Mr. Chairman, I address this—this is an Office of Inspector General report from the Department of Health and Human Services. That is the kind of example of the abuses that are possible through this program. As I said in my testimony, I think it is really important—as you mentioned, I think it is hard to find any one person that understands the Medicaid program completely, and that really understands how to solve the problems that this legislation would address. I do believe——

Mr. MURPHY. But did you see any in here?

Ms. TURNER [continuing]. There needs to be a conversation.

Mr. MURPHY. With regard to the—I appreciate that. Do you see anything with regard to the segment in this legislation which says there should be a moratorium on stopping transportation services for children affecting that part of which you raised the concerns about. I also think that nothing in Medicaid is supposed to be bringing people to bingo games, one of the examples here. But do you see that the moratorium that this bill proposed on some of those cuts with transportation of disabled children is even affected by what you are describing there as an example?

Ms. TURNER. Well, if states are doing this, as we know they are from the Office of the Inspector General report, and if——

Mr. MURPHY. So right now the Office of the Inspector General brought that up, because they are not supposed to be doing it, right?

Ms. TURNER. Exactly, that we are not supposed to be doing that. But if that is, in fact, taking place, by just stopping the regulations and not having a continuing conversation about how to fix that, then we aren't going to get to the solution. I mean it is such a rule——

Mr. MURPHY. OK.

Ms. TURNER [continuing]. Driven program that people are always going to look for ways around the rules, rather than figuring out what is the incentive——

Mr. MURPHY. We will have to remember that when people say government should run health care. Here is another question. I gave some examples about how—in fact, when we had Secretary Leavitt here, he acknowledged that with Medicare we would probably see hundreds of billions of dollars of savings if we could do more to stop nosocomial infections. Is there anybody who can comment on any things that have been done in states that have worked on that and have led to some costs savings? Ms. Edwards,

do you know anything about it? Have any of the Medicaid programs put this into place and have saved money with this?

Ms. EDWARDS. With—Mr. Murphy, with regard to the specific question of infections, states are actively engaged across the country in a variety of efforts to increase the quality of the services that are being delivered. States pick their own strategies around that. There are states that are working on collaboration with the Center for Health Care strategies, for example, to put in place strategies to improve outcomes, reduce errors. Some states are going at that strategy through health information technology——

Mr. MURPHY. What I am—let me say the reason I am getting at this is we have to come up with $1.65 billion in savings on this bill.

Ms. TURNER. Mr. Chairman, Mr. Murphy, within the short timeframe of this bill I think that there are—it is very difficult to come up with quick savings in Medicaid at all, and we could have a long conversation about why that is. But I would suggest that a target for looking for savings opportunities would be within chronic care populations, would be within the duly eligible population, which drives 40 percent of all of the spending in the Medicaid programs for people that are already insured by Medicare. But there is very little collaboration, in fact, even within CMS between those two public programs in terms of finding cost savings. There are large targets for savings in this program.

Mr. MURPHY. This is where we could really use your help on coming up with those ideas. As one of the things they instituted in Pennsylvania was they are not going to pay for never events. If something was amputated that shouldn't have been, they got the wrong medication, so we are not paying. Now, what we need to find out and we are waiting for those numbers from Pennsylvania to see how much that saves. And I believe that could be something we could put into effect fairly quickly.

Ms. TURNER. We are fascinated to watch Pennsylvania's progress on that. I think it is very bold of them.

Mr. MURPHY. There is also something I need your comment on here. There is a section of this bill—I don't expect you—but it is on page 3 where some of our wording has to do with—some questions were raised by some folks about the demonstration projects and other things that some feel that that language is too broad. And might actually prohibit states from talking with CMS with regard to coming up with some provisions of reform. I don't ask you to comment on that now, but I hope that is something you can look at, and other people on this panel could look at as well. Because we want to make sure that those discussions continue between innovations the states may have and CMS, so we can—these issues. It would be important to do this. I might say, Mr. Chairman, too, I have a letter here I forgot to mention before from the secretary of—from Pennsylvania's Dell Richmond, which describes that some of their costs without this moratorium would be some $270 million just in the first year alone. And if it is all right with you I would like to submit that for the record.

Mr. PALLONE. Without objection, so ordered. But the gentleman's time is expired.[The information was not available at the time of printing.]

Mr. MURPHY. Thank you.

Mr. PALLONE. Thank you, Mr. Murphy.

I recognize myself for 5 minutes. I wanted to ask Ms. Edwards some questions. The Administration has referred to a number of these regulations as simply clarifying policies under Medicaid. However, as we know, if implemented they could create significant financial distress for states and hardship for families. Do you view the changes made in the regs as clarifying or as basically an elimination of many of Medicaid's safety net duties?

Ms. EDWARDS. Mr. Chairman, certainly there are regulations in this large volume of regulations that are clarifying. But the fact is, I think states believe strongly that eliminating payments for direct medical education that has been in place for decades is not clarification. Eliminating case management as an administrative billing option is not a clarification. That is change in Federal policy. So I think while there are some regulations that are clarifying, many of these regulations are an absolute change of long-standing Federal policy.

Mr. PALLONE. OK. Now, you know that the bill would stop CMS from implementing these rules through March of 2009. But if Congress doesn't act to block these rules, what would happen to many of the critical safety net rules played by Medicaid? In other words, will states even have enough time to bring their programs into compliance? I use an example, where will a person with a disability who needs rehab services to stay out of a nursing home receive those services? Will they be able to buy a private insurance policy to cover the care? Or use the example of the foster child with a mental illness. Would they be able to secure the case management, the rehab, and the intervention services needed to help get back to school? What would be the consequences?

Ms. EDWARDS. Mr. Chairman, states are already in the middle of this because the targeted case management regulations took effect March 3. And, in fact, we have not received any written guidance from CMS on how we are to come into compliance when we already are not in compliance. And I think we probably have all 50 states that are finding themselves one way or another out of compliance with those regulations. We are—some states have stopped billing for some services, and there are not alternative strategies in place. So services are being lost in some states. Other states are very worried that they are—have a financial liability if they continue to file those Federal claims. Clearly CMS is beginning to recognize this around targeted case management in that they are now beginning, at least verbally, to say well, maybe we will give you a couple of years to come into compliance on that, and on others like the 15-minute billing unit. So far they have mostly said we don't know what to tell you. So I think the reality is whatever regulations get put into place there have to be reasonable implementation timelines as well. There is great concern at the state level that if the provider changes around safety net provider reimbursement, if some of these changes for schools take effect, systems will be broken immediately, and there will not be alternative strategies yet in place. It takes time. It takes legislative action at the state level. It takes alternative funding strategies. Those don't exist.

Mr. PALLONE. What about the individuals though? You know, I use that example of a person with a disability who needs rehab services to stay out of a nursing home. Can they go out and buy a private insurance policy to cover the care? I mean the individuals that are going to be left out essentially? Do they have——

Ms. EDWARDS. Mr. Chairman, the only health plan that I am aware that you actually get into because you are sick is Medicaid. So the fact is folks don't have alternatives or they wouldn't be at our door in the first place. The reality is, though, people can end up in an emergency room and they get care. And eventually those costs get passed back to private payers and people get on health care coverage through Medicaid and Medicaid reaches back and pays those exorbitant costs. So the fact is those costs don't go away. Frequently, if people are undertreated in the right setting they are going to show up in a more expensive setting, and we all absorb those costs eventually.

Mr. PALLONE. And we just end up paying more essentially. Thank you. Let me ask Dr. Raulerson. I know you talked about various services relative to Medicaid. But what about the transportation? In other words, if a family can't get a child there or can't find a specialist who can treat the child's condition, Medicaid provides transportation services. You also have the school-based services that are important. I just wanted to—if you could, comment on the transportation and the school-based services in the context of what you said before.

Dr. RAULERSON. I would like to mention two things about transportation. Shakira, the little baby who is 4 months old was in Birmingham right now. She is coming home to my area today. She has to go back next week. It is a 400 mile roundtrip, and gas in Alabama right now costs $3.25 a gallon. Her family just cannot afford that. In fact, we are going to have to have someone help us figure out how to get her back and forth to Birmingham. But I have children with special needs in my practice who have difficulty getting to school because they are wheelchair-bound and they have to have a special kind of bus to get to school. And just recently the children in my area who were handicapped, who were going to the Head Start program, lost their transportation funds. And I have a couple of children that now have no way to get to Head Start, because of loss of transportation funds. So children need to get where they need to go to get the services that they need, and transportation is a big part of that.

Mr. PALLONE. I appreciate it.

Dr. RAULERSON. Can I mention one other thing? I was talking with the pediatric urologist this week. And he said, you know, you refer these patients and one out of five of them doesn't get there. And I said, you know why? They don't have a car that will go. They don't have the gas money. They can't get there, because Mobile is 90 miles from Brewton.

Mr. PALLONE. I think that is very important, because I think a lot of times we lose sight of the transportation access, you know, the aspect of this in terms of the funding. Thank you. OK. My time has expired. I recognize the gentleman from Texas, Mr. Burgess, for questions.

Mr. BURGESS. Thank you, Mr. Chairman. Can I just start off with a philosophical question, Ms. Turner? Is it still a value to have the private sector involved in health care delivery in this country?

Ms. TURNER. I think that many people feel that that is the case, because competition really does provide people more options, and people do like to have choices. And it helps to provide the same kind of efficiency that we see in other parts of the economy. Wal-Mart's $4 prescription drug I think is a good example.

Mr. BURGESS. And even on a more basic level, Dr. Raulerson, I too started private practice in 1981, so I feel like we have grown up together. The whole concept of the cross-subsidization that occurs with the Federal programs and the private sector is one that—I mean I certainly recognized at an early age if I was losing a little bit on every Medicare or Medicaid patient. I saw it was going to be difficult to make it up in volume and then you get caught in the overhead trap that you so eloquently described. And the only mechanisms that you planned then to deal with that are increased number of hours that you work, which you can do up to a point, hire physician extenders, which you apparently have done. But there does reach a point where you just simply cannot keep up. But it also seems to me we heard—I think it was Mr. Waxman referred to Medicaid as the insurer of last resort. But if 80 percent of your practice is Medicaid it doesn't sound like we—one of your problems at least may be the balance of the patient mix. And I guess we do have to ask ourselves what are we doing and what can we do? And Dr. Antos alluded to this to some degree. And there has got to be some overall structural change in health care across the board, and you have heard a lot of it discussed here this morning. And again, Dr. Antos talked about the dealing with the actuarial aspects when, in fact, we need to be dealing with policy and fundamental change in policy. Again, just my observation after having been here for a few years. Again, I think it was Mr. Towns who said we need reform. I don't disagree with that, perhaps we even need transformation, but Congress is not inherently a reformative or even transformational body. We are transactional. We are going to take from you and we are going to give it to you. We hope you are not too mad at us, and still vote for us, and you surely will vote for us, because we gave you that. And that is the way we work up here until our feet are to the fire, and it looks like—again, we heard the number mentioned, $350 billion. Dr. Antos, was that your figure, $350 billion for the annual expenditure in Medicaid? And when we were doing our hearings on the Deficit Reduction Act in 2005, which dealt with Medicaid, we were told the total spending was $330 billion. So there we have gone up $20 billion while we scarcely have gone by 2 years. That is a pretty rapid rate of rise in that program, so clearly we are going to have to do something to be able to keep up with that. Mr. Buckner, let me ask you. Eighty-nine percent of your newborns are covered under Medicaid. To me that doesn't sound like a program of last resort. That sounds to me like a government-run health care system that is not functioning that well. Would that be a wrong observation?

Mr. BUCKNER. The observation that 89 percent of our Medicaid—of our babies are covered by Medicaid is a reflection of the socio-

economic status of our region of Texas. The distribution of poor are not uniform. They don't exist in some areas of the state or in the country. They are in my——

Mr. BURGESS. Correct, but we were demographically at how to cover groups. So that is one of the groups that is easier to cover. I mean, yes, they are newborns and so you know that they are going to require something. But their cost demands are not great. Occasionally they are very high. So it makes me wonder about—I can't believe I am saying this, because capitation is a concept to me as such—as a provider. But Dr. Antos, when he described so eloquently, it was almost seductive the way he described the per capita caps that he brought forth. Would that be something that we could consider from a policy standpoint that would provide you so relief if there were a—as long as there was not a limit on the enrollment, as he correctly outlines. I think with some of the early HMO experience with capitation, that was where some of the difficulty occurred. But as long as there was no upper limit on enrollment would a per capita cap, with even a provider tax withhold a portion of that cap for catastrophic care, on a philosophical basis is that something—do you think he is on to something there, or has he spent too much time in the Congressional Budget Office?

Mr. BUCKNER. Philosophically for a rural area I could not support per capita. The numbers are too small to make just one catastrophic event in a rural area. I mean if we are talking about per capita payments to a hospital system or to a group of physicians.

Mr. BURGESS. Well, presumably you have the statewide. The per capita would have to be administered on a state-by-state basis. I would imagine, Dr. Antos, you don't want me to put words in your mouth. Feel free to jump in here if it is a—but you certainly would not be able to do it on precinct or even county basis. It would have to be done on a state-by-state basis.

Mr. BUCKNER. Sir, the devil's in the details. I couldn't comment on that philosophical argument. We have seen lots of philosophies promulgated and mandated upon us that have caused rural hospitals to fail and be eliminated from their communities.

Mr. BURGESS. And I don't disagree with that. I watched that in my own practice life. Well, let me then—since we are not going to talk philosophy, we will just have to talk the bill in front of us. Ms. Edwards, have you all had a copy of the bill? I just got one this morning, so I am not being—I am not going to be too picky. But on page three of my bill, under additional moratorium, it says the secretary of Health and Human Services may not, prior to April 1, 2009, impose or continue any requirement to permit the implementation of any provision or condition. The approval of any condition the state plan, on and on and on. So this is fairly restrictive language that has been written into at least the draft that I have, which would preclude—as Dr. Antos said, we are just going—not only do we have a moratorium, we are going to stop work on these for a year's time. Is that your reading of your bill as well?

Ms. EDWARDS. Mr. Chairman, Mr. Burgess, having just sort of looked at the——

Mr. BURGESS. I appreciate the promotion. Can I sit up here?

Ms. EDWARDS. Oh, that was Mr. Chairman, Mr. Burgess. Sorry, my state habits have carried over. Not being an attorney what I

would say is I think the intent as I read it was trying to prohibit CMS from taking action to implement the policy that is expressed in the proposed regulations. Even including through any state one-on-one interaction with states around state plan amendments. I guess I would point out, to be fair I would certainly not want to see a situation where CMS felt they could not engage in an ongoing conversation around the issues. Because one of the things that NASMD has been encouraging from CMS—don't always get responses, but sometimes do, is better understanding of what problems they really believe they are trying to solve with the regulations, so that perhaps we could work with them on finding better solutions. So far we haven't found the right table at which to have that conversation. But I think it is important to point out that many states report they already can't get state plan amendments acted on, and it has been months for some states. Sometimes over a year on some kinds of provisions because states have not been willing to agree to what CMS has been requiring that they agree to before the Federal Government will approve the regulations. So I would simply point out it is not as though it is a well-oiled machine today——

Mr. BURGESS. I would agree with that.

Mr. EDWARDS [continuing]. In terms of the activity. And states would rather see a moratorium than wrong policy put in place.

Mr. BURGESS. Well, we may need——

Mr. PALLONE. The gentleman's time has expired.

Mr. BURGESS. We may need to address this to the bill's authors. I would just offer one other observation. From anyone sitting at the table, if you were going to sit down and construct a program to do all the things Medicaid is supposed to do, would it look anything like Medicaid does today?

Mr. PALLONE. We can't have the questions, Mr. Burgess. I just wanted you to finish your conversation. Thank you. The gentleman's time is expired.

I recognize the gentlewoman from Colorado, Ms. DeGette.

Ms. DEGETTE. Thank you so much, Mr. Chairman.

When I looked at these regulations in total, what I think is, this was just an attempt by the Administration to do two things. Number 1, try to save money by having these slashes in Medicaid. And number 2, to try in some way to make Medicaid look more like private insurance. But the Administration realized they couldn't get policy changes through Congress, and so they just did these regulations with the excuse that they were just cutting some waste or some inappropriate use of the funds. And I want to illustrate that view by talking for a moment about one of the regulations that deeply affects my State of Colorado. That 72 Federal Register, 29748, the payments to public providers. The way we finance Medicaid—or the way we finance our public hospitals in Colorado, because of a state constitutional amendment that was passed some years ago, is we have allowed our public hospitals to find creative ways, and independent ways, to not be financed through the governmental entities. And so the result of this regulation is that Colorado—my safety net provider hospitals in Colorado will lose over $145 million. These are not because our providers—in fact, Denver Health is widely known as one of the most—and I think Ms.

Edwards probably knows about this—it is widely known as one of the most innovative, cost-saving public hospitals in the entire country. And so they are not using the money inappropriately. They just don't have the right financing mechanism, and as a result these cuts are going to cost them. They are going to have to start laying off people right now. And so my question—my first question is to Mr. Cosgrove, because Mr. Cosgrove you discussed this exact regulation I am talking about. And one thing you mentioned was that the GAO recommended that CMS establish or clarify and communicate its policy surrounding supplemental payment arrangements and other financing agreements. Do you think that if CMS were able to do this, or to take other similar action, rather than simply limit payments to public providers, that inappropriate funding mechanisms could be eliminated without having this negative impact on states, that are really having legitimate financing arrangements, that just happen to fall within this scope of the law? Very briefly.

Mr. COSGROVE. Well, in 1994—I mean the context is we were very concerned about these payments that were being recycled. And that is what we——

Ms. DEGETTE. Right.

Mr. COSGROVE. To get to the heart.

Ms. DEGETTE. But do you think—answer my question if you will.

Mr. COSGROVE. Well, I am trying to.

Ms. DEGETTE. Do you think that if they could just establish or clarify the policies they could separate out the wheat from the chaff? Yes or no?

Mr. COSGROVE. That would go a long way.

Ms. DEGETTE. Thank you. Now, I really—I am like the Chairman. I really apologize. They just don't give us much time to ask these questions. Because I want to ask Ms. Turner this question. She talked about, several times, inappropriate use of funds for other purposes and so on and so forth. With respect to this particular regulation, do you think that in enacting this particular regulation that you are going to do more good than—that the Administration is going to do more good than harm? That it is going to eliminate more fraud, waste, and abuse, or the inappropriate programs that you stated?

Ms. TURNER. You know, that is really a question of how you engage in a conversation with the states and the Congress and the Administration to really solve this problem.

Ms. DEGETTE. Well, unfortunately, Ms. Turner, the regulation does not provide for engaging in a conversation with the states. The regulation provides for elimination of these funds altogether with a—it is really with a hatchet, rather than a scalpel.

Ms. TURNER. The regulation is saying that if an entity is rebating funds to the state that it has to get those back. When you look at examples of nursing homes that get——

Ms. DEGETTE. What about Colorado? What about places like Colorado who fund their public hospitals in this way?

Ms. TURNER. Well, it is just——

Ms. DEGETTE. Too bad?

Ms. TURNER. You look and ask is that the right way to run the Medicaid program?

Ms. DEGETTE. OK. But that is not what this regulation——

Ms. TURNER. More explicit——

Ms. DEGETTE [continuing]. Does. This regulation says, no.

Ms. TURNER. Well, because CMS can't pass laws. It is the responsibility——

Ms. DEGETTE. Right.

Ms. TURNER [continuing]. Of Congress to figure out how do we make this——

Ms. DEGETTE. But they did pass it. They said, no, Denver Health.

Ms. TURNER. The CMS can't fix the underlying problem. That is the responsibility of Congress.

Ms. DEGETTE. So why should they have passed the regulation then?

Ms. TURNER. Because they see abuse. They see that the money that is——

Ms. DEGETTE. So just everybody out, because someone abusing it.

Ms. TURNER. It is not being spent for legal Medicaid services. It is being rebated to the states to pay for education and many other services that aren't legal. It——

Ms. DEGETTE. Well, if they——

Ms. TURNER. It is a fiduciary responsibility.

Ms. DEGETTE. Let me just ask you this. If they can't legislate, why are they legislating through this regulation?

Ms. TURNER. They are not—they are trying to make sure that taxpayer dollars that are appropriated for Medicaid are being spent for legal purposes. They see this outside the legal authority of Medicaid.

Ms. DEGETTE. OK. So——

Mr. PALLONE. The gentlewoman's——

Ms. DEGETTE. Thank you.

Mr. PALLONE [continuing]. A minute over. All right. Thank you.

Let me thank this—I think we are done with our questions from members. And I want to thank all of you for being here. I know it was a large panel, and difficult to get through everything, but I think you were extremely helpful. So thank you very much. Thank you for being here.

Not let mention we have two votes on the floor. These are the last two votes of the day. I have 10 minutes on one, a Motion to Recommit, and then 5 minutes on final passage. We will reconvene immediately after that second vote, which I guess may be another 15, 20 minutes, and then we will have our next panel. So for now the Committee is in recess until after the votes on the floor.

[Recess.]

Mr. PALLONE. This subcommittee will reconvene, and I would ask the members of our second panel to come forward, please.

Let me introduce each of you, if I can. First, on my left is Dennis Smith, who is director of the Center for Medicaid and State Operations with the Centers for Medicare and Medicaid Services. And to his right is the Honorable Herb Conaway, who is a physician and a state assemblyman in New Jersey, and who also happens to be the Chairman of our State Assembly Health and Senior Services Committee. And he is testifying on behalf of the National Con-

ference of State Legislatures, where he also serves as Chair of their standing committee on health. And he has been an advocate for not only increased access for health services, but expanding health insurance, and so many things in my state. And I really appreciate your being with us here today, Herb. Thank you.

Dr. CONAWAY. Thank you.

Mr. PALLONE. And then next to Assemblyman Conaway is John Folkemer, who is deputy secretary for Health Care Financing of the Department of Health and Mental Hygiene. Thank you also for being here today.

As I mentioned before, we have 5-minute opening statements from each you. Those become part of the hearing record. Each of you may in the discretion of the Committee submit additional statements in writing for inclusion on the record.

And I will start by recognizing Mr. Smith for 5 minutes. Thank you.

STATEMENT OF DENNIS G. SMITH, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. SMITH. Thank you, Mr. Chairman, and it is a pleasure to be with the members again.

And I will have a full statement for the record. I will try to summarize very quickly. First, the Administration strongly opposes H.R. 5613. The legislation would thwart the efforts of the Federal Government to apply greater fiscal accountability in the Medicaid program. As currently drafted, H.R. 5613 would not simply delay implementation of these regulations, but they in fact may jeopardize policies and interpretations that pre-date the regulations.

Generally, the intent of a moratorium is to preserve the status quo for a period of time until new policies are in place. However, the broad and sweeping language employed by H.R. 5613 would not only delay these rules to accommodate state's time tables for coming into compliance, but may be read to reverse important progress that has already been made.

CMS believes that the rules are vital to inform policy makers about the nature of activities in the Medicaid program that are all too often hidden from view. When definitions of rehabilitative services and targeted case management are so broad that they are meaningless, when the Federal Government cannot identify precise spending on graduate medical education or its direct benefits to the Medicaid population, public trust is eroded. These rules will help bring billions of dollars in taxpayer funds out of the shadows and will provide the accountability that is long overdue.

As CMS and others have testified, there is a long and complicated history that is marked by states seeking to shift funding of the Medicaid program to the Federal Government. The package of recent regulatory activity by the Administration is intended to address types of head-on abuses that have been well documented by the GAO and by the Office of the Inspector General. Our objective is to ensure that Federal Medicaid dollars are matching actual state payments for actual Medicaid services for actual Medicaid beneficiaries. Medicaid is already an open-ended Federal commitment for Medicaid services to Medicaid recipients. It should not be-

come a limitless account for state and local programs and agencies to draw Federal funds for non-Medicaid purposes.

Oftentimes, these arrangements are out of view even of policymakers at the state, local, and Federal levels. It is a—the Medicaid program should be based on transparency and trust, not on hidden funding arrangements that result in a don't ask, don't tell relationship with oversight agencies. CMS is often asked why can't we simply stop these practices through the audit and just allow it to process, which certainly we employ. But audits and disallowances occur on the backend of the process. Obviously, from our perspective it would be better, and I think it would be better for the states as well if there were no opening for practices that are inconsistent with the overall statutory, regulatory framework at the beginning of the process

The rules that we have promulgated helped to eliminate perceived ambiguities, and protect the Federal-state financing partnership. Again, oftentimes that the states use in the audit procedures as their defense. Well, the law was unclear, or the regulations were unclear or ambiguous, where we believe that clarity is really in the interest of everyone in the program. The Federal Government in these rules—I think it is very important and, having listened to the first panel, it is very important to understand these rules are not reducing, restricting, or limiting Federal commitment to pay the full costs of providing medically necessary services to Medicaid recipients as long as the states are contributing their full share as well. The restrictions applying to paying units of government apply to those payments in excess of their costs. We would reimburse the costs. Nor are we restricting states and their ability to share their share of the Medicaid program with their local units of governments.

Oftentimes, again, when we hear these discussions we need to ask when there are claims that they will lose funding. I think it is important for policymakers to ask why they say they will be losing. Is it really a service? Is it really a medically necessary service for a Medicaid recipient? Is it because they do not believe the state will share—will pay its share of the financing, or pay adequate rates for their claims? And was the funding arrangement merely an indirect method for claiming Federal funds for activities that would not otherwise be directly allowable under the Medicaid program, i.e., for non-Medicaid services or a non-Medicaid population?

Also, on the rules, again, just to help bring these into context, when you look at the CBO of the cost or savings, whichever way you look at it, CBO scores the cost rule of $770 million for the remainder of 2008 and 2009. To put that into context, Illinois hospitals themselves paid $747 million in provider taxes in 2007. New York hospitals paid $2 billion in provider taxes. In 2007, states collected $12 billion in provider taxes. So for the providers to come here and say what the impact of these regulations, this is a rather small fraction of what the providers themselves contribute or give up to the cost of the Medicaid program.

In reality, our rules protect providers. We do not believe that hospitals should be taking on the responsibility of the state.

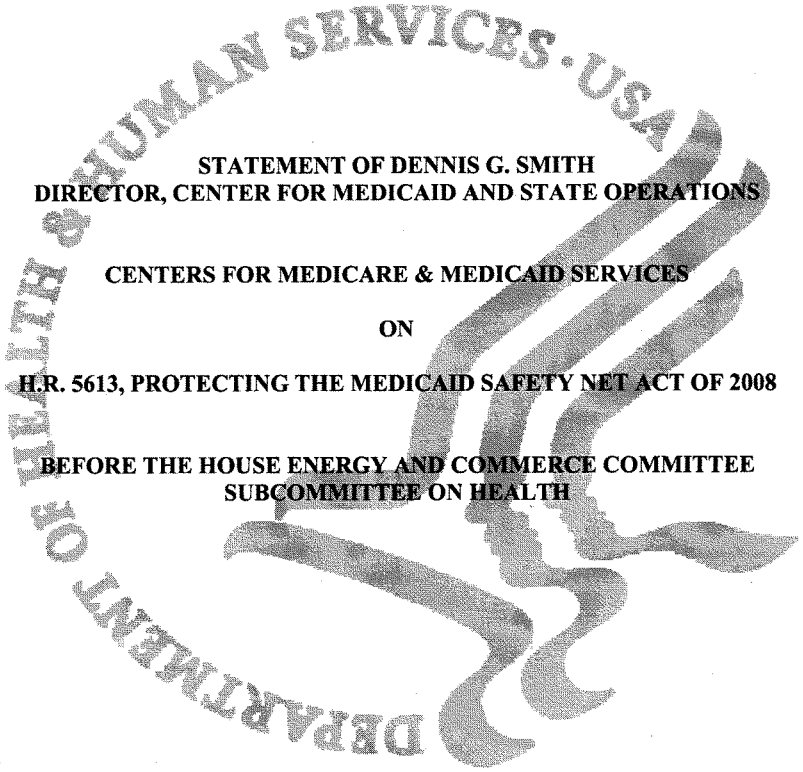
Mr. PALLONE. Mr. Smith, I just—you are a minute over. So if you could wrap up.

Mr. SMITH. Thank you, Mr. Chairman,

Mr. PALLONE. Thank you.

Mr. SMITH. I will leave it there and look forward to your questions.

[The prepared statement of Mr. Smith follows:]



STATEMENT OF DENNIS G. SMITH
DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

H.R. 5613, PROTECTING THE MEDICAID SAFETY NET ACT OF 2008

BEFORE THE HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH

APRIL 2, 2008

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of

Dennis G. Smith,

Director of the Center for Medicaid and State Operations at the

Centers for Medicare & Medicaid Services

On

"H.R. 5613, Protecting the Medicaid Safety Net Act of 2008"

Before the

House Energy and Commerce Subcommittee on Health

April 3, 2008

Thank you for inviting me to discuss H.R. 5613, "Protecting the Medicaid Safety Net Act of 2008." The purpose of this legislation is to prevent the Federal government from finalizing and enforcing a number of Medicaid regulations aimed at strengthening the fiscal integrity of the program. Specifically, H.R. 5613 would prevent the Centers for Medicare & Medicaid Services (CMS), from acting on final rules on Cost Limits for Providers Operated by Units of Government; Medicaid Reimbursement for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School; Health Care-Related Taxes; and Targeted Case Management; as well as, Notices of Proposed Rulemaking on Graduate Medical Education; Rehabilitative Services; and Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit.

These rules will help ensure that Medicaid is paying providers appropriately for services delivered to Medicaid recipients, that those services are effective, and that taxpayers are receiving the full value of the dollars spent through Medicaid. They are rooted in the statutory construction of Medicaid as a matching program and some are the direct result of years of audits and recommendations by the Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS), and the Government Accountability Office (GAO), as well as our experience in reviewing State plan amendments. These watchdog agencies, for the Executive Branch and Congress respectively, have sounded the alarm about the integrity of the program for years.

Ignoring these findings and recommendations for another twelve months will put billions of dollars of Federal funds at risk.

The Administration strongly opposes H.R. 5613. The legislation would thwart the efforts of the Federal government to apply fiscal accountability in Medicaid. As currently drafted, H.R. 5613 would not simply delay implementation of these regulations, but it could be read to jeopardize policies and interpretations that predate these regulations. Generally, the intent of a moratorium is to preserve the status quo for a period of time until new policies are in place. However, the broad and sweeping language employed by H. R. 5613 would not only delay these rules to accommodate States' timetables for coming into compliance, but could be read to reverse important progress that has been made. For example, CMS has previously testified that 30 states have agreed to eliminate financing schemes that forced providers to return funds intended to compensate the providers for services to Medicaid recipients. Should H. R. 5613 become law, there is a risk that States will seek to reinstate those financing schemes, resulting in continued litigation in order to protect the integrity of the Medicaid program. It is also important to note that H.R. 5613 extends moratoria that date back to last year. CMS is concerned that the inactivity of the past will be repeated and the moratoria will actually mean an abandonment of this important work by the Federal government.

Preserving the Medicaid Partnership

CMS believes that these rules are vital to inform policymakers about the nature of activities in the Medicaid program that are all too often hidden from view. When definitions of "rehabilitative services" and "targeted case management" are so broad that they are meaningless, or when the Federal government cannot identify precise spending on Graduate Medical Education or its direct benefits to the Medicaid population, public trust is eroded. These rules will help bring billions of dollars in taxpayer funds out of the shadows and will provide the accountability that is long overdue.

As CMS and others have previously testified, there is a long and complicated history that is marked by States seeking to shift funding of the Medicaid program, to the greatest

extent possible, to the Federal government. Federal recognition of this occurrence dates back to at least 1991 when Congress enacted prohibitions on provider taxes and donations. Many of the policies reflected in these regulations have been advocated or supported by the GAO in the past, or at least have been acknowledged by GAO as a source of potential Federal fiscal vulnerability.

GAO and OIG have provided policymakers with numerous reports on various areas in which States engage in activities to maximize Federal revenues. Here are just a few examples:

- State agencies paid private facilities under a per diem rate for providing room and board, rehabilitation counseling and therapy, educational, and other services to children in State custody, and based their claims on facilities' estimated costs rather than actual costs. This resulted in an increase of $58 million in Federal Medicaid reimbursements.
- Medicaid is frequently billed for costs related to transporting children from home to school and back on a given school day despite the fact that children are transported to school primarily to receive an education, not to receive medical services. In a 2004 review of one state, OIG found that more than 90 percent of transportation claims to Medicaid, made on behalf of almost 700 schools and preschool providers over the September 1, 1993 through June 30, 2001 period, were not in compliance with Federal and State regulations.
- An OIG audit of a State's adult rehabilitative services program found 65 unallowable claims out of a sample of 100. Errors included services that were not rehabilitative; no services actually provided; and conflict of interest because the provider both authorized and rendered the services.

The package of recent regulatory activity by this Administration is intended to address these types of abuses head-on by ensuring that Federal Medicaid dollars are matching actual State payments for actual Medicaid services to actual Medicaid beneficiaries. Medicaid is already an open-ended Federal commitment for Medicaid services for

Medicaid recipients; ***it should not become a limitless account for State and local programs and agencies to draw Federal funds for non-Medicaid purposes.***

In many respects, these hidden arrangements take decision-making out of the hands of elected officials at the Federal, State, and local levels. When Medicaid funds are diverted to purposes not expressly authorized by law, legislatures have not had the opportunity to determine if such funding is warranted or desirable. As a result, the legislative decision-making process is weakened. This is especially true at the State level as Medicaid now typically accounts for one out of every five dollars spent by States. The Medicaid program should be based on transparency and trust, not on hidden funding arrangements that result in a "don't ask, don't tell" relationship with oversight agencies.

CMS is often asked why we cannot simply stop these practices through the audit and disallowance process. Audits and disallowances occur on the back end of the process. Obviously it would be better if there were no opening for practices that are inconsistent with the overall statutory and regulatory framework. The rules listed below and targeted by H.R. 5613 would help eliminate some perceived ambiguities and protect the federal-state financial partnership.

Final Medicaid Governmental Provider Payment Rule

CMS issued the final rule regarding the Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership (Governmental Provider Payment Rule) on May 25, 2007 with a July 30, 2007 effective date. Congress has imposed a moratorium on this rule through May 25, 2008. The final rule implements the President's FY 2007 Budget proposal to strengthen the fiscal integrity of the Medicaid program by: (1) limiting governmentally-operated health care providers to reimbursement that does not exceed the cost of providing Medicaid covered services to Medicaid individuals; (2) reiterating that only units of government are able to participate in the financing of the non-Federal share of Medicaid payments; (3) establishing specific cost reporting requirements that build upon existing requirements for documenting cost when using a certified public expenditure; and (4) reaffirming that all

health care providers receive and retain the total computable amount of their Medicaid payments.

Prior to the effective date of the Governmental Provider Payment Rule, payments to individual State and local governmentally-operated health care providers were not limited to the actual cost of providing these services. Instead, regulations defining the Medicaid Upper Payment Limit (UPL) established aggregate limits on what Medicaid would pay to a group of facilities based on estimates of the amounts that would be paid for similar services using Medicare payment rules. The result of such an aggregate limit would permit a particular governmentally-operated health care provider to receive Medicaid revenue in excess of its Medicaid costs that could be used for non-Medicaid purposes, or returned to the State or local governments (effectively reducing State or local funding obligations).

By requiring that Medicaid payments to governmentally-operated health care providers not exceed an individual provider's cost, the Governmental Provider Payment Rule will ensure that the Federal government pays only its share for Medicaid services delivered by that provider. This reform is critical to strengthening program accountability, consistent with GAO and OIG recommendations.

The Federal government is not reducing, restricting, or limiting the Federal commitment to pay the full cost of providing medically necessary services to Medicaid recipients as long as the States are contributing their full share as well. Restrictions apply to paying units of government ***in excess*** of their costs. Nor are we restricting States in their ability to share their cost of the Medicaid program with local units of government. Therefore, when providers claim they will lose funding under these rules, it is important to ask:

- Is it really for a service for a Medicaid recipient?
- Is it because they do not believe the State will pay its share or adequate rates for their claims?

- Was the funding arrangement merely an indirect method for claiming Federal funds for activities that would not otherwise be directly allowable, i.e., for non-Medicaid services or non-Medicaid populations?

Finally, this rule does not establish a Medicaid payment limit on "public" health care providers that are not units of government. Public health care providers that are not units of government should realize no loss in existing Federal revenue commitments and could actually realize greater gains in current revenue levels as long as States are contributing their full share. This rule actually protects all health care providers participating in the Medicaid program by ensuring that the health care providers are able to retain the payments they receive for providing medically necessary services to Medicaid recipients.

Final Rule on the Elimination of Reimbursement for Administrative Claiming and Transportation Costs for School-Based Services

CMS issued a final rule, published in the Federal Register on December 28, 2007, clarifying that administrative activities performed by schools are not necessary for the proper and efficient administration of the State Medicaid plan. Congress has imposed a moratorium on this rule until June 30, 2008. The rule also specifies that transportation of students from home to school and back is not within the scope of allowable Medicaid-related transportation recognized by the Secretary. Therefore, under the rule, funding for the costs of these activities or services performed would no longer be available under the Medicaid program.

Contrary to the rhetoric surrounding this rule, it is not a limitation on medical services provided by schools. States will continue to receive reimbursement under the Medicaid program for school-based Medicaid service costs under their approved State plans under current law. For example, if a child is Medicaid-eligible and receives physical therapy, this rule does not change the benefit or the level of reimbursement.

CMS has had long-standing concerns about improper billing under the Medicaid program by school districts for administrative costs and transportation services. Both HHS' OIG

and the GAO have identified these categories of expenses as susceptible to fraud and abuse. Congress has also expressed concern over the dramatic increase in Medicaid claims for school-based administrative costs and transportation services, which were the subject of two U.S. Senate Finance Committee hearings.

States reported a total of $849 million of expenditures for administration by schools in FY 2006, of which the Federal share was $428 million. Most of this spending was concentrated in a handful of States. Specifically, two States accounted for 40 percent of the entire claims submitted for administration. Eight States accounted for 80 percent of the claims. Between FY 2002 and FY 2006, two States went from $0 in claims to more than $30 million in claims. Conversely, another State went from $84 million in claims to $3.5 million in claims during the same period. Some States have made larger claims for administration costs than they claimed for actual medical assistance services. In an audit of one county, the OIG determined that $5.8 million out of $12.5 million claimed for administrative costs were in fact not allowable.

Equally notable, school administration and transportation to and from school are basic elements of the operation of public school systems, and are not functions performed to further the Medicaid program. Specifically, transportation to and from schools is furnished for the purpose of ensuring that students have access to a public education, and not for the purpose of facilitating beneficiary access to Medicaid providers. School administration is focused on the education of students and not on the Medicaid program.

Final Rule on Provider Taxes

This final rule, published in the Federal Register on February 22, 2008, reflects recent legislative actions and provides clarifications to current provisions, addressing the following areas: (1) revises the threshold from 6 percent of net patient revenue to 5.5 percent under the first prong of the indirect hold harmless guarantee test as enacted by the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432); (2) clarifies the standard for determining the existence of a hold harmless arrangement under the positive correlation test, Medicaid payment test, and the guarantee test; (3) codifies changes to

permissible class of health care items or services related to managed care organizations (MCO) as enacted by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171); and (4) removes obsolete transition period regulatory language. We believe that this rule faithfully reflects the intent of Congress in enacting the provider tax rules in 1991 and the minor revision in TRHCA.

Interim Final Rule with Comment on Targeted Case Management

The interim final rule, published in the Federal Register on December 4, 2007, clarifies the definition of covered case management services and implements Section 6052 of the Deficit Reduction Act of 2005, which redefined the scope of allowable case management services, strengthened State accountability, and required that CMS issue regulations. The work of GAO and the OIG in particular were key in assisting policymakers' understanding of States' misuse of case management, not as a tool to improve health status of Medicaid recipients, but simply as a supplement for state and local budgets.

This interim final rule has a strong emphasis on ensuring that case management will be comprehensive and coordinated, to fully serve beneficiary needs. High quality case management should result in better outcomes for the individual and better value for the taxpayer. People with complex medical needs often face challenges in the community as well. Their special needs confirm the need for highly qualified, well trained case managers. We certainly recognize that these rules challenge the status quo. We believe this is appropriate and we should be raising our expectations about how people on Medicaid are being served.

We are currently engaged with the States to implement the regulation and have held discussions not only with State Medicaid directors but state officials dealing specifically with populations with mental illness and developmental disabilities. We recognize that a number of concerns have been raised in three areas in particular—the limitation to a single case manager, 15 minute billing increments, and transition period for individuals in institutions. We believe, however, that these are policies important to securing greater accountability in the program.

Rehabilitative Services

CMS issued a proposed regulation, published in the Federal Register on August 13, 2007, that clearly defines allowable services that may be claimed as "rehabilitative services." Congress has imposed a moratorium on this rule until June 30, 2008. Rehabilitation services are optional Medicaid services typically offered to individuals with special needs or disabilities to help restore a lost function and improve their health and quality of life. In recent years, Medicaid rehabilitation services have increasingly become prone to inappropriate claiming and cost-sharing from other programs, because these services are so broadly defined as to become simply a "catch all" phrase. "Rehabilitative services" have become so broad that it has become meaningless and States have taken advantage of the ambiguity and confusion to bill Medicaid for a wide variety of services outside the scope of medical assistance.

This regulation will also include important beneficiary protections to improve the quality of care provided to the individuals who need these rehabilitative services. For the first time, rehabilitative services would be required to be furnished through a written plan of care that identifies treatment goals and methods. Our proposed rule contemplates that care will have a clear foundation in clinical practices, and will be designed and delivered in a patient centered environment.

CMS' recent history in dealing with State Plan Amendments reveals that States themselves often have difficulty in identifying what is actually meant by rehabilitative services and what reimbursement rates are based upon. Medicaid will benefit from greater clarity and should not be left vulnerable to other programs, no matter how important, in search of a funding source.

Proposed Rule on Graduate Medical Education

CMS issued a proposed rule, published in the Federal Register on May 23, 2007 that makes Medicaid graduate medical education (GME) payments and costs ineligible for Federal financial participation (FFP). Congress has imposed a moratorium on this rule through May 25, 2008. Specifically, the proposed rule no longer allows States to include

GME as a payment under the Medicaid State plan or as an allowable cost in determining Medicaid payments. Medicaid is authorized to pay for medical assistance services. Section 1905 of the Social Security Act describes the services eligible for FFP under an approved Medicaid State Plan. GME is not included as a service, or a component of a service, that is eligible for FFP.

The rule also modifies the upper payment limit (UPL) regulations to eliminate the use of the Medicare direct graduate medical education (DGME) payment as part of the calculation of a State's UPL. States may include the Medicare indirect medical education (IME) payment adjustment when calculating the UPL because the Medicare IME payment is an adjustment to the Medicare inpatient hospital prospective payment system (IPPS) to reflect the estimated higher cost of providing medical services teaching hospitals may face. States may include this service cost adjustment in the UPL. While States may not make IME payments under the State Medicaid plan, States may recognize the additional service costs incurred by teaching hospitals through their rate structure for actual services provided. Thus, the recognition of the IME adjustment in the UPL gives States the ability to increase Medicaid payments, for which FFP would be available.

Clarification of Outpatient and Clinic Upper Payment Limit

The proposed regulation, published in the Federal Register on September 28, 2007, intends to clarify the current vague regulatory language in order to define the scope of Medicaid outpatient hospital services and the UPL for those services. Clarifications were made to regulatory language at 42 CFR 440.20 and 42 CFR 447.321. The rule recognizes services paid under the Medicare outpatient prospective payment system or paid by Medicare as an outpatient hospital service under an alternative payment methodology as Medicaid outpatient hospital services. The scope of Medicaid outpatient hospital services may not include a service reimbursed under a distinct State plan payment methodology for another Medicaid covered service. The rule also limits the facilities that may provide outpatient hospital services to hospitals and departments of an outpatient hospital as defined at 42 CFR 413.65.

In addition, the rule would codify HHS policy regarding the UPL for Medicaid outpatient hospital services in private facilities by referencing accurate data sources and the formula to calculate a reasonable estimate of the amount that would be paid for outpatient hospital service furnished by hospitals and outpatient departments of hospitals under Medicare payment principles.

The regulation intends to prevent an overlap between outpatient hospital services and other covered benefits. The potential overlap could result in circumstances in which payment for services is made at the high levels customary for outpatient hospital services instead of the levels associated with the same services under other covered benefits.

By clarifying the UPL definition, CMS seeks to provide additional guidance on accurate data resources and formulas to help States demonstrate compliance with 42 CFR 447.321. CMS has issued this guidance informally to States in the past. Further, CMS does not anticipate a major impact on providers or beneficiaries under this regulation as we do not believe attempts to inflate UPLs through this manner are widely used currently, but we do believe it is important to clarify this policy.

Conclusion

These rules reflect the long-standing work of CMS and others, such as GAO and the OIG, to restore greater accountability to the Medicaid program, while safeguarding limited resources for actual services to those individuals who rely on the Medicaid program. CMS understands that Medicaid is one of the largest programs in State budgets, generally accounting for more than 20 percent of a State's total spending. When the Federal government presents a significant disallowance against a State, the effects ripple through State government. Nevertheless, Medicaid is fundamentally a partnership that relies on both sides to contribute their share to the cost of the program. As Medicaid competes for resources at the State level against all the other demands that are present, an erosion of confidence in the integrity of the Medicaid program ultimately is not good for Medicaid or for the people who rely on it. These rules provide greater stability in the program and equity among the States.

Mr. PALLONE. All right. Thank you very much.
Dr. Conaway.

STATEMENT OF HERB CONAWAY, JR., M.D., STATE ASSEMBLYMAN, LEGISLATIVE DISTRICT 7, STATE OF NEW JERSEY

Dr. CONAWAY. Thank you, Mr. Chairman.

I am Dr. Herbert Conaway, chairman of the New Jersey State Assembly Health and Senior Services Committee. I am testifying on behalf of the National Conference of State Legislatures where I serve this year as chairman of the NCSL Standing Committee on health.

NCSL is a bipartisan organization representing the 50 state legislatures, the legislatures of our Nation's commonwealths, territories and possessions, the District of Columbia. I hope that one day I will appear before you to discuss ways to expand coverage, to improve the quality of benefits and services to Medicaid beneficiaries, and to share best practices in the provision of state-of-the-art care to our most vulnerable citizens. But today I appear before you to express NCSL's support for H.R. 5613, Protecting the Medicaid Safety Net Act of 2008, and to congratulate you yourself, Chairman, and sponsors Dingell and Murphy for their leadership in this issue.

The bill will delay, as you know, until March 2009 the implementation of seven Medicaid rules whose cumulative effect will be to severely reduce critically needed services to the most vulnerable among us. Folks and children who are suffering from autism, disabled individuals who are meeting the challenge and need help to meet the challenge of their disabilities, children and families who struggle to achieve what is guaranteed to them in the Constitution in terms of access to public education, and being assisted in overcoming the difficulties that they face in achieving that education are the people who are impacted so negatively by these rules.

Last year, NCSL strongly supported the moratoriums pertaining to these rules and regulations. This year, our sense of urgency has increased as the economy continues to decline. Many states, New Jersey among them, face unprecedented budgetary shortfalls. The impact of these rules going into effect and taking billions of dollars out of the Medicaid program will strike a devastating blow to states as they struggle to maintain critical services. NCSL has been and remains concerned about regulatory activism being exercised by the Centers of Medicare and Medicaid Services within the U.S. Department of Health and Human Services. By regulatory activism we mean moving a regulatory agenda and promulgating regulations that are not supported by legislative activity, that are not imposed pursuant to direction from Congress, and that exceed authority provided in legislation.

Over the past several months, significant changes in Medicaid, law and policy have been put forth through regulation, letters, and other administrative activities. Some of the rules were first put forward as legislative proposals in Congress that Congress failed to embrace. While these provisions failed as legislation, they sit before us today as rules ready to be implemented unless legislation is enacted to stop them.

It is important to note that while this legislation would delay the implementation of seven rules, there are additional CMS rules forwarded to state health officials that are also of concern to states. In fact, my state and others have filed suit to stop the implementation of some of the provisions of—I should call—the infamous August 17 letter to state health officials that essentially changes the income eligibility standards for the State Children's Health Insurance program and Medicaid without so much as a respectful nod to Congress.

The other regulation would give the Secretary of the U.S. Department of Health and Human Services broad authority to overturn decisions of the Department's appeal board, thereby potentially preventing states from obtaining programs to meet the particularized needs of their respective constituencies. NCSL regards this as a particularly problematic proposal.

Regulatory activism as exercised by CMS effectively transfers legislative powers to the executive branch and comprises the process by which states and other stakeholders provide input. What results is a legislative process that is fundamentally compromised. NCSL recommends that this be stopped. While NCSL strongly supports H.R. 5613 and urges its adoption, we recognize that it is a short-term solution. Unless action is taken to address these rules in a more permanent fashion, next year at this time we will be back asking for more delays. We cannot continue to seek delays and spend limited state resources to fight rules in the courts. The Medicaid program and its beneficiaries deserve better.

States need stability in the Medicaid policy and financing, uniform rules, consistent application of the rules, and transparency in a policymaking process. The Federal Government must allow states the flexibility needed to administer a cost-effective Medicaid program. And stakeholders at all levels of government need to have a stake in making the Federal-state partnership work.

Finally, unless the economy vastly improves over the next several months, states can anticipate a surge of Medicaid enrollment that will be extremely difficult for states to support. With this in mind we urge you to study options to include a provision establishing emergency assistance to states within the Medicaid statute. The provision would, upon some triggering event such as a recession, natural disaster, active terrorism, or public health emergency provide additional financial assistance to states through an enhanced Federal match or some other mechanism, the effect of which would terminate with the resolution of the triggering event. This is a complex but critical component to support the fiscal security of the Medicaid program in difficult times.

NCSL looks forward to working with Congress and the Administration to identify options and establish and implement emergency assistance programs. NCSL supports the addition of the emergency assistance provision and as it would help states maintain the health care safety for the Nation's most vulnerable citizens during extremely difficult times.

I thank you for this opportunity to share our perspectives with you, and look forward to answering any questions you may have.

[The prepared statement of Dr. Conaway, Jr. follows:]

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

TESTIMONY OF

ASSEMBLYMAN HERB CONAWAY, JR
NEW JERSEY STATE ASSEMBLY

ON BEHALF OF THE

NATIONAL CONFERENCE OF STATE LEGISLATURES

REGARDING

H.R. 5613, PROTECTING THE MEDICAID SAFETY NET ACT OF 2008

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES

APRIL 3, 2008

Chairman Pallone and Distinguished Members of the Subcommittee:

I am Herb Conaway, Jr., a member of the New Jersey State Assembly and chair of its Health and Senior Services Committee. Today I am testifying on behalf of the National Conference of State Legislatures (NCSL) where I serve this year as chair of the NCSL Standing Committee on Health. NCSL is the bi-partisan organization representing the 50 state legislatures and the legislatures of our nation's commonwealths, territories, possessions and the District of Columbia.

While I hope one day to appear before you to discuss ways to expand coverage; to improve the quality of benefits and services to Medicaid beneficiaries and to share best practices to provide state-of-the-art care to our most vulnerable citizens, today I appear before you to express NCSL's support for H.R. 5613, Protecting the Medicaid Safety Net Act of 2008, a bill that proposes to delay until March 2009 the implementation of seven pending Medicaid rules. NCSL strongly supported the moratoriums enacted by Congress last year. This year our sense of urgency has increased as the economy continues to decline and many states, New Jersey among them, face unprecedented budget shortfalls. The impact of these rules going into effect and sucking billions of dollars out of the Medicaid program would strike a devastating blow to the Medicaid program, Medicaid beneficiaries and our network of safety-net providers.

NCSL continues to be concerned about the "regulatory activism" being exercised by the U.S. Department of Health and Human Services, particularly the activities of the Centers

for Medicare and Medicaid Services (CMS). By regulatory activism we mean moving a regulatory agenda and promulgating regulations that: (1) are not supported by legislative activity; (2) are not imposed due to direction by Congress; or (3) exceed the authority provided in legislation. Over the past several months, significant changes in Medicaid law and policy have been put forth through regulation, letter, and other administrative activities. Some of the rules were first put forward as legislative proposals that Congress failed to embrace. While these provisions failed as legislation, they sit before us today as rules ready to be implemented unless legislation is enacted to stop them.

It is important to note that while this legislation would delay the implementation of seven rules, there is at least one more rule and a letter to State Health Officials that is also of concern to states. In fact, my state and others have filed suit to stop the implementation of some of the provisions of the August 17th letter to State Health Officials that essentially changes the income eligibility standards for the State Children's Health Insurance Program (SCHIP) and Medicaid without a flick of the legislative pencil. The other regulation would give the Secretary of the U.S. Department of Health and Human Services broad authority to overturn decisions of the Departmental Appeals Board. A very problematic proposal.

Regulatory activism as exercised by CMS effectively transfers legislative powers to the executive branch and compromises the process by which states and other stakeholders provide input, fundamentally changing the legislative process. This should be stopped.

While NCSL strongly supports H.R. 5613 and urges its adoption, we recognize that it is a short term solution. Unless action is taken to address these rules in a more permanent fashion, next year at this time we will be back asking for more delays. We cannot continue to seek delays and to spend limited state resources to fight these rules in the courts. Medicaid and the individuals who depend on it for their health care coverage deserve better.

States need: (1) stability in Medicaid policy and financing; (2) uniform rules and application of the rules; and (3) transparency in the policymaking process. We must find ways to: (1) maintain state flexibility; (2) allow states to raise matching funds using local government funds as provided in current law; (3) provide coordinated care to vulnerable populations in a cost-effective manner that allows the various state agencies that serve those individuals to work together; (4) provide some Medicaid administrative services in schools, using trusted school employees and/or contractors who can receive Medicaid reimbursement; (5) define rehabilitative services in a way that will not disenfranchise hundreds of Medicaid beneficiaries currently receiving those services; (6) establish a hold-harmless test for Medicaid provider taxes and donations that is more objective than those proposed in the rule; and (7) maintain Medicaid reimbursement for Graduate Medical Education to provide continued support for our primary care physician workforce. We must make the state-federal partnership work.

Finally, unless the economy vastly improves over the next several months, states can anticipate a surge in Medicaid enrollment that will be extremely difficult to support.

With this in mind, we urge you to study options to include a provision establishing emergency assistance to states within the Medicaid statute. The provision would upon some triggering event, such as an economic downturn, natural disaster, act of terrorism, pandemic or other public health emergency, provide additional financial assistance to states through an enhanced federal match or some other mechanism that would revert back to the regular federal-state cost-sharing formula when the triggering event has been resolved. This is a complex, but critical component to fiscal security for the Medicaid program. NCSL added this "Emergency Assistance" provision to its Medicaid policy as the result of the work and recommendations of its NCSL Task Force on Medicaid Reform. NCSL looks forward to working with Congress and the Administration to identify options and to establish and implement an emergency assistance program.

I thank you for this opportunity to share our perspectives with you and look forward to answering any questions you may have.

Mr. PALLONE. Thank you, Assemblyman.
Mr. Folkemer.

STATEMENT OF JOHN G. FOLKEMER, DEPUTY SECRETARY, HEALTH CARE FINANCING, DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Mr. FOLKEMER. Thank you, Mr. Chairman, and members of the subcommittee. I thank you for the opportunity——
Mr. PALLONE. I think your—yes, put your mic up.
Mr. FOLKEMER. There it goes. Is that better?
Mr. PALLONE. Yes.
Mr. FOLKEMER. OK. Thank you, Mr. Chairman, and members of the subcommittee. I thank you for the opportunity to be able to testify here before you today.

My name is John Folkemer. I have worked in the Maryland Medicaid program for more than 25 years. And for the past year I have been the Medicaid director.

Medicaid, as we all know, is truly the insurer of last resort. In recent years there has been a significant increase in the number of Americans who are uninsured, as employer-sponsored health insurance has steadily eroded. States have responded to this by covering many of these uninsured families and individuals in their Medicaid and their State Children's Health Insurance programs.

In Maryland in the last 10 years we have added about 200,000 individuals who have lost their health insurance and have come to us to get their insurance coverage. And spending for Medicaid now accounts for 20 to 25 percent of most states' budgets. In addition, of course, as was mentioned this morning, Medicaid insures a lot of individuals that nobody else will insure, such as elderly people in nursing homes who have exhausted their life savings, individuals with disabilities and chronic conditions, and children who have special needs and debilitating diseases.

Over the past year or so, CMS has issued an unprecedented series of Medicaid regulations that significantly shift costs to states and restrict services, leaving states unable to effectively provide access to quality services for the most vulnerable of our citizens. These regulations impose harsh cuts in Federal matching funds under the guise of reducing fraud and abuse. While it is true that there have been instances of abuse—and I don't think anybody would deny that—CMS's response of overarching regulation is excessive, inappropriate, and harmful. Cases of fraud and abuse should be dealt with on a state-specific basis, rather than restricting services and cutting funds from all states.

While all seven regulations addressed in this legislation have adverse impact on the states and their citizens, I would like to focus on just four of them that I think are of greatest concern to Maryland.

Number 1, case management. For Maryland, the case management regulations are probably the most harmful of these regulations. CMS followed the guidance of the DRA in defining case management services in this regulation, but the resulting interim final rule harmfully overreaches the original language and intent in Congress in numerous ways.

Nearly 200,000 people in Maryland receive some type of Medicaid case management services or components of those services, and all of those programs that we have would be affected by these regulations.

To come into compliance with the provisions of the rule Maryland may be forced to leave many vulnerable populations without any access to needed case management services. Transitions from institutions to community living will be much more difficult, resulting in individuals being forced to remain in institutions. The quality of case management provided to recipients could be affected as state oversight becomes more difficult. And administrative costs for both providers and the state will increase dramatically.

Secondly, just a word about rehabilitative services. Many states, including Maryland, use the rehabilitative services option as a way to allow individuals with developmental disabilities or severe mental illness or other chronic diseases, or special needs, to be able to live independently in community-based settings or their own homes, avoiding costly institutional placements. This rule would have a significant impact on certain mental health services and programs, specifically and particularly in Maryland. Right now we have about 30,000 Medicaid recipients in Maryland who would be affected by this regulation.

The third I want to mention is the governmental provider payment rate. The rule imposes new restrictions on payments to providers operated by units of government. While for most states this has a very large impact on their large hospitals or nursing homes, as you heard this morning in some of the testimony, in Maryland we are also concerned about some of the small public safety net providers. This rule would require significant increases in administrative burdens for state and local agencies. All government providers would be required to do cost settlements of the rates each year. Small safety net providers, especially in rural areas, who serve very vulnerable populations may have to discontinue services or reduce the scope and quality of their services. Because for some of these small public clinics and services, the cost of the annual cost settlement could be greater than their entire Medicaid reimbursement.

Finally, a word about graduate medical education. Historically, almost all payers have shared in the cost of providing training of medical professionals in hospitals. Medicare law specifically requires Medicare to recognize that. State Medicaid programs, for the most part, have always recognized this for over 40 years. Now, suddenly, because there isn't any specific language in Title XIX that says states are allowed to pay for it, CMS has come out with these regulations prohibiting states from doing so. Providing funding for GME is essential to help ensure an adequate number of trained medical providers, especially as our country faces a massive physician shortage in the next decade.

So just in conclusion, CMS maintains the eliminating $20 billion in Federal funding for the series of programs that are affected is appropriate. Because some of these things were intended to be paid for by Medicaid in spite of the fact that states have been paying for these for many decades with the approval of CMS.

It is particularly ironic that this philosophy should come at a time when most experts in the field would say that the Nation's health care system is in a state of crisis. Emergency rooms are bursting at the seams. Mental health and substance abuse providers are completely strained. Persons with disabilities are struggling to find more creative alternatives to live independent and productive lives. And an entrenchment by Medicaid would only make these struggles more and more difficult for millions of Americans.

I thank you for the opportunity to testify.

The prepared statement of Mr. Folkemer follows:]

STATEMENT OF JOHN FOLKEMER

Good morning Mr. Chairman and members of the Subcommittee, and thank you for the opportunity to testify at this important hearing. My name is John Folkemer. I have worked in Medicaid for the State of Maryland for more than 25 years, and have been Maryland's Medicaid Director for the past year.

The mission of the Medicaid program, which is a state and Federal partnership, is to provide health care to the neediest and most vulnerable populations in our country. Medicaid currently provides comprehensive coverage to well over 50 million Americans. It is the single largest payer for the long-term care costs that are perhaps the greatest economic and health care challenge that we face as baby boomers approach retirement. Medicaid provides support and services for millions of Americans with a wide range of disabilities that enables them to live independent lives in the community. It is the single largest payer of mental health services; the largest purchaser in the nation of pharmaceuticals; and the source of health insurance coverage for most of the Nation's working poor. Medicaid is the largest source of care for children in low-income families and is the largest payer in most states for maternity and prenatal care.

In recent years there has been a significant increase in the number of Americans without health insurance, as employer-sponsored coverage has steadily deteriorated. States have responded by covering many of these uninsured families and individuals in their Medicaid and State Children's Health Insurance (SCHIP) programs. In Maryland, approximately 200,000 individuals have been added to our Medicaid and SCHIP rolls over a 10-year period, with current enrollment at about 650,000. Spending on Medicaid and SCHIP now account for 20–25% of most states' budgets. However, many states are again facing huge budget shortfalls, creating incredible pressure to figure out how to provide quality Medicaid services to ever expanding populations while operating under increasingly tighter budget constraints.

States have long had flexibility to structure their Medicaid programs to best serve the needs of their beneficiaries in a streamlined, cost-effective manner. Over the past year, the Centers for Medicare and Medicaid Services (CMS) has issued a series of Medicaid regulations that significantly shift costs to states and restrict services, leaving states unable to effectively provide access to quality services for the most vulnerable of our citizens: low-income uninsured children and families; the elderly; and persons with disabilities. The series of regulations aims to restrict states' flexibility and impose harsh cuts in Federal matching funds under the guise of reducing fraud and abuse. While it is true that there have been instances of abuses in claiming Federal Medicaid matching funds, CMS's response of overarching regulations is excessive, inappropriate, and harmful. Cases of fraud and abuse should be dealt with on a state-specific basis, rather than restricting services and cutting funds from all states. The cut in Federal funds comes at a time when the need for services continues to increase, leaving already financially strapped states with additional cost burdens. Maryland feels that it is critical to delay these regulations to allow for consideration of their full impact.

IMPACT IN MARYLAND

While all seven regulations addressed in this legislation have adverse impacts on the states and their citizens, I would like to focus on the regulations that are of greatest concern to Maryland.

CASE MANAGEMENT:

The case management regulations, which took effect on March 3, 2008, are probably the most harmful of these regulations. CMS followed guidance in the Deficit Reduction Act (DRA) of 2005 to issue regulations defining case management services more clearly in order to reduce potential abuses of such services. The resulting interim final rule, however, harmfully overreaches the original language and intent of Congress. Nearly 200,000 people in Maryland receive some type of Medicaid case management services or components of those services, and all of these programs will be affected, potentially putting more than $60 million in federal funds at risk for the State.

To come into compliance with the provisions of the rule, Maryland may be forced to leave many vulnerable populations without any access to needed case management services, or create disruptions and confusion in how they receive them. Recipients may have to change case managers as program structures are changed. Transitions from institutions to community living will be more difficult, resulting in individuals being forced to remain in institutions. Recipients may receive less case management if billing limits are set. The quality of case management provided to recipients will likely be lowered as it becomes more difficult for the State to adequately monitor an expanded array of case managers. Administrative costs for both providers and the State will increase dramatically.

Maryland has long-established case management programs that have been approved by CMS, including targeted case management, case management provided to home and community-based services (HCBS) waiver participants, and administrative case management. The new rule will require restructuring of all of these programs, causing major administrative disruptions and significant additional costs. Medicaid can no longer reimburse for Individualized Education Plan (IEP) services, which are care planning and coordination activities for children aged 3 to 21 performed by schools. This will result in a $20 million cut in funds to school systems. Programs that provide important services to Medicaid recipients but do not meet the complete definition of case management or all of the administrative requirements will lose funding, resulting in cost-shifting to states or termination of programs.

The broad interpretation CMS has taken of the rule to include all case management provided in HCBS waivers is inappropriate and harmful. The strict requirements of the regulations will mean that Maryland Medicaid will lose the ability to effectively monitor and control programs. For example, because case management cannot be required in order to receive other Medicaid services, the State will not be able to ensure proper and cost-effective plans of care for waiver participants. With any willing provider able to enroll as a waiver case manager, the State will have little control over quality of services provided to the most vulnerable populations. Maryland's seven HCBS waivers serve medically fragile adults and children, individuals with developmental disabilities, the elderly, and autistic children.

REHABILITATIVE SERVICES:

Many states use the rehabilitative services option to allow individuals with developmental disabilities, severe mental illness, or other special needs the ability to live independently in community-based settings, avoiding costly institutional placements. Although Maryland has not been able to quantify the fiscal impact, it is clear that this rule would have a significant impact on certain mental health services and programs. It could also have a negative impact on reimbursement for services provided to children in out-of-home placement. Losses in federal funds for these services will result in the need to implement further cost containment, which generally results in decreases in services, or could force individuals who could live successfully in the community to be institutionalized. Approximately 30,650 Medicaid recipients currently receive rehabilitative services that could be affected.

INTERGOVERNMENTAL TRANSFER (IGT):

Medicaid programs do not function alone—it takes collaboration with other governmental agencies and providers such as teaching hospitals, local health departments, school systems, public health agencies, and child welfare agencies to provide a continuum of care to recipients. These collaborations have been encouraged and sometimes mandated by Congress. The rule imposes new restrictions on payments to providers operated by units of government and clarifies that those entities involved in the financing of the non-federal share of Medicaid payments must be a unit of government. In addition, the rule formalizes policies for certified public expenditures and other reporting requirements. This rule will require significant increases in administrative burdens for state and local agencies. All government pro-

viders will be required to cost settle payments on an annual basis. This mainly affects schools and local health departments throughout Maryland. Small safety net providers, especially in rural areas, who serve vulnerable populations, may have to discontinue services or reduce the scope and quality of services. For some small public community clinics and services, the cost of an annual cost settlement may be greater than their total Medicaid reimbursement.

GRADUATE MEDICAL EDUCATION (GME):

Historically, payers have shared in the cost of providing training of medical professionals in hospitals. Medicare law specifically requires these costs to be recognized in establishing reimbursement rates. State Medicaid programs have always recognized their obligation to pay for their fair share of these costs, a practice which has always been approved by CMS.

Nonetheless, because there is no specific language in Title XIX that requires states to pay their fair share of GME costs, CMS is now prohibiting state Medicaid programs from doing so. Providing funding for GME is essential to help ensure an adequate number of trained medical providers, especially as our country faces a massive physician shortage in the next decade. Maryland Medicaid could lose about $7 million in federal matching funds as a result of this regulation.

CONCLUSION

CMS maintains that the elimination of $20 billion in federal Medicaid funding for Medicaid administrative activities in the schools, or rehabilitation services for children with developmental delays, or graduate medical education, or the numerous other affected services and programs is appropriate because these activities were never intended to be part of Medicaid, despite decades of approved State Plan provisions across the nation. There are no appropriations on the horizon to replace this loss of revenue—Medicaid is simply supposed to reduce the scope of its activities. It is particularly ironic that this philosophy should come at a time when most experts in the field would say that the Nation's health care system is in a state of crisis. The emergency rooms of our teaching hospitals are bursting at the seams as they try to provide both emergency and non-emergency care to the 47 million Americans who have no health insurance. A greater awareness of autism spectrum disorders and mental illness among very young children has placed a strain on the entire mental health system. Persons with disabilities are struggling to find more creative alternatives to live independent and productive lives. A retrenchment by Medicaid will only make those struggles more difficult for millions of Americans.

Maryland, like many other states, has been forced to impose new taxes and cost containment initiatives to deal with huge budget deficits. During these difficult fiscal times, it is even more critical that we continue to provide health care to our most vulnerable populations. Implementation of CMS's excessive and damaging regulations will only serve to reduce such critical care. I urge Congress to enact this legislation placing a moratorium on these regulations. CMS created the regulations without sufficient consideration of their impact on Medicaid beneficiaries, providers and states. I encourage an open discussion that is focused on outcomes as well as costs, and that is mindful of the needs of our most vulnerable citizens.

Thank you. I would be happy to try to answer any questions.

Mr. PALLONE. Thank you, Mr. Folkemer.

We will have questions now from the two of us and I will first yield to myself for 5 minutes.

I wanted to start—I wanted to ask Assemblyman Conaway—you are well aware that the legislative process is often slow and deliberative, and it can take states more than one legislative session to adopt proposals or adapt to program changes depending on the—it is important, obviously , to have a predictable process from the Federal Government in order to have states manage their affairs effectively. So what can you tell me about the way that CMS has managed the process with these seven rules that are addressed in this bill? Can states possibly absorb all these changes and cuts at once that they face?

Dr. CONAWAY. Well, we do have concerns about the way CMS has managed this process. They have had a period where they have invited comments from stakeholders. If you look at the comments over the provider tax rule, there were 422 pieces of correspondence received. Only one positive comment. Of the hospital outpatient rule, 91 pieces of correspondence, only one contained a positive comment. And the rehabilitation rule, 1,845 pieces of correspondence, not one in support of the changes, and yet these changes are coming forward anyway, in spite of a lot of advice by stakeholders that these changes are going to cause devastating effects. In working in state legislatures, as you very well know, the ship is not always so easy to turn around. I work in health care. I see patients during the week. I understand how important it is to get people to the suite where I practice so that they can receive—we can work together to advance their health care. I see transportation services as very critical. If those are not there how are they going to be provided? For case management services, finding the resources to get—either to pay for case managers or finding some other way to deliver or coordinate that care. You can't just flick a switch and expect that that service is going to remain. This—it will be very difficult for states to comply with this in a short timeframe.

And when you consider the budgetary constraints that states are under, the options for coming in with alternate ways to deliver the service are very narrow indeed.

Mr. PALLONE. So it is not only that there is a problem though, Assemblyman, but with—for the states, but they really haven't even been consulted effectively. All the comments are saying we don't like this, and nobody's actually made any major effort to address those comments as far as you know.

Dr. CONAWAY. As far as I know. It would appear certainly from the date that I received from my staff. It certainly appears that no one's listening even though the missives are going forward.

Mr. PALLONE. Thank you. I appreciate that.

Let me ask Mr. Folkemer—there seems to be some sentiment that the services provided under the case management benefit or the rehab benefit, or the school-based care is inappropriate because those services are not what people would consider medical. But still they are critical for Medicaid beneficiaries if they are going to arrange for care or transport someone, or coordinate care. While CMS and its allies may not support those services, do you believe there is a clear and important role in Medicaid for them? What would happen to access without those services?

Mr. FOLKEMER. Mr. Chairman, I absolute agree with what you have said. It is critically important. It is especially important because the Medicaid population is not like the commercial population, where all they need basically is medical services and they can take care of themselves. As I said, many people are on Medicaid because they are disabled, because they are elderly, because they have special needs. So these additional support type services are exactly what it is they need, whether it is transportation, it is help getting referrals to providers, help them keeping—complying with what the providers ask them to do. There is a whole series of support services which are absolutely necessary for these populations.

Mr. PALLONE. And then on the first panel, Ms. Turner actually said and I quote, "that Medicaid doesn't support the kind of coordination that would lead to better care and more efficient spending." I was a little shocked by that lack of understanding of what Medicaid does. Isn't the role of the targeted case management benefit, which your state is so concerned with, exactly the kind of coordination benefit that Ms. Turner doesn't think Medicaid provides?

Mr. FOLKEMER. Yes, that is exactly the kind of thing that case management does, and some of the other support services. I would be concerned if she is saying that she doesn't think Medicaid does it now, and yet CMS is trying to take away what authority we have to do it. So I think, if anything, we need more of those services, not fewer.

Mr. PALLONE. OK. Thank you. Thank you, all of you.

Mr. Deal.

Mr. DEAL. Thank you. Mr. Chairman, first of all I would like to ask unanimous consent that a letter to me dated April the 2nd of 2008, from Dr. Michael Bond from Cleveland State University be included in the record.

Mr. PALLONE. Without objection, so ordered.

[The information was not available at the time of printing.]

Mr. DEAL. And I would also like to ask unanimous consent that the full text of the OIG and GAO reports that were late to the rules affected by this bill, of the list of which was provided by CMS as an attachment to Dennis Smith's testimony, be included for the record.

Mr. PALLONE. Again, without objections, so ordered.

Mr. DEAL. Thank you.

Mr. Smith, could you please tell me how the Medicaid program integrity initiatives, including CMS's health care fraud and abuse control programs, produce favorable results for the taxpayers?

Mr. SMITH. Yes. Mr. Deal, thank you very much. One of the things that I think is very important is to have both front-end review and back-end review. Front-end review on the state plans themselves as states are developing state plan amendments to make certain they are consistent with Federal law and regulation, provider taxes, who is a government entity, et cetera, is very important. We have made use of funds to support roughly about 90 FTEs. And I am very proud to say every year that we have made that effort, the amount of money averted in Federal funds at risk has increased. In 2006 those FTEs helped divert $417 million in funds at risk. In 2007 they averted $652 million in FFP at risk. And, again, that is because we are doing a better job on the front end. We do talk to states. That is what the FTEs do. They are in states, they talk, they go to legislative hearings, they talk with Medicaid directors, et cetera. So they are—what they adopt in state plan amendments are approvable in the first place. In many respects we help them to come into compliance, to deal with provider taxes, for example, which is very complicated, and assist the states to develop state plan amendments that are in compliance. On the back-end the Deficit of Reduction Act—thanks to your leadership, Mr. Deal—provided funding, direct-line funding, for Medicaid integrity that was never there before. Now we have a dedicated stream of funding to look at the fraud and the abuse side on the

back end by auditing providers. And while we have now been through a contract period to procure the expertise that we need to do those audits, those audits will be occurring this year. We will start this year, and we will grow over time to ensure integrity on the back-end, but both ends are very important.

Mr. DEAL. If this bill passes and these regs are prohibited from going into place, does that inhibit your agency from being able to deal with the waste, fraud and abuse?

Mr. SMITH. Mr. Deal, I believe that it would. Again, I think the broad language of it would be very problematic. It very well may—even reviewing a state plan could put us in court.

Mr. DEAL. One of the things we have heard from states, and heard in the first panel, is this issue of requiring a non-governmental health care provider to pay back part of their Medicaid money to the state. And I personally think that is a very problematic issue. But I understand that the state of California has tried to address this problem in a positive way. Could you tell us what California has done and has it worked?

Mr. SMITH. Yes, Mr. Deal. And, again, I agree with you. Medicaid's a matching program, and if the state isn't putting its share of the program you are eroding the very framework of the Medicaid program. California—we developed a hospital financing waiver with the State of California, I believe 2 years ago, really based on the rules that are now part of our regulations. The result of that has increased hospital revenues by 12 percent, which is again why we say our rules actually protect the provider from—they should be getting the full measure of what they provided on behalf of the Medicaid recipient. They provided the service. They should get the money. They should be able to keep the money, and not have to return it on the back-end.

Mr. DEAL. Because the effect is that it dilutes the states legitimate share of participation in Medicaid, does it not?

Mr. SMITH. You are precisely right.

Mr. DEAL. And by doing that it shifts that burden by increasing the Federal money to other states and taxpayers all across the country?

Mr. SMITH. If the state is not providing up its share of the Federal dollars, then from—the rest of the states are contributing more than what they should have.

Mr. DEAL. Thank you. I apologize. I didn't get a chance to ask you gentleman any questions.

But thank you, Mr. Chairman.

Mr. Smith, the studies from GAO and the Inspector General's Office are rather voluminous. Is it my understanding that your reference in your testimony includes a list of those with the linkage to where they can be found?

Mr. SMITH. That is correct, Mr. Deal.

Mr. DEAL. OK. Well, Mr. Chairman, then I would modify my initial request to simply have the reference made to the linkages, rather than include their, I believe, 1,000 pages, maybe.

Mr. SMITH. I think we have the stack of them over here.

Mr. DEAL. Yeah, we got a stack up here. I would modify that request to include the linkage and the summaries.

Mr. PALLONE. Without objections, so ordered.

And let me just ask one more thing, Mr. Smith. On March 19 Mr. Dingell, myself and Mr. Waxman sent a letter to Secretary Leavitt requesting further information about state use of contingent fee consultants and CMS actions to restrict this use. The response was due March 31, but the Committee has yet to receive a response. When can we expect that we will get a response to that?

Mr. SMITH. Mr. Chairman, I was very hopeful that you would have had it this morning before I appeared. We had a little bit of logistics on our end. The administrator's on travel, but we have prepared a response and you will be getting it very shortly.

Mr. PALLONE. So can we get it in the next few days?

Mr. SMITH. I believe that, yes, sir.

Mr. PALLONE. All right. Thank you.

All right. That concludes our questions. And I do want to thank all of you again for being here. And I want to remind members that we can submit additional questions for the record to be answered by the relevant witnesses. So you may get additional questions from us in writing, and they should be submitted to the Committee clerk within the next 10 days, and then we will notify you.

But again, thank you. And particularly the Assemblyman from my state. I appreciate your coming down here for us and testifying. I know your time is—being a doctor and being an assemblyman I don't know how you do it all. But God bless you for doing that.

And without objection this meeting of the subcommittee is adjourned.

[Whereupon, at 1:40 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

STATEMENT OF HON. HEATHER WILSON

Thank you, Mr. Chairman, for holding this hearing today on H.R. 5613, the Protecting the Medicaid Safety Net Act of 2008. H.R. 5613 would place a moratorium on seven different Medicaid regulations through April 1, 2009.

I share the concern of many here today about these Medicaid rules—not because they are bad policy, although clearly some have been ill-conceived, but because they were implemented without congressional input and approval.

One of these rules in particular would affect New Mexico and I want to discuss that particular rule.

CMS–2258–P puts limitations on intergovernmental transfers and certified public expenditures that states use to help pay their share of the federal Medicaid match, and also places cost limitations on providers operated by units of government.

These are fancy words to say 1) states can't use certain local taxes to put up their share of the match, and 2) Medicaid is only going to pay the cost of services and not supplemental payments to public hospitals known as the upper payment limit (UPL).

This rule hurts New Mexico in two ways.

We have a special program called the Sole Community Provider program that helps hospitals in rural communities in New Mexico with only one hospital receive funding for the care of indigent patients.

Our Sole Community Provider program uses local property taxes and gross receipts taxes to put up the county's share of funds that are sent to the state and used for matching funds. It does not include the "recycling" problem identified elsewhere, that supposedly is the intent of the IGT Rule. However, CMS has said that county indigent funds would not be allowable for intergovernmental transfers and several independent analysts have told us this rule would terminate NM's Sole Community Provider Program.

This would result in loss of Federal funding of $114 million annually to rural hospitals in NM, undoubtedly impacting patient care and quality.

I've heard from hospital administrators and county officials from around New Mexico about what a calamitous impact this regulation would have on the health care in their communities.

The other part of this rule, limiting Medicaid reimbursement for public hospitals to cost, would result in a loss of revenue to the University of New Mexico Hospital of about $40 million annually. This is the only Level 1 Trauma Center in the State of New Mexico and is a main source of emergency care for the City of Albuquerque, particularly lower-income patients.

Because of my concern with this regulation, I have signed on as a cosponsor of the Public and Teaching Hospital Preservation Act, H.R. 3533, sponsored by Reps. Eliot Engel and Sue Myrick. This bill would extend the moratorium on this rule for one more year and is included in the bill being discussed today, H.R. 5613. I have decided to become a cosponsor of H.R. 5613 as well, because it is the legislation being considered and would help avoid the loss of an important funding stream for New Mexico hospitals.

I am also concerned about some of these other regulations including targeted case management and rehabilitative services, and their effect on care for the developmentally disabled and those with mental illness.

I look forward to hearing the testimony of the witnesses here today.