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HEARING ON THE ADMINISTRATION'S

REGULATORY ACTIONS ON MEDICAID:

THE EFFECTS ON PATIENTS, DOCTORS,

HOSPITALS, AND STATES

Thursday, November 1, 2007

House of Representatives,

Committee on Oversight

and Government Reform,

Washington, D.C.

Committee Hearings

of the

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The committee met, pursuant to call, at 10:05 a.m. in room 2157, Rayburn House Office Building, the Honorable Henry A. Waxman [chairman of the Committee] presiding.

Present: Representatives Waxman, Towns, Cummings, Kucinich, Davis of Illinois, Watson, Higgins, Braley, Cooper, Van Hollen, Hodes, Murphy, Sarbanes, Davis of Virginia, Shays, Mica, Platts, Foxx, Sali, and Jordan.

Also Present: Representative Engel.

Staff Present: Phil Barnett, Staff Director and Chief

Counsel; Kristin Amerling, General Counsel; Karen Nelson, Health Policy Director; Karen Lightfoot, Communications Director and Senior Policy Advisor; Andy Schneider, Chief Health Counsel; Teresa Coufal, Deputy Clerk; Caren Auchman, Press Assistant; Ella Hoffman, Press Assistant; Kerry Gutknecht, Staff Assistant; Bret Schothorst, Staff Assistant; Art Kellerman, Fellow; Tim Westmoreland, Consultant; Jennifer Safavian, Minority Chief Counsel for Oversight and Investigations; Kristina Husar, Minority Counsel; Patrick Lyden, Minority Parliamentarian and Members Services Coordinator; Benjamin Chance, Minority Clerk.

Chairman WAXMAN. The meeting of the Committee will please come to order.

Throughout this year our Committee has held a series of hearings on making Government work again. We have focused on programs or agencies that once were effective but are now broken or dysfunctional. Today's hearing examines one of our Government's most important agencies, the Centers for Medicare and Medicaid Services at the Department of Health and Human Services. Called CMS for short, the Agency is responsible for administering the Country's two largest health insurance programs, Medicare and Medicaid, which cover nearly 100 million Americans at a cost of over $600 billion. As the largest single purchaser of health care in the Country, CMS has enormous power to do good or do harm.

Medicaid is funded jointly by the Federal Government and the States. It covers more than 60 million low-income Americans. Medicaid is the largest insurer of infants and children in the United States, covering more than 28 million kids. It is also the largest insurer of people with disabilities, covering almost 10 million people. Medicaid is the single largest source of funding for our Nation's public teaching hospitals, children's hospitals, and community health centers and public clinics--programs that benefit not only the poor, but everyone in their communities.

Unfortunately, little notice has been paid to a series

of Medicaid regulations proposed by the Administration over the last ten months, but these proposals would have enormous impacts. They are, in my opinion, a thinly disguised assault on the health care safety net. If implemented, they would cause major disruptions to State Medicaid programs and the people and institutions that depend on them.

In total, the proposals would shift at least $11 billion in cost to State and local governments, the largest Medicaid regulatory cost shift in memory. Since these are Federal matching funds, the real cuts in programs at the local level could be at least twice this amount. This could force States to make a difficult choice: either raise taxes or cut vital services.

This morning our Committee will examine six rules the Bush Administration has proposed. Three of these proposed rules target some of our Nation's most vulnerable citizens by cutting funding and services to disabled children, disabled adults, and elementary school children. The other three would cut billions of dollars in Federal funding from some of our Nation's most vital health care institutions: teaching hospitals, safety net providers, and public hospitals that support trauma centers, burn units, and other vital but unprofitable programs that benefit everyone in the community, insured and uninsured, alike.

What is almost as troubling as the impact of these rules

is the manner in which they are being pursued. Some of these proposals have been proposed in the past, but when they were proposed 300 Members of the House and 55 Members of the Senate signed letters to Secretary Leavitt opposing the efforts.

Undeterred, CMS pressed ahead and proposed these regulations. During the 90 day comment period on the proposed rule, CMS received more than 400 negative comments. The bipartisan National Governors Association, bipartisan National Council of State Legislatures, bipartisan National Association of Counties, numerous State and county governments, and a large number of hospital organizations, professional associations, and consumer groups all raised concerns. Not one person wrote in support of the rule.

In response, Congress imposed a one year moratorium on CMS' authority to implement the rule. Despite all this, CMS is still moving ahead.

This rule that I am referring to is just one example. All of the proposed regulations are made up out of whole cloth by CMS. They are reinterpreting laws, some of which have not been changed in 40 years. These changes, in my opinion, are not anchored in statute. They do not have the support of the Congress, and they should deserve no deference from the courts.

These actions and the subsequent issuance of five more

proposals that shift an additional $7 billion in costs to the States bring us to today's hearing. The first panel will describe the effects of these rules on individual Americans, their community providers, and the States. Dennis Smith after the, the official at CMS who wrote these regulations, will join us on the second panel.

I think that we need to look at what is happening very, very carefully at CMS, and I hope that they will look very carefully at the hearing record today, because, let's be clear, these regulations are not about program integrity. If they are redefining guidance and improving accountability, that would be one thing; but if they are prohibiting services that have been successful for decades in order to cut funding that Congress has specifically preserved, this is not a careful surgery on Medicaid, this is a reckless amputation.

I hope CMS will listen carefully to what our witnesses and the members of the Committee have to say about their proposals, and I hope they will go back to the drawing board. If there are truly fiscal integrity concerns that need to be addressed through new rules, this Committee would work with CMS to accomplish that goal. There is no other Committee that has been as active in trying to make sure that we have integrity in our fiscal management than this Committee has been.

I look forward to the witnesses, and I hope that this

hearing will have an impact.

I ask unanimous consent that my complete opening statement be part of the record in its entirety. Without objection, that will be the order.

[Prepared statement of Chairman Waxman follows:]

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Chairman WAXMAN. Mr. Davis?

Mr. DAVIS OF VIRGINIA. Thank you. Mr. Chairman, I want to thank the Chairman for holding today's hearing to review six proposed Medicaid regulations.

I hope these hearings will examine the justification of the proposed changes and their potential impacts not only on the individual beneficiaries, but on the financial sovereignty of the program, as a whole. Preserving the integrity of Medicaid is of great importance to this Committee, and most importantly to millions that it serves.

Medicaid is one of the fastest-growing parts of the Federal budget. It is one of the fastest-growing parts of State budgets, as well. But it is also the safety net provider within the health system offering care to our most vulnerable citizens.

In 2006 over 63 million individuals relied on Medicaid program, including children, pregnant women, individuals with disabilities, and the elderly. Given the important role Medicaid plays in the health care system, Congress, States, and the Centers for Medicare and Medicaid Services, CMS, need to be vigilant stewards of Medicaid's financial resources.

Medicaid surpassed Medicare in 2002 to become the largest Government health care program. In 2005 the cost of providing this care exceeded $300 billion, and it is projected to double in a decade. Such rapid growth strains

Federal and State budgets. Fraud and abuse, along with questionable financial arrangements, can contribute to this growth and possibly jeopardize legitimate Medicaid services.

Medicaid is jointly financed by State and Federal governments. The Federal share of funding is between 50 and 77 percent. While Federal participation is necessary and appropriate, this financing arrangement can incentivize States and providers to shift the cost of non-Medicaid services to the Medicaid program in order to obtain additional Federal funds.

While this is an understandable motivation, especially in light of the pressures on State budgets, it does put additional strain on the Medicaid program and it should be evaluated.

For these reasons and others, the GAO has placed Medicaid on its high-risk list. The GAO found that inadequate fiscal oversight has led to increased and unnecessary Federal spending. Specifically, GAO has pointed to schemes that leverage Federal funds improperly, and inappropriate billing of providers serving program beneficiaries as factors in this designation.

For this reason, I am pleased that Dr. Marjorie Kanof, the Managing Director of Health Care at GAO, is here to speak to these overriding risk factors and fraud and abuse concerns within the Medicaid system.

In the last year, CMS has issued a number of proposed Medicaid regulations. My opening statement doesn't afford me sufficient time to comment on all six. I look forward to an informative discussion that will hopefully lead to a more clear understanding of the genesis of these regulations and their impact on Medicaid beneficiaries, States, and providers.

I do understand that some of these regulations were, in part, prompted by CMS' concern about the diversion or inappropriate use of Medicaid funds that may not have violated the letter of the law or regulations but are inconsistent with the spirit of the program. For example, as detailed in the proposed rehabilitative services regulation, Medicaid funds have been used to pay for services in wilderness camps in which juveniles are involuntarily confined. It would seem such programs are primarily within the domain of the Justice System and would be provided by the State, regardless of the juvenile's Medicaid eligibility. As such, juvenile detention wilderness camps may be better funded as part of State justice system as opposed to Medicaid health services.

As with any effort to improve fiscal integrity of the Medicaid program and address potentially inappropriate uses of scarce Medicare sources, a delicate balance must be achieved to ensure that legitimate needs and services of

beneficiaries are not, in fact, harmed.

I anticipate that a good portion of today's hearing will focus on whether or not CMS has struck the right balance in these proposed regulations, and I look forward to witnesses' feedback on this.

With that in mind, I want to thank today's witnesses for participating in this hearing, and I want to thank the chairman for calling it.

[Prepared statement of Mr. Davis of Virginia follows:]

********** INSERT **********

Chairman WAXMAN. Thank you, Mr. Davis.

Without objection, since we have eight members on the first panel, I would like to proceed without any further opening statements.

Let me ask unanimous consent that Congressman Elliott Engel, who is not a member of our Committee, may wish to join us, and I would ask unanimous consent he be permitted to participate in this hearing.

Mr. DAVIS OF VIRGINIA. No objection.

Chairman WAXMAN. That will be the order.

Now we are going to receive testimony from the witnesses on our first panel.

Mr. David Parrella is the Director of Medical care Administration for the Connecticut Department of Social Services. He is testifying on behalf of the National Association of State Medicaid Directors.

Ms. Barbara Miller is a resident of Rockville, Maryland. Ms. Miller is a former Medicaid beneficiary who benefitted from rehabilitation services, and she is testifying on behalf of the National Council for Community Behavioral Health Care.

Ms. Twila Costigan is Program Manager for the Adoption and Family Support Program at Intermountain in Helena, Montana. Intermountain is a nonprofit organization that provides services to children under severe emotional distress. She is testifying on behalf of the Child Welfare

League of America.

Ms. Denise Herrmann is a school nurse with St. Paul public schools in St. Paul, Minnesota. She regularly works with the Medicaid children in the St. Paul school system. She is testifying on behalf of the National Association of School Nurses.

Mr. Alan Aviles is President of the New York City Health and Hospitals Corporation. He is testifying on behalf of the National Association of Public Hospitals.

Dr. Sheldon Retchin is Vice President for Health Services at the Virginia Commonwealth University Medical College in Richmond, Virginia. He is testifying on behalf of the American Association of Medical Colleges.

Dr. Angela Gardner is a practicing Emergency Physician at the University of Texas Medical Branch in Galveston, Texas, and she is testifying on behalf of the American College of Emergency Physicians.

Last but not least, Dr. Marjorie Kanof is Managing Director of Health Care for the Government Accountability Office in Washington, D.C. She is testifying on behalf of the GAO.

I welcome all of you. You are, of course, testifying from your own personal knowledge and experiences, as well as on behalf of other organizations who share your point of view. We thank all of you for being here.

It has been the practice of this Committee that all witnesses that testify before us are asked to be put under oath, and so I would like to ask each if you if you will to please rise and raise your right hand.

[Witnesses sworn.]

Chairman WAXMAN. The record will indicate that each of the witnesses answered in the affirmative.

We have prepared statements from you, and those statements will be made part of the record in their entirety. What we would like to ask each of you to do is to limit the oral presentation to no more than five minutes. You will have a clock in the center. It will be green. When there is one minute left, it will turn yellow. And then when the five minutes are up, it will turn red. We would like you at that point to conclude your testimony.

I know you have a lot to say, and it is difficult to say in such a short period of time, but it is the only way we can hear from everybody and get questions and answers. But the whole statement will be in the record expressing all of your views, which is what I did in my opening statement, because I have a lot of strong views on this subject which I had in the opening statement, and I want it to be in the record.

Mr. Parrella?

STATEMENTS OF DAVID PARRELLA, DIRECTOR, MEDICAL CARE ADMINISTRATION, DEPARTMENT OF SOCIAL SERVICES, STATE OF CONNECTICUT, HARTFORD, CONNECTICUT, AND CHAIR, EXECUTIVE COMMITTEE, NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS (ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS); BARBARA MILLER (ON BEHALF OF NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE); TWILA COSTIGAN, PROGRAM MANAGER, ADOPTION AND FAMILY SUPPORT PROGRAM, INTERMOUNTAIN, HELENA, MONTANA (ON BEHALF OF THE CHILD WELFARE LEAGUE OF AMERICA); DENISE HERRMANN, SAINT PAUL PUBLIC SCHOOLS, SAINT PAUL, MINNESOTA (ON BEHALF OF THE NATIONAL ASSOCIATION OF SCHOOL NURSES); ALAN AVILES, PRESIDENT, NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS); SHELDON RETCHIN, VICE PRESIDENT FOR HEALTH SCIENCES AND CEO OF HEALTH SYSTEM, VIRGINIA COMMONWEALTH UNIVERSITY, RICHMOND, VIRGINIA (ON BEHALF OF THE AMERICAN ASSOCIATION OF MEDICAL COLLEGES); ANGELA GARDNER, ATTENDING EMERGENCY PHYSICIAN, UNIVERSITY OF TEXAS MEDICAL BRANCH, GALVESTON, TEXAS, AND VICE PRESIDENT, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ON BEHALF OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS); MARJORIE KANOF, MANAGING DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF DAVID PARRELLA

Mr. PARRELLA. Thank you, Chairman Waxman. Good morning Congressman Davis, Members of the Committee. My name is David Parrella. For the past ten years I have had the privilege of serving as Connecticut's Director of Medical Care Administration. I am currently the Chairman of the National Association of State Medicaid Directors, an affiliate of the American Public Human Services Association.

Thank you for the opportunity to speak briefly with you today about the recent spate of regulations promulgated by my colleagues at the Federal Centers for Medicare and Medicaid Services, known as CMS.

Let me be clear that, regardless of our differences on these issues, I do regard Dennis Smith and his staff at CMS as colleagues, and I share their commitment to be good custodians of the public dollars that we spend on health care.

Let me begin by summarizing the broad mission of the Medicaid program, which is a State and Federal partnership to provide health care to the neediest and most vulnerable populations in our country.

Medicaid currently provides comprehensive coverage to over 63 million Americans. It is the single largest payer for the long-term care costs that are perhaps the greatest

economic challenge that we face in health care as members of my own generation approach retirement.

But Medicaid is more than a long-term care program. It is generally the largest health care program, if not the largest program, period, in most State budgets. It 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.

As you debate the future of the State children's health insurance program, please remember that 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.

Across this immense landscape of health care delivery that is literally from cradle to grave, Medicaid programs have been encouraged, and in many cases mandated, by Congress to work in partnership with other State and Federal programs that touch upon the same populations. Teaching hospitals and substance abuse programs, programs for children with special education requirements and developmental delays, programs for children in the child welfare system, residential placements for postal with developmental disabilities, community-based

services for persons with mental illness and HIV, child immunization programs and outreach programs to schools to reach DDN-entitled children. All these programs have benefitted from collaboration with Medicaid programs around the Country as a source of Federal matching funds to help States meet the mandates placed upon them by Federal laws regarding the early and periodic screening, diagnosis, and treatment program--known as EPSDT--IDEA, the Americans with Disabilities Act, et cetera.

We have done so economically. National budget figures show a very low rate of growth of 2.9 percent in the Medicaid program in fiscal year 2007. Providers will tell you that the rates that we pay for health care services are far from exorbitant. Furthermore, we manage the program in an indirect cost rate that would be the envy of any CEO in the private market.

So, despite the occasional messiness that ensues in a program of this size, we are not a runaway train on spending. Yet, in recent months, we have experienced a stealthy release of regulation after regulation seeking to reduce the scope and breadth of the Medicaid program. We have seen regulations that would limit facilities that could be reimbursed as public facilities, that would eliminate payment for graduate medical education, regulations that would impose burdensome new accounting measures on the funding for

community-based services, and limit the ability to partner with the schools, where millions of Medicaid-eligible children can be enrolled and served.

CMS is seeking to place new limits on how States are able to raise their required State's share for the Federal match, and perhaps most disturbingly, CMS is attempting to redefine what services can be covered under Medicaid as part of the rehabilitation State plan option, likely the single greatest vehicle for creativity and the design of programs for persons with life-long needs.

Now, CMS officials will tell you that they do not seek to harm the Medicaid program, and I am sure they are sincere in this belief. Their rationale is based largely on a two-part premise that allowing Federal matching funds under Medicaid for these purposes is inevitably too tempting for the States and will lead them to create arcane schemes to draw down excess Federal revenues for services that were traditionally a State responsibility.

Let me say here, as someone who has worked in Medicaid for the past 20 years, that they have a legitimate concern regarding program integrity, especially when times are tight in State budgets. But the other part of the premise is simply wrong. They maintain that the elimination of $20 billion in Federal Medicaid funding for Medicaid administration activities in schools or rehabilitation

services for children with developmental delays or graduate medical education is appropriate because these activities were never intended to be part of Medicaid, despite decades of approved State plan amendments across the Nation.

CMS' argument continues that ''If States want to fund these activities, they can simply appropriate more money. Special education is purely the responsibility of the Education Department. Services for persons with mental illness should be under the purview of SAMHSA, and disease prevention under Public Health, and medical education is limited to funds appropriated in the budgets of the State teaching hospitals.''

However, there is no new appropriation on the horizon to replace Medicaid funding for these services through Federal IDA legislation or elsewhere, and Medicaid is simply reduced in the scope of its activities.

It is surprising 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 47 million Americans who have no health insurance.

A greater awareness of autism and 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 these struggles more difficult for millions of Americans at a time when no comprehensive reform of the health care system is even on the horizon.

We are apparently unable to agree on what income levels should qualify a child to receive assistance with health care under S-CHIP, much less comprehensive health reform.

As Chair of the National Association of State Medicaid Directors, I applaud your efforts to review some of the changes that CMS officials have placed. I further appeal to you to continue your efforts to expand the moratoriums that you have already placed on some of these regulatory initiatives. It is the belief outstanding the National Association of State Medicaid Directors that these issues need to be part of a broader debate on the future of health care here in these chambers. On many of these issues you did debate them during the discussion that led to the Deficit Reduction Act and chose not to act.

Please do not allow CMS to further limit the ability of the States to derive their share of Medicaid from taxes imposed on medical providers.

Please do not allow CMS to eliminate the option for States to use Medicaid funding to pay for graduate medical

education.

Please do not permit CMS officials to jeopardize the future of children with developmental disabilities by subjecting the services they receive to an artificial distinction between having lost their cognitive abilities or never having had them at all.

Please do not force persons with disabilities back into institutional settings because States cannot match cost report standards for the community-based services they receive to a Medicare institutional standard.

Please do not cut off information gathered by school personnel from helping States to determine eligibility for their programs.

Please do not dictate to States what facilities can be designated units of government for reimbursement purposes.

And Please do not take hospital reimbursement back to the future by mandating retro cost-based methodologies.

[Prepared statement of Mr. Parrella follows:]

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Chairman WAXMAN. Thank you, Mr. Parrella. I gave you a little extra time.

Mr. PARRELLA. Sorry, Mr. Chairman.

Chairman WAXMAN. I appreciate that testimony on behalf of all the States that are running the program actually at the State level, which is, of course, a Federal and State program. Thank you very much.

Ms. Miller, we would like to hear from you.

STATEMENT OF BARBARA MILLER

Ms. MILLER. Chairman Waxman and distinguished members of the Committee, thank you for the opportunity to testify this morning on behalf of the National Council for Community Behavioral Health Care. My name is Barbara Miller.

Today I am on the road to recovery from a serious mental illness. I am a program assistant at the Hearing Loss Association of America. Before starting that job, I did a lot of volunteer work for senior citizens and people with physical disabilities. I am also deaconess in the Word of Hope Fellowship Church. At the church I volunteer as assistant director of the youth department. There is a teenage girl in my apartment building who needs a steady, sensible adult influence, and I am trying to provide that to her as a mentor.

But my future didn't always look so bright. I was first diagnosed with bipolar disorder in the early 1970s. I lived in the Springfield State Hospital in Sykesville, Maryland, for two and a half years. Chairman Waxman, it was a terrible experience. The doctors there struggled to give me a proper diagnosis, and I have to tell you the truth: it was like living in a warehouse.

That is what happened to most people with serious mental

illnesses in the 1960s and the 1970s: they were warehoused in State mental hospitals.

However, with the help of treatment, rehabilitation, and housing provided by Threshold Services in Montgomery County, Maryland, I got where I am today.

When I first started participating in rehabilitation services in 1990, I received assertive community treatment at a house where I lived with several other people. Staff would come out regularly to check on me, measure progress on my treatment plan, and see how I was responding to medications. They always provided training about living with mental illness to the pastor and his wife who ran the house.

Some time ago, I moved to the Halpine Apartments. It was a huge step for me because it was the first time I had lived on you own for many, many years.

Threshold Services provided counseling to me during the transition and offered groups where people could support each other and not become isolated.

Threshold Services runs a residential rehabilitation program and off-site psychiatric rehabilitation teams which serve a combined total of 250 people. These rehabilitation programs are important because they prepare people with serious and persistent mental disorders to go back to work and cope with life in the community. Threshold also helps 40 people choose, get, and keep jobs where they work side by

side with non-disabled individuals through their supportive employment initiative, in partnership with St. Luke's House. This is tremendously impressive, because the nationwide unemployment rate among people with severe mental illnesses exceeds 80 percent.

Finally, Threshold has a psycho-educational day program that aims to develop community living skills and improve interpersonal relationships.

With the help of treatment, rehabilitation, and housing provided by Threshold services, I got to where I was to where I am, and now Threshold services helps me maintain my success. So now I give back as a member of the board of directors. God and the members of my church are with me all the way. It takes a lot of faith in God to persevere. Now I give back as a deaconess and assistant youth director in the church.

I was supported by public assistance; now I give back by working and paying taxes.

Mr. Chairman, I am told by the National Council that almost every service that you have heard me describe during this testimony--assertive community treatment, psychiatric rehabilitation, and psycho-educational day programs--are in jeopardy because of a new rehabilitation option rule. In addition to medication and therapy, it is worth noting that these rehabilitation services permit people like me to live

in the community and make a contribution to the community. If the Federal Government withdraws financing from them, many more people with serious mental disorders will end up in emergency rooms, inpatient hospitals, nursing homes, or in the prison system.

I want to conclude this testimony with a simple plea: please don't send people with mental illnesses back to places like Springfield State Hospital. We have fought too hard and we have come too far to go back now.

[Prepared statement of Ms. Miller follows:]

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Chairman WAXMAN. Thank you very much, Ms. Miller, for that testimony.

Ms. Costigan?

STATEMENT OF TWILA COSTIGAN

Ms. COSTIGAN. Good morning, Mr. Chairman, members of the Committee. My name is Twila Costigan. I live in Helena, Montana, and I just want to make it clear that we do have plumbing in Montana. Even though we live way out there in the west, we do have it.

I am here on behalf of the Child Welfare League of America, the Montana Children's Initiative--which is a group of providers across the State of Montana--and Intermountain Children's Home.

Intermountain Children's Home is a magical place where we seek to restore hope to children and their families. We deal only with children with serious emotional disturbance.

I am going to talk to you a little bit about how kids get to be SED, or seriously emotionally disturbed. I want to talk to you about two kids. One's name is Johnny, the other's name is Susie.

Johnny is a young infant. As we all know, the first three years is when your brain is going crazy up there wiring, making you who you are going to be, giving you the skills that you will need to be successful in the community.

Johnny lays in his crib and he cries because he needs his diaper changed, because he is hungry, because he is just

not comfortable with where his mom is, or his caregiver is. Somebody comes to Johnny. Somebody picks Johnny up, and somebody looks at Johnny and says, you are beautiful. You are my son. You belong. I love you.

I want to talk about Susie next. Susie cries because she is hungry or she needs her diaper changed or she's just not comfortable with where people are. She doesn't feel safe. For Susie, people don't come often enough. People don't pick her up and look in her eyes and talk to her and tell her that she is beautiful and that she is loved and that she belongs. Susie will probably some day be a seriously emotionally disturbed child, removed from her birth home, in the custody of the State, placed in foster care homes, maybe more than one. The average placement is three.

For Susie and for Johnny and for each and every one of us, we are born with a drive to have relationships with other people. It is what we are here for.

After a while, kids like Susie quit crying. Nobody is taking care of them, and they are not going to let anybody into their world. These are the kids who are most severely disfigured by adults in their life. Susie is driven to attach, to connect with this other human being. For our seriously emotionally disturbed kids, most of the time that adult that they are driven to attach to is the one who provides the trauma that leads to the serious emotional

disturbance.

In Montana we have a continuum of care. We provide services in the home, in the birth home, to try to keep kids in the home, which is always the best option. We have short-term foster care. Some of those kids are placed in adoptive care. The seriously emotionally disturbed children are a very small percentage of the kids who are in foster care. Most of those kids either go back to their birth home--about 77 percent in Montana--or a relative, or they are returned to their other parent. A small percentage of them are adopted.

For our program, the rehabilitative services allow us to help these kids to bring hope into their lives, to provide in-home services, to help their parents learn how to deal with them. Our continuum of care is the preservation in the beginning, in the birth home, foster care, therapeutic foster care, therapeutic group home care, residential treatment. The rehab services are a huge piece of the funding of therapeutic foster care and therapeutic group homes.

It is really important for these kids to have some hope, and so I ask you, as you deliberate, as you think about this, think about Susie, who cried and cried and cried and nobody came to help her. Keep the rehab services intact and allow places like Intermountain and other wonderful places across the Nation to provide hope to these children who are our most

vulnerable citizens and dependent on us as adults.

Thank you.

[Prepared statement of Ms. Costigan follows:]

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Chairman WAXMAN. Thank you very much, Ms. Costigan.

Ms. Herrmann?

STATEMENT OF DENISE HERRMANN

Ms. HERRMANN. Mr. Chairman, Mr. Davis, and members of the Committee, my name is Denise Herrmann and I am a school nurse from St. Paul, Minnesota. I am privileged to be here today representing the National Association of School Nurses on this critical issue of Medicaid funding regulations.

I commend the Committee for bringing attention to the fact that the Centers for Medicare and Medicaid Services have been issuing proposed rules that, if finalize, will negatively impact the lives of school children and the practice of school nursing.

Through my testimony I hope I can explain how school nurses are involved with Medicaid administrative claiming in the areas of eligibility, enrollment, and referrals, and perhaps the best way to do this is to tell you the stories of school nurses, children, and families from across the United States.

Healthy children learn better. School nurses are doing everything they can within Medicaid regulations to enroll eligible children and make appropriate medical referrals. How do we work with Medicaid eligibility? Parents routinely ask school nurses, Where do I go to begin this process of applying for Medicaid? How do I know my child's eligible?

How do I enroll?

Our school nurses located in Chairman Waxman's District tell us that in this past month 18 families have gotten medical assistance through the case management and case work of school nurses. This is an appropriate use of Medicaid claiming dollars. They are helping children access much-needed medical and dental care and are keeping them out of expensive and time-consuming emergency health care facilities.

Regarding enrollment, here is a scenario that happens regularly in my district. I call a mother and I say, Your child is in my office. This is the second time today. Their asthma is out of control. They are coughing. They are wheezing, and their emergency medication doesn't seem to be working.

I ask the mother, Are they taking their regular controller medication that prevents asthma attacks? No. We stopped a month ago. We lost our health insurance and it costs $120 to get that medication this month. I was hoping he would get by without. And can you keep him in school, because I can't afford to miss work to come and get him.

I remind her that her son was hospitalized a year ago because he hadn't been on his controller medications and I make a promise then to help her find health care for her child and get in one of the State programs.

Health needs and problems are not something children leave at home. They come to school for six to eight hours a day with their health needs and their problems. Parents feel comfortable and they trust the school nurse. It is the school nurse who is often the child's first and only access into that health care system. If society doesn't want our children to be left behind, then we need to be there to help them to be healthy, stay in school, and achieve academic success.

Here is a typical referral example for a little girl I will call Amanda. She is a second grader and has type I diabetes and she needs insulin injections four to six times a day and has to test her blood sugar six to eight times. After being gone six months, she came back to our school district without any health insurance. Her diabetes is out of control. The mom had no supplies to test her blood sugar, and only enough insulin to last a week, and no money to buy any more.

It was the school nurse who managed Amanda's care and worked closely with a local clinic to obtain insulin supplies, insulin samples, syringes, test strips so that diabetes could be brought under control. These actions prevented Amanda from being hospitalized over the next five months until she was eventually covered by Medicaid.

Members of this Committee, I know you must have to deal

with lots of tedious and faceless numbers and regulations regarding this issue. I want to put one more face on this. True story, a little girl I will call Ann. Her dad came to enroll her in our school district and she had a heart condition, and the nurse began the paperwork to get her enrolled in Medicaid, but in the meantime had to find a cardiologist who would see her and give her the medication she needed. Members, it is very hard to find a cardiologist who will take care of a kid without health insurance.

I am happy to report that Ann is healthy and doing well today, but without the school nurse's persistence and intervention this family would have had to pursue much more expensive health care, such as a hospitalization or an emergency room visit for a condition that was treated by outpatient care.

In addition, the process for this successful outcome would not have happened if the proposed rule to eliminate Medicaid administrative claiming by schools was in place.

From these examples, I hope you will understand why our association is in disagreement with the CMS position that school-based administrative activities performed by school nurses fail to meet the statutory test of being necessary for the proper and efficient administration of a State plan.

According to the Kaiser Commission, children represent half of all Medicaid enrollees, but only account for 17

percent of total program spending. Therefore, children are by no means draining the fund.

On behalf of the National Association of School Nurses, I implore this Committee to do whatever they can to let CMS know the harm that would occur by changing certain Medicaid regulations for administration claiming. It is painfully obvious to school nurses, as we work in these public systems, that by eliminating the Federal financial participation for school-based administrative claiming, the health needs of innocent children will go unmet and preventable consequences will be long-lasting for families and society.

Thank you. I appreciate this opportunity to testify.

[Prepared statement of Ms. Herrmann follows:]

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Chairman WAXMAN. Thank you very much for your testimony.

Mr. Van Hollen, I know you tried to get here in time to hear Ms. Miller's testimony. Do you want to say anything at this time?

Mr. VAN HOLLEN. Thank you, Mr. Chairman. I apologize for being late. I had a prior commitment, but I did also want to welcome my constituent, Barbara Miller. Thank you for your testimony. I had a chance to read your testimony, and I am so pleased you could be here to tell your story as we make these important decisions.

I also want to thank Threshold Services for all that they do in our community. I see Craig Nowel, the Executive Director, and I want to welcome him and thank them for all the rehabilitation services they provided and allow people like you to be able to tell your story here today. Thank you for all that you have done to share with us today.

Chairman WAXMAN. Thank you, Mr. Van Hollen.

Mr. Aviles?

STATEMENT OF ALAN AVILES

Mr. AVILES. Good morning, Mr. Chairman and members of the Committee. I am Alan Aviles, President of HHC, the New York City Health and Hospitals Corporation. I am pleased to have this opportunity to testify this morning on behalf of NAPH, the National Association of Public Hospitals and Health Systems.

NAPH is deeply concerned about the severe adverse impact of all of the regulations you are reviewing today. I will focus my attention this morning primarily on the Medicaid cost limit regulation, which is subject to a Congressionally adapted one year moratorium until May of 2008. If that regulation is permitted to go into effect, it has the potential to devastate essential safety net hospitals and health systems in many parts of the Country.

In addition to the Medicaid cost limit regulation, HHC and other NAPH members will be severely impacted by the proposed CMS rule affecting graduate medical education and a proposed Medicaid outpatient payment regulation that CMS recently published.

Let me begin by briefly describing my own organization. HHC is the largest municipal health care system in the Country. We provide health care to 1.3 million New Yorkers

every year. Nearly 400,000 have no health insurance. We operate eleven acute care hospitals, four skilled nursing facilities, six large diagnostic and treatment centers, more than eighty community health centers, and a home health program.

More than 60 percent of our budget comes from Medicaid. HHC's facilities provide nearly 20 percent of all general hospital discharges and 40 percent of all inpatient and hospital-based outpatient mental health services in New York City. One-third of New York City's emergency room visits occur in HHC hospitals, and we provide five million outpatient visits every year.

My submitted written testimony describes the situation of other NAPH member hospitals nationally and also details billions of dollars in potential Medicaid cuts facing those hospitals as a result of these regulations.

Let me briefly touch upon the potential impact of those cuts on the vulnerable patient populations and communities we serve.

While it is not always possible to predict with precision which services will be reduced or eliminated, I can give you a few examples of decisions that might be required if public hospitals are faced with Medicaid cuts of this magnitude.

We believe the impact in New York of the reduced costs

and limit regulations would be upwards of $200 million per year. Faced with cuts of that magnitude, we would have to dismantle significant components of our ambulatory care system and scale down our emergency departments. These Medicaid funds help to support our extensive primary care network that prioritizes prevention, early detection of disease, and engagement of patients in the management of their chronic conditions.

These funds also support the provision of prescription medications to hundreds of thousands of low-income New Yorkers, and the operations of our eleven public hospital's emergency departments and six trauma centers rely heavily on Medicaid funding.

In California Dr. Bruce Chernoff, CEO of the Los Angeles County Department of Health Services has said, ''It is the equivalent to shutting down all the outpatient clinics we own and operate, as well as those we contract with in the community.''

Gene Marie O'Connell, San Francisco General Hospital CEO and Chair of NAPH, states, ''San Francisco General Hospital is just holding its head above water with the current rates. The impact from the Medicaid cost limit rule means the loss of $24 million, and from the GME rule an additional $5 million. If these rules become reality, we would need to close three nursing units, or 90 beds out of 550 beds, which

would have a dire impact on services to the residents of San Francisco.''

In Colorado, Dr. Patricia Gabow, Denver Health CEO and Medical Director, states, ''We need Congress to stop these rules. The impact of this rule on Denver health would be devastating. We might as well turn over the keys. We would no longer be able to serve as the major safety net system for Denver and Colorado and the region. The health of the entire community will be compromised through the impact on our trauma system, our disaster preparedness, and public health.''

Mr. Chairman, my submitted written testimony includes numerous other examples from around the Country. For this reason, it is imperative that Congress act now to stop these rules and to reaffirm your role in setting Medicaid policy for this Country. We believe that CMS ignored Congress and violated Federal law by moving forward to implement several of these Medicaid regulations. We need the Congress to move quickly by the end of this calendar year to prohibit CMS from implementing the Medicaid cost limit, GME, and Medicaid outpatient regulations.

We strongly urge the members of this Committee to support and co-sponsor H.R. 3533, a bill introduced by New York Congressman Elliott Engel and Sue Myrick, which had 133 co-sponsors as of this past Monday.

Once again, I thank you for granting me the opportunity to speak with you this morning on behalf of NAPH. I would be happy to answer any questions you may have.

[Prepared statement of Mr. Aviles follows:]

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Chairman WAXMAN. Thank you very much, Mr. Aviles.

Mr. Towns?

Mr. TOWNS. Let me just say, first off, thank you so much for being here. He heads the largest public hospital system in the United States. Of course, I am delighted for you to come and share with us your views and we hope to be able to talk further as we move forward into the question and answer period. I want to thank you so much for taking time from your busy schedule to come to share with us today.

Thank you, Mr. Chairman. I yield back.

Chairman WAXMAN. Thank you, Mr. Towns. Thank you very much, Mr. Aviles.

Dr. Retchin?

STATEMENT OF SHELDON RETCHIN

Dr. RETCHIN. Thank you, Chairman Waxman, Mr. Davis, members of the Committee. I am Sheldon Retchin. I am Vice President for Health Sciences at Virginia Commonwealth University and CEO of the VCU Health System in Richmond, Virginia. I am here to testify before the Committee about the detrimental impact of the proposed CMS rule to eliminate Federal matching payments for graduate medical education, or GME, under the Medicaid program.

I am also here on behalf of the Association of American Medical Colleges and I want to put a face to the devastating consequences these cuts would have on the Nation's teaching hospitals.

The VCU Health System is really two health systems. On the one hand it is a tertiary care center and is the region's only level one trauma center, and one of only two burn centers in the entire Commonwealth of Virginia. We perform solid organ transplants and attract referrals from not only across the Commonwealth, but all up and down the Mid-Atlantic region.

On the other hand, we are also a primary provider of hospital and intensive services and primary care services for inner-city Richmond. Let me tell you why.

Over the past three decades, there has been a migration of approximately 750 hospital beds from the city of Richmond to the surrounding suburbs. These beds were not replaced and, in fact, led to the closure of four major hospitals in the city of Richmond, three of which relocated into more affluent suburbs. So today the VCU Health System is the last remaining health system with a major hospital in the inner city, downtown Richmond.

So what happens is we take care of the inner city of Richmond, and during the past year we had 8,400 hospital discharges covered by Medicaid, 26 percent of all hospital inpatient work. Medicaid beneficiaries crowd our emergency rooms, they overwhelm our clinics. We had 65,000 outpatient Medicaid visits this past year. And that is not the whole story. In addition to the Medicaid population, the VCU provides a significant amount of care for low-income but income too high to be eligible for Medicaid. These are indigent patients.

So, taken together, Medicaid and indigent care represent about 45 percent of all the care our teaching hospital provides. So this devotion to care for the disadvantaged in our region is unrivaled.

Now, we do this judiciously. We are very careful stewards of these precious resources, and, not only that, we are innovators. So we contract with primary care physicians

in the community to decompress the emergency room, and we contract with those inner-city community physicians, about 30 different practices, with funds that are not even Medicaid. That is because we want to be judicious, and we are doing this and putting band-aids as much as we can on the solution.

Believe me, this is a safety net, not a safety hammock.

CMS suggests that the Medicaid program should not make payments towards the cost of graduate medical education. The timing of this proposal is especially perplexing. As you all know, the Nation faces a looming physician shortage in conjunction with the rise in the health care demands that are being placed on it by baby boomers. This rule would undo a history of support that stretches back more than two decades.

During this time, CMS has long recognized graduate medical education as a legitimate and authorized Medicaid expenditure, has consistently approved State plans for this expenditure, and has always matched Medicaid GME payments along the way.

In 2005, 47 States and the District of Columbia made and provided GME payments under the Medicaid program. In Virginia this past year we received $6.7 million in direct GME Medicaid costs.

I assure you, Virginia's Medicaid funding for GME is a Federal-State partnership split 50/50, so you have to ask why so many States like Virginia are making this commitment to

graduate medical education that are now proposed for Federal reduction. That is because sustenance of the physician workforce is at least as important, if not more so, for Medicaid beneficiaries than it is for Medicare.

While adequate access is vulnerable for beneficiaries of both programs, I can assure you that physician Medicaid participation in most States is even more sensitive than Medicare to the workforce supply.

Over the past 20 years, despite modest health care reforms, unfortunately we have made little progress reducing the total number of our citizens who remain uninsured. That certainly has had its consequences in downtown Richmond. Employer-based coverage has eroded during the past seven years, as we all know, and most of the uninsured and Medicaid beneficiaries are hard-working Americans who are either self-employed or employed by businesses, small businesses who cannot afford health care coverage for its employees.

With all due respect, I feel like we are walking up a down escalator. These cuts will merely unravel the safety net yet further and make health reform and expanded coverage that much harder to accomplish in the horizon ahead.

With 47 million Americans uninsured and another 40 million Americans on Medicaid or under-insured, the safety net is stretched tight, and the teaching hospitals are holding the corners.

I thank you for the opportunity to testify today. The teaching hospital community greatly appreciated the one year moratorium preventing regulatory action on this rule until May of 2008, and we contend that this moratorium may have already been violated. We are also very grateful to Representatives Engel and Myrick and over 133 bipartisan co-sponsors for advocating in support of the Public and Teaching Hospital Preservation Act to extend the moratorium for an additional year.

My fellow teaching hospital and medical school leaders and the Association of American Medical Colleges look forward to working closely with you on these issues which are of such importance to the health and well-being of all Americans.

Thank you.

[Prepared statement of Dr. Retchin follows:]

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Chairman WAXMAN. Thank you very much, Dr. Retchin

Dr. Gardner?

STATEMENT OF ANGELA GARDNER

Dr. GARDNER. Thank you, Mr. Chairman and members of the Committee. My name is Dr. Angela Gardner. I am an Assistant Professor at the University of Texas Medical Branch in Galveston. I have been providing emergency care to Texans for more than 20 years. I am also Vice President of the Board of Directors for the American College of Emergency Physicians, ACEP. We represent 25,000 emergency physicians in 53 chapters across the Nation.

I would like to thank you for allowing me to testify today on behalf of ACEP to discuss the impact on vulnerable populations and safety net hospitals if CMS is allowed to reduce Medicaid payments to States by approximately $5 billion, as it has proposed to do in the regulatory process. Today I would like to share with you several important factors that make the care received in the emergency department unique and how the proposed Medicaid cuts will further erode access to life-saving emergency medical care in Texas and the rest of the Nation.

Actually, I would like to tell you a story.

I worked in the emergency department on Tuesday night, and on my arrival all 48 of my beds were full. We had 22 patients in the hallway. We had 14 patients in the waiting

room. We had three ambulances unloading and two helicopters waiting to land. That is a normal day. And, as I hear from Dr. Retchin and Mr. Aviles, that is a normal day in New York and Denver and San Francisco, as well.

When I arrived, 25 percent of my beds were taken up by patients who were waiting on a bed inside the hospital, four of those on respirators waiting on ICU beds. This is a normal Tuesday night.

At midnight I got a patient who arrived to me comatose from the back seat of his mother's car. He had been driven 250 miles to my emergency department to get our care. I will call this man Norman to preserve his privacy.

Norman had been having headaches for about a month. On the third week, when his right hand wouldn't work any more and he started vomiting, his mother said, you have to go to the hospital. They went to the emergency department at their local hospital, where he was diagnosed with a brain tumor on the left side of his brain.

They don't have a neurosurgeon at this hospital--and this is a regular-sized city--so they called UTMB for a transfer. We accepted the patient to neurosurgical service.

Unfortunately, we didn't have a bed. The process is he has been put on a list to get a bed when one becomes available.

After waiting eight days for his bed in the hospital

there in his home town, Norman, in pain and vomiting and unable to move out of that bed, begged his parents to take him home to die, and they did.

He went home to die, and when he became comatose his mother loaded him in the back seat and brought him to me. I put him on a ventilator. I gave him drugs. I got him a neurosurgeon. What I could not get him was a bed.

If you will excuse me, this is emotional. I left the hospital Wednesday morning. I do not know if Norman died, but I believe that he will die in that trauma bay. He will never see the inside of a hospital. He will have his neurosurgeon, but he will not have a bed.

As you sit here and absorb the impact of the story, I would like to let you know something. Norman is not indigent. Norman is a working man with health insurance. The problem with the cuts that Medicaid wants to make, the cuts to Medicaid that are being proposed, is that it affects not only the indigent but everyone out there. This could happen to you, it could happen to someone that you love.

Of our children in Texas, 32 percent are on Medicaid. Another 18 percent of them are uninsured. That is 50 percent of our children who are under-insured or lacking access to health care. I can't see that any cut in that program is going to help anyone.

More to the point, we don't have beds, and we don't have

beds in the same way that New York doesn't, in the same way that other colleges in Virginia don't. Cutting our programs is not going to give us beds. It is not going to help people like Norman, whose main need is a neurosurgeon and a bed.

I would like to wrap up today by thanking you for allowing me to be here, by tolerating my emotion for my patients, and by asking you: please, don't cut funding to our valuable public hospitals.

[Prepared statement of Dr. Gardner follows:]

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Chairman WAXMAN. Thank you very much, Dr. Gardner.

Dr. Kanof?

STATEMENT OF MARJORIE KANOF

Dr. KANOF. Mr. Chairman, Mr. Davis, and members of the Committee, I am also pleased to be here with you today as you explore recent regulatory actions of CMS related to the Medicaid program and the potential impacts of these actions on patients, providers, and States. I think we have heard several examples of this this morning.

Medicaid fulfills a crucial role in providing health coverage for a variety of vulnerable populations, but ensuring the program's long-term sustainability is critically 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 at a State's typical Medicaid payment rates.

In March, 2007, 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 the fiscal integrity of the

Medicaid program and on CMS' initiative begun in 2003 to end these.

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 funds by paying certain government providers, such as county-owned or-operated 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.

States could use these Federal matching funds received in making these payments, which essentially made a round trip from the State to the provider and back to the State, at their own discretion. Such financing arrangements have significant fiscal implications for the Federal Government and the States. The exact am the of additional Federal Medicaid funds generated through these arrangements is unknown, but it is estimated that it was 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.

Because they effectively increased the Federal Medicaid share above what is established by law, these arrangements

threaten the fiscal integrity of Medicaid's Federal and State partnership. They shift costs inappropriately from the State to the Federal Government and take funding intended for covered Medicare costs from providers who do not under these arrangements retain the full payment.

The consequences of this arrangement is illustrated in one State's arrangement in 2004 which increased Federal expenditures without a commensurate increase in State spending. The State made a $41 million supplemental payment to a local government hospital. Under its Medicaid matching formula, the State paid $10.5 million, CMS paid $30.5 million as the Federal share of a supplemental payment. After receiving the supplemental payment, however, in a very short time the hospital transferred back to the State approximately $39 million of the $41 million payment, retaining just $2 million.

This March we reported on CMS' initiative to more closely review State financing arrangements through their State plan amendment process. From August, 2003, to August, 2006, 29 States ended one or more arrangements for financing supplemental payments because providers were not retaining the Medicaid payment for which States had received Federal matching funds.

We found CMS' action to be consistent with Medicaid payment principles that payment for services is consistent

with efficiency and economy. We also found, however, that the initiative lacked transparency, and that CMS had not issued any written guidance about the specific approval standards.

When we contacted twenty-nine States, only eight reported receiving any written guidance or clarification from CMS. 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 had been treated in 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 and providers. The Federal Government and States have a responsibility to administer the program in a manner that ensures expenditures benefit those low-income people for whom benefits were intended.

Congress and CMS have taken important steps to improve the financial management of Medicaid, yet more can be done to ensure the accountability and fiscal integrity of the Medicaid program.

Mr. Chairman, this concludes my statement. I will be happy to answer questions.

[Prepared statement of Dr. Kanof follows:]

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Chairman WAXMAN. Thank you very much. I want to thank all of the witnesses for your presentation. You have given us excellent, excellent information to think about as we look at this issue.

We are now going to proceed to questions by the members of the Committee in five minute intervals. I will start with myself.

Dr. Kanof, as you know, one of the proposed rules issued by CMS would limit Medicaid payments to public hospitals to the direct cost of serving each Medicaid beneficiary. No payment would be allowed for the indirect cost that might be part of running the hospital, say, for example, the losses that the hospital might incur for emergency rooms, burn units, or trauma care. Has the GAO supported a policy of Medicaid payment for direct costs, alone?

Dr. KANOF. No. In fact, we have, though, supported a recommendation made to Congress in both 1994 and repeated in 2004 that costs should be limited to cost, but have never defined what is in that cost, what is direct or what is indirect.

Chairman WAXMAN. In 1994, though, you said Congress should enact legislation.

Dr. KANOF. We did, and, in fact, we did that because in comments that we received from HCFA at that time they indicated that they could not do this without Congressional

legislation, and, in fact, in 2005 the President's budget proposal actually requested legislation for this.

Chairman WAXMAN. So would it be inaccurate for CMS to imply that GAO supports the proposed cost rule?

Dr. KANOF. I think you have an interesting question you are asking me. GAO definitely recommends cost, but GAO has not commented what should be in that cost.

Chairman WAXMAN. You recommend legislation. I know that you also know a great deal about the Medicare program. Does Medicare include direct and indirect costs within its payment system?

Dr. KANOF. Yes. That is sort of a fundamental of how Medicare pays its providers.

Chairman WAXMAN. Thank you. It has been one of the fundamental ways Medicaid has paid its providers, as well.

Dr. Gardner, last week southern California suffered from a terrible disaster with devastating fires, and during this calendar year we have seen other problems such as the recent bridge collapse in Minneapolis. Communities relied on public teaching hospitals to provide critical emergency, trauma, and burn care. In the major cities of our Country public hospitals provide nearly half of all level one trauma services and two-thirds of burn care beds. Are you concerned that the rules proposed by CMS will damage our communities' ability to manage the next natural disaster or public health

emergency?

Dr. GARDNER. Absolutely. I cannot be more clear that we have no surge capacity. As demonstrated in Los Angeles and in the counties surrounding San Diego, dealing with a catastrophe is a problem for them. They have seen the closure of six hospitals with emergency departments in the last several years. Had this catastrophe been worse, they would not have been able to deal with those patients. And there is nowhere else for them to go.

Chairman WAXMAN. Well, one out of five hospitalized patients received care in a public hospital, one out of four babies is born in a public hospital, and one out of five ER patients receive care at a public hospital. Given this volume of services, will other hospitals be able to fill the void if public hospitals are forced to close beds or curtail services due to the CMS regulations?

Dr. GARDNER. No, sir. The private hospitals are in much the same shape as the public hospitals. There is no bed capacity. There aren't nurses. There aren't specialists. There isn't room anywhere for any overflow of the system. There will be nowhere for these patients to go.

Chairman WAXMAN. We all know public and teach hospitals operate emergency rooms, trauma centers, burn units, and sophisticated ICUs, but these hospitals also manage large outpatient clinics that keep community members healthy and

out of the hospital. Today in our major cities over one-third of patients who need outpatient care receive it at a public hospital clinic. If CMS implements the proposed rules and public hospitals are forced to curtail these outpatient services or close these clinics, what options will these patients have to receive care?

Dr. GARDNER. Well, sir, as you know, regulations require that the emergency department stabilize and see any patients who present to our doorways, and my presumption is that those patients will show up in the emergency department and we will see them.

And if I could just take two seconds to dispel a common myth, there is a myth out there that our emergency departments are overrun by patients who don't need to be seen in the emergency department, but our recent research shows that 70 percent of the people who come to see us need to be seen within two hours, and 15.3 percent of those need to be seen within 15 minutes. So we will be adding clinic patients to an already overburdened system.

Chairman WAXMAN. Thank you.

Mr. AVILES. Mr. Chairman, I would just add, as well, that this highlights the extent to which this can be viewed as penny wise and pound foolish. To the extent that you strip out--

Chairman WAXMAN. I thank you for that, but I have one

last question. You can see the red light, so my time is going to be up if I don't ask my last question of Ms. Herrmann.

The President says he wants to make sure that the low-income children are covered under Medicaid and S-CHIP. Now, Medicaid, of course, covers the poorest of the poor children. What would happen if you had the school nursing program made ineligible for treating some of these Medicaid patients?

Ms. HERRMANN. Thank you for your question. We see every day I would rather be a poor child because I am going to get Medicaid. If I am a little bit poor but not poor enough for Medicaid and I have diabetes, I have asthma, I have a broken arm, I have a bad respiratory virus, those children are not going to get seen. They are going to be delayed in treatment. What happens is that then--

Chairman WAXMAN. Well, they won't even be in Medicaid, because you would enroll them in Medicaid.

Ms. HERRMANN. No. That is right.

Chairman WAXMAN. If they are not in Medicaid and they have asthma, you can't even give them the services that they need.

Ms. HERRMANN. Exactly.

Chairman WAXMAN. Thank you very much.

Ms. HERRMANN. Exactly.

Chairman WAXMAN. I don't want to exceed the time. That red light is staring at me. But thank you very much for your answer. Maybe there will be further questions.

Mr. Davis?

Mr. DAVIS OF VIRGINIA. We will have some time later, but I want to get through this panel. Thank all of you for coming. I have got to start with Dr. Retchin. He is from my State and he has been here before, and we very much appreciate your being here.

Your written testimony quotes the proposed rule in which the CMS points out that the Federal Government does not know or track which States are making GME payments, the amounts States are spending, or the total number of hospitals receiving such payments. Given that, what is the answer? Should it be paid through Medicaid? Should it be better tracked and overseen from us?

Dr. RETCHIN. Well, I think it is an excellent question. I am all for a better monitoring system, a better tracking system. I think CMS first has to realize these are legitimate costs. I mean, I think in part it could be obfuscation that if we can't track it then we can't pay it. That is illogical to me. In this case I think it is incredibly important for CMS to recognize the historical tradition of the payment, itself track it legitimately, and continue the payment for GME.

Mr. DAVIS OF VIRGINIA. What part of GME payments or what part of--if you didn't have that coming, you are an urban hospital, you have a lot of people who can't pay that are presenting themselves at the door.

Dr. RETCHIN. Well, if you combine the direct and the indirect, it is a substantial portion. I would venture to say it could be as much as 10 percent of our total revenues.

The direct payment for graduate medical education is a substantial portion of our direct payments for graduate medical education. The other portion is only Medicare.

Mr. DAVIS OF VIRGINIA. And the same would apply to New York, I am sure.

I want to get to Dr. Kanof for a couple of minutes.

How does the inappropriate maximization of Federal Medicaid reimbursement impact the financial integrity of the program? Does this have implications for Medicaid beneficiaries? Are we merely moving costs from the Federal to the State? I mean, what is your overview of that?

Dr. KANOF. Well, in fact, what we have found and what we have reported is that the supplemental payments can undermine the fiscal integrity of the Medicaid Federal-State partnership, and we have looked at this and summarized it in three ways. They clearly, effectively increase, as I spoke about the Federal matching rate established under statute. They allow States to use Federal Medicaid funds for

non-Medicaid purposes. And they enable States to make payments to government providers that significantly exceed their costs.

While we have not specifically looked at the impact that this would have on Medicaid beneficiaries, a natural extension would be that if there are funds that are in the Medicaid program that are going to the States and then being returned to the States and not used for Medicaid, this would, in fact, harm a beneficiary.

In fact, the HHS IG found that, in fact, there were Medicaid funds that were going to an institution. The institution had returned these funds to the State, and then the State Department of Health and Human Service actually put the provider in jeopardy for not providing quality care to the beneficiaries.

Mr. DAVIS OF VIRGINIA. Let me follow up on my earlier question. Is the GAO aware of any examples of concerns regarding Medicaid payments for school-based administration that may speak to the need for greater accountability or oversight in that area?

Dr. KANOF. We have not examined this issue in great detail. Two years ago we looked at contingency fee payments, and in Georgia we found that, in fact, there were funds that have been directed to the State for State programs and they had specifically gone back into the State and not been used

for education purposes. In reviewing that, we determined that there needed to be better guidance to ensure accountability of these funds.

Mr. DAVIS OF VIRGINIA. Dr. Gardner, as it relates to uncompensated care, will government-operated facilities still have access to the dish payments which are meant to address caring for the uninsured?

Dr. GARDNER. I am not sure that I am adequately prepared to answer that question at this time. I can get back to you.

Mr. DAVIS OF VIRGINIA. If you would try to get back to us, just for the record, that would be helpful to us.

Dr. GARDNER. All right.

[The information to be provided follows:]

********** COMMITTEE INSERT **********

Mr. DAVIS OF VIRGINIA. Mr. Aviles, some of the quotes in your written testimony speak to a very broad list of services that hospitals would purportedly have to discontinue under the proposed cost limit rule. I understand that you are challenging the CMS' estimate of the impact of the rule. For argument's purposes, if the impact was twice as large as CMS estimates, it still would be less than 1 percent change in Federal Medicaid spending. Can you talk to the magnitude of this change from your perspective?

Mr. AVILES. It may be 1 percent in the aggregate, Congressman, but, in fact, NAPH members constitute 2 percent of the hospitals in this Country, and we cover 25 percent of the uncompensated care. These regulations are directed at the public hospitals in the Country, and therefore the impact is concentrated there.

As I mentioned in my testimony, just for us the impact would be about 4 percent of our budget on the cost limit regulation alone. All three regulations together aggregate to closer to 9 percent of our budget, or in the range of $400 to $500 million.

Others of our members in California, for example, the estimates are in excess of $500 million, in Florida in excess of $900 million, and in Tennessee and North Carolina and Georgia it is a combined impact of $800 million on an annual basis for the cost limit regulation, alone. That necessarily

would devastate our ability to deliver services.

Mr. DAVIS OF VIRGINIA. Thank you.

Chairman WAXMAN. Thank you, Mr. Davis.

We are being called to the House floor for a series of three votes. We are going to take a recess and come back at ten minutes to 12:00--I think that would be a good prediction of time--to complete the questions for this panel.

Thank you.

We stand in recess.

[Recess.]

Chairman WAXMAN. The hearing of the Committee will please come back to order.

Mr. Cummings?

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

First of all I want to thank all of our witnesses for your testimony. I thank you for bringing and presenting a face for the people who are affected by these proposals.

I also want to say to Ms. Miller, I want to thank you for your testimony. As a fellow Marylander, I am very, very, very proud of you. Thank you so very much for taking your story and bringing it to us. I really appreciate that, too.

Dr. Gardner, please do not ever apologize for your passion. We are talking about the lives of human beings. We are talking about life and death situations.

To all of you, I thank you for your passion.

It seems, Mr. Chairman, that we are currently engaged in a very public debate over the future of S-CHIP, which covers six million children and potentially will cover four million more. But today, after listening to this testimony, I am concerned that, while we wrangle over that program in the press, CMS has launched a systematic attack on Medicaid which serves 60 million people, 28 million of them children, behind our backs and in their suites.

Your testimonies highlight how vitally important it is that we shed a light on these ill-advised proposed regulations. Left to their own devices, it appears that CMS will leave our most vulnerable citizens--that is, the poor, the sick, the disabled, and the elderly--far, far behind, if not left out completely.

Mr. Chairman, that is not the American way. As I listened to some of this testimony, I must tell you that if I closed my eyes I had to wonder whether or not we were still in America.

America has gained its moral authority by the way it treats its people, not by military might. It may have been backed up by military might, but the way we treat every single American. This is not a matter of fiscal responsibility. I have concluded it is a matter of moral irresponsibility.

Are we so morally bankrupt that we are willing to

shortchange life and death services?

That leads me to you, Mr. Parrella. I want to thank you for your testimony. You testified that you worked in Medicaid for the past 20 years. In your experience, is there any precedent for what CMS is doing with the six proposals we are discussing today? Has the Federal Medicaid agency ever proposed a set of Federal rules that would shift $11 billion in costs from the Federal Government to the States?

Mr. PARRELLA. Thank you for that question, Mr. Cummings.

I am not aware of a regulatory initiative that would have an impact of this magnitude that we have experienced.

Mr. CUMMINGS. And I take it from your testimony that the State Medicaid directors, the managers like you who actually run the program on a day to day basis, I guess you all oppose each of these six CMS proposals we are discussing today. And is that opposition bipartisan?

Mr. PARRELLA. Our organization--

Mr. CUMMINGS. First of all, are you opposed?

Mr. PARRELLA. I am, sir.

Mr. CUMMINGS. All right. And is that the view of your organization?

Mr. PARRELLA. It is, sir.

Mr. CUMMINGS. It is a bipartisan organization?

Mr. PARRELLA. It is, sir.

Mr. CUMMINGS. Do you all have opportunities to express

your concerns to the folk who sit in the suites making these decisions affecting people's lives on a day to day basis?

Mr. PARRELLA. We do.

Mr. CUMMINGS. And how do you do that? How do you go about doing that?

Mr. PARRELLA. CMS is very good about meeting with us on at least a quarterly basis. We have direct access to Mr. Smith. In terms of the regulations that are issued, we provide written comments.

Mr. CUMMINGS. I always find these hearings fascinating because we hear your stories and, having been here 11 years, the fascinating part is we will hear the story from CMS in a few minutes. They will probably say--well, Mr. Smith has already said in his written testimony, ''These rules will provide for greater stability in the Medicaid program and equity among States.'' Do you agree with that statement?

Mr. PARRELLA. I do not. I am sympathetic to the task that Mr. Smith and CMS have in that it is their responsibility to maintain program integrity, and part of program integrity is to hold the States accountable for the State share that they provide for Medicaid. So to the extent that these regulations were an attempt to correct any practices historically which have shifted inappropriately responsibility to the Federal Government from the States, I understand and support what Mr. Smith is doing. However, I

think what these regulations do is they go far beyond that in terms of the impact that they are having on the kind of public providers and recipients who are here who benefit from these programs. I think that is the reason why we are in opposition.

Mr. CUMMINGS. I see my time is up. Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Cummings.

Mr. Davis?

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman. I want to thank you for holding this hearing. As a matter of fact, I represent a District that has more than twenty-five hospitals, four medical schools, thirty community health centers. As a matter of fact, we are, indeed, a health mecca, and so you can imagine that these proposed rules frighten me to death. As a matter of fact, every time I think about them I shake in my boots in terms of the devastating impact that they could have, because we also care for people from not only in our State but we care for many people from all over the Country and, indeed, from all over the world. So I thank all of you for your testimony.

Let me just ask you, Mr. Aviles, the Senate Finance Committee recently confirmed Mr. Kerry Weems as the CMS Administrator, and in response to questions submitted by the Committee as it considered its nomination he made the

following statement. I am going to quote it. He said, ''I appreciate that Medicaid is a vitally important program that serves very vulnerable populations. I am concerned that the perception that this Medicaid rule is intended to harm public providers. In fact, I understand it to protection public providers. Governmentally operated health care providers are assured the opportunity to receive full cost reimbursement for serving Medicaid-eligible individuals instead of being pressured to return some payment to the State.''

It sounds like Administration Weems believes that CMS is doing safety net hospitals like those in New York and like the three that I represent in my District in Chicago a favor by proposing these rules. Do you agree?

Mr. AVILES. Absolutely not, Congressman. As I have mentioned before, the cumulative impact on these regulations is a massive cut in funding to our public hospitals across the Country.

The argument that it does us a favor by limiting our reimbursement to actual cost really turns a blind eye to the role that public hospitals play across the Country. Those costs that we incur include the cost of running our trauma services, include the cost of running those burn beds.

As you have heard, our members in communities across this Country on average provide 50 percent of the trauma services, provide two-thirds of the burn beds.

If you are in Miami and you need trauma services, the only place you are going to get those trauma services is in a public hospital. If you are in Los Angeles, California, or Ohio, Columbus Ohio, the only place you are going to get specialized burn bed treatment is in a public hospital.

So those costs need to be borne, and historically have been borne through supplemental Medicaid payments that recognize that that is an essential part of the mission and role of public hospitals in this Country.

Mr. DAVIS OF ILLINOIS. Well, on the next panel the CMS witness, Mr. Smith, will argue that his proposed rules will not have a negative impact on providers and that if the rules were to negatively affect providers--and I am going to quote what he said--''It would be due to decisions made by State and/or local governments, not by CMS.''

If CMS implements this rule, the Federal Medicaid payments are no longer available to public hospitals for costs not directly attributable to Medicaid patients, will the State of New York and the city of New York pick up the financial slack and cover the difference on their own? And what about other States and localities?

Mr. AVILES. With all due respect, that statement is a lot like saying that if we eliminated the Federal share of Medicaid entirely the States could pick up the slack and therefore there would not necessarily be a negative impact.

We are talking about a massive de-funding of public hospitals. As I have mentioned, in New York City, alone, the combined effect of these rules would be in the neighborhood of $400 to $450 million. It is inconceivable that we could continue to run the public hospital system we currently have in our city with that type of defunding. Quite frankly, neither New York state or other States around the Country have the wherewithal to make up that massive amount of defunding.

Mr. DAVIS OF ILLINOIS. My time is about to run out. Let me ask you, If the States and local governments can't pick it up, do you think that the private sector hospitals and health systems would now be able to pick up the slack?

Mr. AVILES. Absolutely not. We know that in many areas of the Country the emergency departments are absolutely crowded. Many hospitals, certainly in the northeast and elsewhere, struggle just to stay above water. We are talking about a public hospital system that provides 1.7 million hospital discharges each year and close to 30 million outpatient visits. The private sector simply could not make that up, does not have the excess capacity to do that.

Mr. DAVIS OF ILLINOIS. Thank you very much, and thank you, Mr. Chairman.

Chairman WAXMAN. Thank you very much, Mr. Davis.

Mr. Towns?

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

Let me begin by first thanking all of you for your testimony and for the many examples that you were able to give to highlight the fact that we are moving in the wrong direction.

Let me ask, did any of you comment on the rules? Did any of you comment on the rule?

[Panel members nodding affirmatively.]

Mr. TOWNS. You did? All of you?

[Panel members nodding affirmatively.]

Mr. TOWNS. You know, in looking at the situation, it seems to be not a single person supported this rule, so I am wondering now if comments make a difference. If nobody supported it and, of course, here we are. Of course, you expressed your concerns, which I hear you. I am hoping that the Agency will also hear you, as well.

Let me ask you, Dr. Aviles, what would this do to the graduate medical education programs that we have in our hospitals?

Mr. AVILES. This would be extraordinarily destabilizing to the graduate medical education across the Country. There is a very close inter-weaving of graduate medical education and public hospitals. Of NAPH members, 85 percent are teaching hospitals. In New York City, HHC has nearly 2,400 residents being trained on any day of the week. So this is a

central component of the infrastructure for academic medicine, and the training of physicians in our Country. With projected physician shortages going into the future as the Baby Boom generation requires more services, and as we look around the Country and see physician shortages even now, it is a very dangerous proposition, indeed.

Mr. TOWNS. There is legislation being put forth by my colleague from New York, Elliott Engel. I would like to move down the line and ask you, in terms of your views, whether you support it or not, basically yes or no, starting with you, Ms. Miller, and coming all the way down the line, the Elliott Engel legislation. Are you familiar with it?

Mr. PARRELLA. I am not, sir.

Mr. TOWNS. You are not familiar with it? Okay.

Mr. PARRELLA. Is it a moratorium legislation?

Mr. TOWNS. Yes. Let's go right down the line.

Mr. PARRELLA. Extend the moratorium. We would be in favor of that, sir.

Mr. TOWNS. You would be in favor. Okay. Right down the line.

Ms. MILLER. Yes.

Mr. TOWNS. Yes. Yes or no, basically.

Ms. COSTIGAN. Yes.

Ms. HERRMANN. Yes.

Mr. AVILES. Yes.

Dr. RETCHIN. Yes.

Dr. GARDNER. Yes.

Dr. KANOF. I am not in a position to offer an opinion.

Mr. TOWNS. Okay. All right. So that is neither yes nor no. Okay. I got it.

Let me just say to you, do you think that legislation would really help the delaying it a year rather than dealing with it now?

Mr. PARRELLA. Yes, it would help. This legislation would help us.

Mr. AVILES. It would help. We obviously would welcome a more permanent solution that would not require us to come back yet again, but certainly, given the alternatives, we would welcome a further moratorium.

Mr. TOWNS. Do any others have any comments as to what this would do to your facility if these cuts go forward, as to what it would do to your facility in terms of if we do not rectify this?

Ms. COSTIGAN. We run an adoption program at Intermountain in Helena and Great Falls, Montana. If this rehab rule stays the way it is, we would potentially lose that program. We have served over 100 SED kids, and we have found permanent homes for many of them, and we have kept them in permanent homes. We have a 73 percent success rate. The program would be gone.

Mr. TOWNS. Thank you.

Ms. HERRMANN. The Medicaid administrative claiming dollars that come back to school districts and programs, once that is gone the program is gone. That is it. Everything will be. So school nursing positions, social worker positions, preventive care--all of those kinds of things would be gone and we wouldn't be able to enroll or help kids with eligibility.

Mr. AVILES. These funds help to subsidize the extraordinary cost of running six trauma centers in New York City, as well as our high-level neonatal intensive care units. All of those types of services would absolutely be endangered by this level of cuts.

Dr. RETCHIN. The cuts as they stand in the proposed rules taken together would be absolutely devastating for our teaching hospital.

A few years back we were actually on the cover of the Wall Street Journal because a cancer patient from a distant part of the State could not receive chemotherapy where he was, and he traveled about 150 miles to MCB hospitals where he got chemotherapy and treatment for his cancer and actually went into remission and survived. Those are the kind of programs at a cancer center like that we would have to reconsider. These would be devastating in terms of the consequences.

Dr. GARDNER. If I am allowed, I will have a short, two-part answer. One is that Texas is 51st already in administration of Medicaid, and we have 50 percent of our children and 30 percent of our adults who are also uninsured. We have research that says that over 20 percent of the adults and 25 percent of the children reported that they needed to see a doctor in the past two years and could not do so. This will certainly not improve that.

Mr. TOWNS. Thank you very much, Mr. Chairman. You have been very generous with the time. Thank you. I appreciate it.

Chairman WAXMAN. Thank you, Mr. Towns.

Ms. Watson?

Ms. WATSON. I really want to thank the Chair for holding this hearing. I think this is one of the more important issues that we have brought out to the public, and I want the public to listen closely.

If all the new regulations were to be implemented, Federal Medicaid funds to States would be cut over $11 billion over the next five years. This loss in funding would be detrimental to the program and its recipients and would cause States to roll back valuable services that poor and low-income families would need and otherwise would not be able to afford.

I represent the State of California. We are the first

State in the Union to be a majority of minorities. We get a lot of people coming from over the Pacific Ocean, southeast Asia, over the border, and so on, with tremendous health needs. Where do they go? They go to emergency.

We just lost one of our public hospitals because the funding was cut back, Martin Luther King down in Watts. I think all of you are aware of that. I heard someone on the panel mention the dish hospitals. Let me tell you, in the same area there is St. Francis, a Catholic hospital. They can't take another patient. The dish hospitals are under-funded.

We are going to see more cases of people dying in the emergency room. We don't have an emergency room at King Hospital, as many of you know.

I am a teacher, worked in the District, so I want to direct this question to Ms. Herrmann. I believe that you have answered most of my questions. What would happen in our schools? I think the worst thing we do in our districts--we have 1,100 of them in California--is cut out the daily nurse. We don't even see the doctors.

So in his testimony, Mr. Smith for the next panel--he is the CMS witness--will defend this proposal rule on the grounds that there has been improper billing under the Medicaid program--In California we have our own. It is called MediCal--by school districts for administrative costs

and transportation services. There is no over-billing, because in a State as large as ours, the largest one in the Union, you are going to have to have an administration, you are going to have those costs.

I want to ask Ms. Herrmann, Does your school district improperly bill your State's Medicaid program for the cost of your services? Or are there administrative costs? And even if there had been abuses in other school districts, is this rule a common-sense solution to the problem?

Ms. HERRMANN. No, we do not improperly bill Medicaid, and I can't imagine any school district would knowingly and intentionally try to defraud the Medicaid program.

I forgot the second part of your question. I am sorry.

Ms. WATSON. That is all right. I think you have answered it all.

Ms. HERRMANN. Thank you.

Ms. WATSON. It was a comprehensive question. But my second part was, Is this rule a solution?

Ms. HERRMANN. No, this rule is not the solution. Children will lose out and school districts will lose out because we will not be able to enroll them or assist to enroll them in Medicaid.

Ms. WATSON. And I am so pleased that I still see the green light. Mr. Chairman and Members, we are being asked again to fund a war over in Iraq. Soon it will be a trillion

dollars. And we are going to cut off health care to the poorest and most deserving children in our Nation? It doesn't make any sense, and I am going to say for all of you to hear I will not cast a vote for another penny in Iraq if this rule goes through and we cut off the services to our children and our schools and we cut off the services in our county hospitals and we close the county hospitals by pulling back on the funds, as has happened to us in L.A. County, the largest county in the State of California. It doesn't make sense.

If we are talking about protecting our homeland, it is not about the land, it is about the people on the land, and if we can't provide those services we ought to go out of business.

Thank you, Mr. Chairman, for the time. I yield back.

Chairman WAXMAN. Thank you, Ms. Watson.

Mr. Higgins?

Mr. HIGGINS. Thank you, Mr. Chairman. I have no questions, but more of just to thank the panel for being here. Most of the questions I had have been asked and answered. We appreciate very much your being here, because in making policy or challenging this administrative policy it is fundamentally important for us to know what the impact is going to be on the ground, whether it is graduate medical education and the impact to public hospitals and their

ability to deliver services, be they at hospitals or clinics throughout the communities, are very, very important. I want to assure you that we are here to ensure that nothing is done that is going to have a detrimental impact relative to service delivery at a time when we should be providing more health care, not less, particularly to those who are most vulnerable in our community.

Your presence here and the chairman's presentation of this hearing is fundamentally important towards shaping policy moving forward, and I thank you for being here.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Higgins.

Mr. Murphy?

Mr. MURPHY. Thank you very much, Mr. Chairman. I would like to especially thank Mr. Parrella for joining us today. He has served incredibly ably as the Director of Medicaid Services in my own State of Connecticut. I got to serve eight years on the Public Health Committee, four of those years chairing it, working together on a number of issues there.

Mr. Parrella, I wanted to give you the opportunity to expand upon I think an important point in your testimony, which is that much of the rationale for these rule changes seems to be the contention from the Administration that Medicaid was never supposed to cover these services in the

first place. For someone that has only worked in this field for ten years, even for me that contention seems incredibly wrong-headed. Your experience is much deeper and broader, and I would like you to just expand a little bit on the response, for those of us, when the Administration tells us that the reason for these changes is simply because Medicaid was never supposed to cover it in the first place, and the corollary argument from the Administration that there is other money out there to cover the services that they are cutting.

Mr. PARRELLA. Thank you, Congressman. It is a great pleasure to refer to you as Congressman Murphy in an official setting.

There are many examples you could find, but I think a best example is in the schools, in particular. I think some of the opposition comes from the sense that school business is the business appropriately of the Department of Education, that Medicaid should not cross that line. I think that we all know that Medicaid does cross that line because many of the children in schools receive services through special education.

There is Federal mandate for special education services through the IDEA, the Federal Act for special education. IDEA does not come close to funding the full cost of the medical portion of special education services that States and

cities provide. So Medicaid was actually directed by Congress in the Medicare Catastrophic Act back in 1988 to participate in paying for special education services that were medical in nature.

So we have had direction at various times in the past to be intimately involved in payment for services through the schools, so it does appear to be something of a retrenchment or a revisiting philosophically to say that, for the purposes of promoting program integrity, there are going to be areas like school education, like graduate medical education where Medicaid does not have a role.

On the graduate Medicaid education issue, Medicaid does have a role because we have a great vested interest in training doctors who will continue to serve the low-income population. So if you were to take a strict constructionist view and say that education at large is not part of Medicaid, that argument might hold some ground in a pure philosophical sense, but in the real world where States are simply not going to be able to replace the kind of funds, as Mr. Aviles said, for special education or graduate medical education, to take Medicaid out of the equation without some kind of supplemental Federal program to take its place is simply not realistic.

Mr. MURPHY. Thank you very much, Mr. Parrella.

Ms. Costigan, I just want to talk to you for one second

about foster care. One of the proposed regulations would, as I understand it, require therapeutic foster care homes to unbundle their services in how they bill for those services, creating, at least at first view, a whole new level of bureaucracy for families that are looking to take on some pretty difficult and emotionally complex children.

What do you think the effect of that proposed regulation is going to be on efforts of States that are already difficult, as it is, to try to get parents to come into the therapeutic foster home system?

Ms. COSTIGAN. I think it will be very destructive to any recruitment efforts. I also think that our agencies will not have the ability to track everything by 15-minute increments, especially when what we are talking about is giving kids back a social life, giving them skills to be able to have a friend and keep a friend and be a friend. I think this Medicaid rule will eliminate the support that therapeutic foster parents need, and if we want permanent homes for our kids, which is one of the things that Intermountain is very interested in is permanent homes for seriously emotionally disturbed kids, we deal with therapeutic adoptive care, but we fall under therapeutic foster care.

If we want these homes for these kids, we have to be willing to support them and to help them to help the child grow.

Mr. MURPHY. Thank you very much, Ms. Costigan.

Thank you, Mr. Chairman, for holding this very important hearing.

Chairman WAXMAN. Thank you very much, Mr. Murphy.

Mr. Hodes?

Mr. HODES. Thank you, Mr. Chairman.

I thank the panel for coming today. I am a co-sponsor of H.R. 3533, and I really appreciate the opportunity to have you here today to highlight this critical issue.

I want to thank Mr. Cummings for his remarks, which I associate myself with. Like Mr. Cummings, I have been gravely concerned about what seems to be this Administration's undeclared war on children and the poor under the Orwellian guise of a claim of fiscal responsibility. It is not what this Country is about.

I am wearing a pin which says Article I on it. The Article I initiative is a new initiative by the Democratic members of the Class of 2006 to help the people in this Country understand that checks and balances are vital in our system of Government, and this oversight hearing is one prime example of a check and a balance in a system where the Administration seems to believe that it makes the law and not Congress.

We will not be silent on this issue.

In my home State of New Hampshire we have one large

teaching hospital, Dartmouth Hitchcock Medical Center in Lebanon, New Hampshire, in association with Dartmouth College. It really is the sole teaching hospital there.

I want to focus for a moment on the graduate medical education issues. I understand that a recent report by the Agency of Health Care Research and Quality, which is a sister agency to CMS, found that teaching hospitals have a terrible patient revenue margin. In fact, they are losing almost $0.10 on the dollar.

Dr. Retchin, would you simply explain why this is so. Why do they lose money? And how do you make up the difference?

Dr. RETCHIN. Well, the old joke you make it up on volume probably doesn't apply here.

The teaching hospitals are at a disadvantage from the start all the way to the finish line because they have so many missions, so they are asked to be the tertiary referral centers, the cutting edge for technology and development of new research, new therapeutics. They are asked to supply tomorrow's workforce for health care workers, not only physicians but nurses, physical therapists, pharmacists, occupational therapists. And then they are asked, after all of that, to be a safety net in the partnership for taking care of the disadvantaged.

So it should be no surprise that all of these missions

require funding, and they all require subsidization, so the cross-funding of these is very difficult. I can tell you the safety net care generates no margins to subsidize either education or research, so all of these have to pay for themselves, and some fall by the wayside. They have to give up or compromise on one of those missions. It has got to be research, education, and, as a last resort, patient care. They can't make it up. That is the answer.

Mr. HODES. Dr. Retchin, CMS says that its proposed rule eliminating Medicaid GME would ''clarify that costs and payments associated with graduate medical education programs are not payments for medical assistance that are reimbursable under the Medicaid program.''

Do you agree with the CMS characterization that their proposed rule is a ''clarification''?

Dr. RETCHIN. Well, after 20 years of approving the State plans for GME payments, after more than two decades of not only approving State payments but actually making the payments and sharing, this has been a great Federal-State partnership. It seems unusually convenient to come to the conclusion that this is merely a clarification. It took a long time to clarify.

I think that everybody has got skin in the game. We all have to train the workforce of tomorrow. Here you have a Federal-State partnership, so it seems unusual, as one way to

cut this, to make it merely a technical clarification.

Mr. HODES. Well, if the rule goes through, why can't the States simply step in and pick up the slack? And if they can't, what will happen if they don't? What will happen to training the Nation's doctors? What will happen, for instance, in your hospital on emergency care and disaster preparedness?

Dr. RETCHIN. All of these have to be compromised. You know, it is sort of funny about this, because if you look at the 47 States that actually have GME payments through Medicaid, most of those States, if not all, have balanced budget amendments. They are the ones that have to ride out the business cycles and yet continue year after year to make these payments and make a commitment to funding the most disadvantaged in our society.

You would think actually it would be the Federal Government that would actually be saying to the States, You need to make these payments because we are concerned about the work force. It is just odd that it is the other way around.

So the States will not be able to make this up. I hope some of the States would continue their portion, because, like I said, they both have skin in the game, but they won't be able to make up the defunding of the Federal portion. Can't happen.

Mr. HODES. Thank you.

I yield back.

Chairman WAXMAN. Thank you, Mr. Hodes.

Mr. Shays?

Mr. SHAYS. Thank you, Mr. Chairman. Again, thank you for having this hearing.

I sometimes find, when everything is weighted one way, I want to bring some balance, even if I may not feel as strongly about that as I do. But in this case I am looking at administrative changes that change not 10 percent, not 1 percent, but 9/10ths of 1 percent, so I am hard-pressed to know how terrible things are going to happen.

We are talking about one thousand two hundred billion [sic] dollars of money spent and $11 billion in alterations over five years. That is tiny times ten, so I don't want to blow this whole hearing out of proportion.

With regard to the GAO, GAO has looked at a number of financing arrangements with Medicaid. In your experience, how does the joint nature of Medicaid program, joint Federal-State, 50/50, incentivize inappropriate financing arrangements?

Dr. KANOF. Well, it does it in several ways. Clearly, one way is as was mentioned this morning, earlier today, through the supplemental payments that can be excessively large and then can be transferred back from a provider to the

State because there is an inter-government transfer allowed and there is an excessive amount of money now returned to the State. It allows this in that the payments are now not to the providers, because they have not rendered these services for this payment, and it creates tension in that it increases the Federal match to the State.

Mr. SHAYS. In other words, what we have found in my 20 years here, and that is why we looked at this issue in 1997, what we did in the late 1990s was, with President Clinton's support, we balanced the Federal budget. We pretty much allowed discretionary spending to go up 1 percent, slowed entitlements for one year alone by a few percentage points--not 9/10ths of 1 percent--and we balanced the budget. That is what we did, Democrats and Republicans.

Here we are talking about an $11 billion savings over $1.2 trillion, and it is clear--all of us know this on this side, not there--that a smart State looks to take 100 percent of its costs, and if it can transfer it to Medicaid it now only has 50 percent and now the Federal Government picks up the other 50 percent. That is the incentive, isn't that true?

Dr. KANOF. Without appropriate safeguards, those are the incentives.

Mr. SHAYS. Absolutely. Now, I am very proud of how our State operates. I am also proud of our State's ingenuity.

Mr. Parrella, I think that you get rewarded if you find ways to increase programs and reduce the State's costs, and if I were governor I would want to make sure you did that every time. And if I was on that side of the table I would be arguing for it every time.

But I am not on that side of the table. Medicare is going up $16 billion from last year to this year's budget, $17 billion next, $18 billion the year after, $19 billion the year after, $21 billion the year after. It is not like the Federal Government isn't invested in this program, isn't that clear?

Mr. PARRELLA. That is true, Congressman.

Mr. SHAYS. So let me ask you, to the degree that some States use creative financing mechanisms, does that put States who choose to follow both the letter and spirit of the law and regulations at an unfair disadvantage by, frankly, undermining the overall financial integrity of the Medicaid program? In other words, if some States are using creative financing and you are a State that is pretty much playing by the letter and spirit of the law, doesn't that put you at a bit of a disadvantage?

Mr. PARRELLA. I think the danger of creative financing, the way it has been described, is that it can undermine the relationship between the States and the Federal Government, which is based on a partnership. It is. We have to have

integrity in what we represent to the Federal Government when we want to talk to them about matching funds for programs that we are trying to do to cover the uninsured. There has to be some integrity behind that so that they believe that we are really going to spend money on services that are really going to go to providers. That is part and parcel of what we do.

I guess I would concede that if there are attempts to recycle funds or divert funds from that purpose, it undermines the credibility of every State.

Mr. SHAYS. Well, Mr. Murphy and I both served at the State level, and when we were at the State level we thought like State legislators and we were eager to have you get every penny you could from the Federal Government. But I hope there is no disrespect on my side here. Please understand, I feel my job is to make sure it is fair for all States so that one State doesn't gain the system, and that we have a system that we can afford both on the State and Federal level.

I thank all our witnesses again.

Thank you, Mr. Chairman, for this hearing.

Chairman WAXMAN. Thank you, Mr. Shays.

Just for the record, Dr. Kanof, the GAO has recommended both improved accountability and transparency in many of these areas that are the subject of these proposed

regulations. Has GAO ever recommended prohibiting Medicaid payment for school administrative services?

Dr. KANOF. Based on my own knowledge of the reports that GAO has done, the answer to that would be no.

Chairman WAXMAN. How about school transportation services?

Dr. KANOF. No.

Chairman WAXMAN. Therapeutic foster care services?

Dr. KANOF. Not that I am aware of. No.

Chairman WAXMAN. Rehabilitation services?

Dr. KANOF. No.

Chairman WAXMAN. Indirect hospital costs?

Dr. KANOF. I don't think so.

Chairman WAXMAN. Okay. Graduate medical education costs?

Dr. KANOF. No.

Chairman WAXMAN. And assertive community treatment?

Dr. KANOF. No.

Chairman WAXMAN. Thank you.

Let me thank all of you for your testimony.

Mr. SHAYS. May I ask a question in regards to the question you asked?

Chairman WAXMAN. Certainly.

Mr. SHAYS. Have you looked at each one of these issues?

Dr. KANOF. No. And what we have looked at is

indications of more how is the State using some of these funds, but we have not looked at these issues.

Chairman WAXMAN. If the gentleman would permit, these proposed regulations would impact each of those areas. We are not just talking about mechanisms for drawing more money. As I understand it, these are services that would no longer be available.

I thank you all very much for your presentation. I think this is very, very helpful. It is a record that we are going to be able to share with our colleagues. Thank you so much.

[Recess.]

Chairman WAXMAN. The Committee will come back to order.

Mr. Smith, I am going to ask you to come forward.

Dennis Smith is the Director of the Center on Medicaid and State Operations at the Centers for Medicare and Medicaid Services, Department of Health and Human Services.

We are pleased to have you here today. As I indicated, it is the practice of this Committee that all witnesses answer questions under oath, so please rise.

[Witness sworn.]

Chairman WAXMAN. Do you have a prepared statement? We would like to recognize you for comments you might wish to make.

STATEMENT OF DENNIS SMITH, DIRECTOR, CENTER ON MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DENNIS SMITH

Mr. SMITH. Thank you very much, Mr. Chairman. I will make my remarks brief and try to respond really to some of the issues that were raised from the previous panel and questions from the Members, themselves. Hopefully we will be helpful to help to understand the context of the rules, the impact across the program, and really how the rules do work, because I think that in some respects the interpretation of rules get interpreted and reinterpreted and stretched a little further than what the rules actually say.

I think I first also want to thank David Parrella for his very kind remarks. We do work very closely together with the Medicaid directors and we have a great deal of respect for David personally and for Martha Rorety, who runs the Medicaid Directors, and we do have a great deal of exchange. We talk a lot about these regulations before they ever become regulations and what is going on out there in the States.

The Medicaid program speaks through State plan amendments, so while you work within the confines of the

statute, itself, in title 19, the States change their program, update their program, et cetera, through State plan amendments. And we do learn new things over time.

We have learned new things through the submission of State plan amendments. I think I have done what my predecessors have done. In the area of school-based services, for example, and the discussion that we heard on the previous panel about the school nurse, some of the things that she was describing would not have been allowed under the guidance of the previous Administration. Direct services that you are doing for routine medical care falls under the free care rule, and the rationale that no other payer is paying for it so it should not be billed to Medicaid. So some of the activities that she was describing would not have been allowed under the previous Administration, as well.

The previous Administration became increasingly concerned about what is called bundling, to where schools would bundle payments together. They came out with guidance saying no, we are not going to recognize bundling any longer.

In terms of provider taxes, the previous Administration, again, was very concerned, took a disallowance against five States in excess of $1 billion. In many respects, the cost associated with Medicaid was not being shared by the State but, in fact, being passed off onto the providers, themselves. The previous Administration stepped in and acted.

We also provided a table as an attachment to my testimony that shows the history of deferrals and disallowances that we have taken as a result of our financial management activities, and I think in looking at the chart I think that we are very much in line with our predecessors.

In terms of there was a lot of discussion about the cost rule, in particular, and again I have talked to a lot of groups, a lot of hospitals, and tried to explain what has been going on in Medicaid is the States have been passing their obligations on to providers. When we have stepped in, their providers have benefitted from that.

In California, for example, we have worked with California in their hospital financing. Revenues to California public hospitals went up. They went up by 12 percent, according to their own Public Hospital Association.

Provider taxes, again, to sort of reveal what is below the surface, when is the last time someone came in and asked to be taxed? Provider taxes are related then to payments, because the provider is willingly paying a tax knowing that there is going to be a return on that through increased payments. So, again, the financing is left to the Federal Government because the provider is not really paying the tax. The State is not really paying its share, but it is the Federal Government who is funding.

I think these things really can be summed up in terms of

what we are funding and what we are for in these rules.

Is it a medically necessary service? Is it for a Medicaid beneficiary? Is the matching requirement under the Federal-State partnership intact? The answer is yes to all of those, we pay. Federal dollars follow State dollars. They are the ones who are determining the services. They are the ones who are determining the reimbursement rate to providers. They are the ones who are determining the scope of services when you get to an issue like rehabilitative services. We are not talking about a disagreement about is physical therapy covered as a rehab service. Of course it is. There is no disagreement about is speech therapy in a school covered. Of course it is. That is not what the disagreement is about. The disagreement is about pushing the edges of the envelopes even further to see where an activity or a program of the State is being funded with State-only dollars. If you can get Medicaid money out of the Federal Government by calling it Medicaid, then you are ahead of the game.

That is where the issues of the discussions are about when we are talking about rehab services. We, again, learned a great deal in our conversations as States submit State plan amendments, do things like on therapeutic foster care. There is not a definition of therapeutic foster care in the Medicaid statute. There are many different definitions of

therapeutic foster care when you go out and ask the States, themselves, what do you mean by therapeutic foster care.

Again, when you are talking about that, in itself, are these a component of services for people with mental illness? We will pay. Is this for a mental health counselor? We pay. is this for the prescription drugs that someone needs? Of course we will pay.

This is about pushing the envelope to the outer boundaries to where is therapeutic foster care a juvenile justice wilderness camp. Then I think you do expect me to push back on the States and say no, that is outside the bounds.

David Parrella's quote about the creativity of the States I thought had great double meaning to it. The creativity of the States, new things out there on the horizons. States contemplating, talking openly about four our elderly prisoners in our penal system, in our correction system, can we somehow get them into a nursing home and have Medicaid start picking up the cost for them?

These are things that have been pushed to the edge, beyond the edge, and, in our opinion, yes, beyond the edge when we ask you what do you mean by therapy and we get the answer is we are going to pay for small engine repair. We think that that is our obligation to be saying what are we really paying for here. Is the Federal-State partnership

intact?

Again, if the State is paying its share, if it is for a medically necessary service, we are going to be there with you, as we have matched and we have matched over the years.

[Prepared statement of Mr. Smith follows:]

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Chairman WAXMAN. Thank you, Mr. Smith. Your prepared statement is all going to be in the record.

I want to start the questions, if I might.

Over the past ten months, CMS has issued six proposed Medicaid rules that would reduce Federal Medicaid payments to States by over $11 billion. There are persistent rumors that CMS is considering issuing more proposals that will cut Federal Medicaid payments to States even more. Members of this Committee, the States, providers, and beneficiaries would all be very interested in knowing whether these rumors are true, so I want to ask you, between today and the end of this Administration does CMS plan to propose regulations that would cut Federal Medicaid payments to States for targeted case management services? And if so, when will these proposed rules be published and how much do you estimate they will cut Federal payments to the States?

Mr. SMITH. We are to publish a rule on targeted case management. This is implementing the changes made under the Deficit Reduction Act of 2005, so we will be publishing final rules on that. The estimated savings I think is in the neighborhood of $4 billion.

Chairman WAXMAN. And these proposed rules are where?

Mr. SMITH. These are under review. I believe they are in the final stages of review. They have been with OMB, so other agencies are looking and commenting, as well, so it is

near the end of the process.

Chairman WAXMAN. In the next 15 months, does CMS plan to propose regulations that would restrict the flexibility that States now have to use their own methods for counting income, flexibility that enables States to give Medicaid beneficiaries incentives to work or to recognize the unique expenses many disabled individuals face in their efforts to remain independent? And if so, when will these proposed rules be published and how much do you estimate they will cut Federal payments to the States?

Mr. SMITH. Are you referring to changes in how States do income disregards for eligibility, Mr. Waxman?

Chairman WAXMAN. Yes.

Mr. SMITH. That is an issue that is under consideration. The S-CHIP debate was referenced earlier, and in some respects reflective of that, of how, in discussions about what is the upper limit for income eligibility for Medicaid or S-CHIP, through the use of income disregards going to actually even higher levels than that--

Chairman WAXMAN. So you are looking at this area, as well, for--

Mr. SMITH. It is under consideration. Yes, Mr. Chairman.

Chairman WAXMAN. Okay. Let me ask you this: in the next 15 months, does CMS plan to propose any other regulations

that would reduce State flexibility or reduce Federal Medicaid payments to the States? If so, what are these proposals, when will they be published, and how much will they cut Federal payments to the States?

Mr. SMITH. Mr. Chairman, we are in the formulation of next year's budget. Decisions have not been made in terms of whether any further regulations, to my knowledge, any further regulations in Medicaid will be proposed. But, as I said, that is the normal pass-back between agencies and OMB, and final decisions are still generally a month away, month and a half away.

Chairman WAXMAN. Well, we want to know if there are proposals, so we would like to have you inform us of that.

Mr. SMITH. Doing that prior to the release of the President's budget is usually an issue of some sensitivity.

Chairman WAXMAN. The Federal Government spends about $200 billion to help the States cover over 60 million low-income Americans. Because of the program's size, changes in Federal Medicaid policy could have major impact on States, on counties, on hospitals, on other providers, and, of course, on beneficiaries, who, by definition, are the most vulnerable among us. They have to be very, very poor to get covered under Medicaid.

Each of the proposed rules we are discussing today would make major changes in Federal Medicaid policy. As we heard

from the witnesses on the first panel, many of these changes could well cause great harm. Yet, with one minor exception, each of these proposed rules have no statutory authorization, much less a statutory directive. Congress has made no change in the Medicaid statute relating directly to limits on payments to public providers for Medicaid patients since 1997. In fact, the Administration in its fiscal year 2005 and 2006 budgets proposed such a statutory change and Congress rejected the proposal.

Congress has made no change in the Medicaid statute relating directly to payments to teaching hospitals for GME since the program's enactment in 1965.

Congress has made no change in the Medicaid statute relating directly to outpatient hospital services since 1967.

Congress has made no change in the Medicaid statute relating directly to payments for rehabilitation services since 1989.

Congress has made no change in the Medicaid statute relating directly to payments for school administrative and transportation costs since 1989.

In only one instance provider taxes has Congress made a change in the Medicaid statute in this past decade, and that change does not support the harmful changes you propose in your March 23 rule.

In that red folder is a compilation of Social Security

Act in the red cover. The Medicaid statute begins at page 1677, where there is a yellow sticker. Could you show us where in the Medicaid Act Congress has specifically directed CMS to issue the rules you propose that we are discussing this morning, other than the provider tax rule?

Mr. SMITH. Well, I think the Medicaid statute, itself, has a number of provisions that instruct the Agency to assure that there is a match rate that Congress has established by statute that is updated every year. There is a provision in the Medicaid statute that specifically excludes payments under Medicaid for things that are not Medicaid services. So there are provisions in the Secretary's authority to review State plans, to whether or not those State plans are consistent with the efficiency and economy of Federal reimbursement. So there are a number of provisions in the statute to give us the authority to do what we have done.

Chairman WAXMAN. I just must disagree with you very strongly. I don't see anything in the statute that allows you to decide what is Medicaid eligible and what is not Medicaid eligible. I see nothing that allows you to withdraw $11 billion in Federal Medicaid funds from the States.

It looks to me like you have just decided to take matters into your own hands. It is a blatant disregard of the prerogative of Congress to make major changes in Federal Medicaid policy. If you want changes, you should propose

them. If you propose them and Congress doesn't agree with them, you don't have the ability, in my view, to just come in and propose them by way of rule-making. I regret sincerely that matters have come to this point, and I strongly urge you to reconsider your course.

Mr. SMITH. Mr. Chairman, if I may, in particular, be able to give you the exact cite, in terms of the cost rule that we have discussed this morning and the impact on the hospitals and the States, et cetera, again, through State plan amendments, which we have the obligation to review, 1902(a)(2) specifically says that the State match must be assured by the State, that it requires ''Federal participation by the State equal to all of such non-Federal share, or provide for the distribution of funds, et cetera.''

That does tell me when a State submits a State plan amendment to increase reimbursement for a hospital, that it is my obligation to say I am willing to commit the Federal dollar, but show me your State dollar. That has been the genesis of the problems that we have been talking about in terms of recycling where providers are being required by the State or county government to return money that was meant to pay them for services provided to a Medicaid recipient.

Chairman WAXMAN. I have to move on to other Members, but Mr. Parrella testified that we have had an ongoing working relationship between the Federal Government and the States, a

partnership to provide care for the poorest among us for two decades, and some of these State plans are routine. You are taking routine State plans and then trying to jam through changes that Congress never intended, and I don't think you have the authority to do it.

Mr. Davis?

Mr. DAVIS OF VIRGINIA. Thank you very much.

Mr. Smith, if you wait for Congress to act on this, it is an airplane flying into the mountain. It is the fastest-growing part of the Federal budget. It is the fastest-growing part of State budgets. It is annual appropriations $300 billion a year. That is more than the Defense budget. And we don't vote on it or touch it at this point in Congress. So I think you have a responsibility to make sure that the dollars are spent wisely, and I don't have a comment on these six proposals that you have made, but I think you have every right to get out there and put them out for comment and to see where the public is, who is going to get hurt.

It is not really a question of dollars; it is a question of services and, as you say, making sure that the taxpayers are getting their benefit on this.

It is a difficult job, but if you wait for Congress to act on this there won't be any money left in the budget. This is the single fastest growing part of the Federal

budget.

The cuts that they talk about, too, we are not talking about cutting Medicaid payments? The payments go up, don't they, every year? This is just a cut in anticipated growth; is that fair to say?

Mr. SMITH. You are correct, Mr. Davis. This is slowing the rate of growth. As Mr. Shays pointed out, we are talking about $11 billion over five of which Federal spending will be over a trillion dollars in that time period.

Mr. DAVIS OF VIRGINIA. My understanding is that the Federal portion right now is set to go up $16 billion in 2008, $17 billion in 2009, $21 billion in 2012. That is a lot of money as we go forward.

Health care is a complicated issue and we want to try to make sure that everybody gets served one way or another, but ultimately it is going to be a Congressional responsibility to try to sort that out.

I am as frustrated as you are by Congress' inability to act or give you appropriate direction. A blank check isn't the way to solve it.

Let me ask you this: it is projected that the cost of the Medicaid program will double in the next ten years. To the degree that States are inappropriately shifting costs to the Medicaid program because of the open-ended entitlement structure, what pressure does this add to the Medicaid

program and its ability to fulfill its mission to provide medical services to those that are most in need?

Mr. SMITH. Well, Mr. Davis, I think, again, part of it is overall health care and Medicaid's role in that. Clearly, health care in itself is increasing and continues to grow. That is part of that. Medicaid is a component of that larger system. To some extent it causes the increase, even in the private sector. General Schwarzenneger, for example, has talked about the increased pressure on the private sector because MediCal under-pays its providers. So there are relationships throughout the system.

It does put greater pressure on everyone. Some changes we have applauded and helped to lead.

Mr. DAVIS OF VIRGINIA. I mean, pressure is everywhere. The providers that were here today, I think we all understand their frustration, as well. I hear from the providers, whether it is doctors or whether it is hospitals, in our area. Everybody is pressured under this current system.

One thing that was noted, they talked about hospital closing in one of the Members' District. Five hospitals were closed in San Diego County over the last three years just because of people coming across the border and presenting themselves at the emergency room.

This is a complicated issue.

Let me ask a couple questions. For the purposes of

clarifying the impact of harmonizing Medicaid's definition of outpatient services with that of Medicare, will those services that are no longer considered outpatient services no longer be reimbursed by Medicaid?

Mr. SMITH. No, sir. The issue is not whether or not a service will be paid for. Again, there are lots of services provided in an outpatient setting. We would continue to pay for those services.

The issue, though, again, as we saw in State plan amendments in asking States about what they were going to include in, what they were trying to do was basically inflate their upper payment limit for their outpatient hospital service. So it is not an issue whether or not you are going to pay for a clinic service; it is how it can be used to count towards potentially supplemental payments.

Mr. DAVIS OF VIRGINIA. To clarify the impact on transportation services and Medicaid, could you try to explain how the proposed rule affects the following:

First, transportation to school and back for non-school-aged children to receive medical services.

Mr. SMITH. For non-school-age, if they were receiving a medical service at the school, we would pay in that respect. Yes, sir.

Mr. DAVIS OF VIRGINIA. Transportation from school to a community-based provider and back for medical services?

Mr. SMITH. We would pay for that, Mr. Davis.

Mr. DAVIS OF VIRGINIA. Okay. Coverage of medical equipment necessary for a disabled student, like a breathing apparatus or wheelchair, to be transported to and from the school?

Mr. SMITH. In that respect, an individual is going to have their own. A child who is on a respirator has the need for a respirator before school, during school--

Mr. DAVIS OF VIRGINIA. Do you cover the equipment, though?

Mr. SMITH. Yes, sir.

Mr. DAVIS OF VIRGINIA. Some of that equipment would be covered by you, and that would continue to be covered?

Mr. SMITH. That would already have been paid for by Medicaid.

Mr. DAVIS OF VIRGINIA. Do you think that some of the services included in therapeutic foster care, when unbundled, will continue to be covered by Medicaid?

Mr. SMITH. Again, Mr. Davis, that is the issue in terms of when we are asking the States what are the components of what they mean. Therapeutic foster care is kind of a catch-all term, and different States are giving it different meanings. But in terms of services, and particularly for individuals that are mental health services, et cetera, those are all covered services. It is the components that, as I

suggested, pushing the corners of the envelope--

Mr. DAVIS OF VIRGINIA. My time is up. Real quick, conceptually what would be covered and what wouldn't be covered? Do you have any concept of what you would be likely to approve and what you wouldn't in an unbundled--

Mr. SMITH. Again, when you are providing mental health counseling, when you are providing intensive mental health services, but when you are going and pushing to say therapeutic foster care also means child care or some other type of more of a social service, we would push back.

Chairman WAXMAN. Thank you, Mr. Davis.

Mr. Davis?

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman. Thank you, Mr. Smith.

Mr. Smith, in recent speeches the President has repeatedly said that the Administration has a clear principle; that is, put poor children first. Medicaid is the program that insures the poorest children in America. Could you tell me how prohibiting public school nurses from enrolling kids in Medicaid is putting that principle of putting poor children first?

Mr. SMITH. Happy to respond, Mr. Davis.

One of the issues that we face is in the administration and training side of what is being claimed. It is very difficult to actually establish what is happening when we pay

that. School-based administration really is concentrated on only a handful of States. Whether or not what they are doing with those funds is widely discussed, GAO has done studies and acknowledged that there were abuses in that setting.

Through audits we are finding Medicaid paying for capital costs of schools because it is being hidden under administration, and Medicaid is being billed for indirect costs.

We obviously want every child who is eligible to be signed up. I have had discussions with California, one of those States. Illinois uses school-based administration. Those two States combined account for 40 percent of all of the school administrative costs that Medicaid is being paid for.

But if you want to sign a child up at school, which I have suggested to California, have the social workers take their laptop down to school on Tuesday afternoons and enroll people.

Mr. DAVIS OF ILLINOIS. You express a number of allegations in your response. Could you tell me what sources of data CMS relied on to develop this proposed rule with respect to both school-based administrative claiming and transportation services?

Mr. SMITH. In terms of what data we have?

Mr. DAVIS OF ILLINOIS. Yes.

Mr. SMITH. The data reporting is uneven because there are different line items in the Medicaid service categories and in administrative costs. There is not a school-based, per se, so we are, to a large extent, relying on the States on how they are reporting what they are doing. But in terms of informing our decision, going forward our Inspector General reports, our own financial management reviews, prior GAO reports. I know Marjorie was here previously and wasn't aware of whether GAO had spoken to school administration, but they did do a report in 2000.

Mr. DAVIS OF ILLINOIS. Well, in this 2000 GAO report on school-based Medicaid services, it was indicated that what was then, of course, HCFA was providing confusing and inconsistent guidance across regions and had failed to prevent improper practices and claims in some States. I guess my question becomes: what activities has CMS engaged in to improve such oversight of school-based administrative claiming in response to this GAO report.

Mr. SMITH. Again, the way States typically talk to us is through their State plan amendments. As State plan amendments come in to us, we discuss those with the States, what is being covered, what is not.

We did release a school-based administration claiming guide in 2003 to clarify, for example, on the match rate on skilled medical personnel.

We have States out there claiming without State plan amendments. We have States out there claiming, saying that the non-Federal share is being paid for with certified public expenditures. We ask where are the certified public expenditures to show that, in fact, the cost has been incurred in the first place, that there was a non-Federal share. Quite frankly, States are often in difficulty producing such documentation.

So we have been increasingly uncomfortable that this is an area that Medicaid is being appropriately making payments, whether or not there is sufficient accountability. That is my concern, that there is not.

Mr. DAVIS OF ILLINOIS. So you can trust the Medicaid employees but not the school employees?

Mr. SMITH. Mr. Davis, I think that there are a number of examples to where schools and the Medicaid agency, even at the State level, don't see eye to eye.

Mr. DAVIS OF ILLINOIS. Thank you very much.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Davis.

Mr. Murphy?

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

I guess I want to talk about what is happening in the real world out there, which is that you simply can't take a look at the cuts that are being made in Medicaid and make

statements such as the one that you have made, or at least that the agency has made, that special education funds should be taken care of by the Education Department or that services for people with mental illness should be the purview of SAMHSA and disease prevention should be in public health without figuring out that the Federal funds flowing to those programs are receiving the same, if not worse, cuts than you are seeing under the ones proposed by these regulations.

It would be one thing if the cuts you were proposing now were being made up in increased or even stable funding in burn grant funding, juvenile justice funding, in IDEA funding, in maternal and child health block grant funding. But the fact is that at the same time that these regulations are being proposed, the very Federal funds that might assist States in trying to find other avenues of funding have been cut, as well, even with more Draconian cuts.

So I guess the question is this: when you are taking a look at these cuts and making claims that these services should be picked up by other State programs, is there any effort to take a look at the other Federal programs that fund those services? And is there any recognition of the fact that those funds coming from the Federal Government that could potentially supplement States in order to make up for your cuts are experiencing even more drastic cuts? I mean, is there any view towards that big a picture?

Mr. SMITH. Thank you, Mr. Murphy. Again, in terms of service, Medicaid services that Medicaid covers that is a medically necessary service, again, we are saying yes to bill Medicaid for that individual and we will pay for it. Oftentimes, as I said, we are being stretched beyond that.

I think, to some extent, again, because there are differences among States and local agencies where these services, programs vary across the country, what we often find it is it started at the local or State level and there is--again, if you have a successful program that you believe is working, that is effective, that is helpful in that individual's life, you support that program.

Medicaid usually comes later, because then they are saying now we have this program but we are paying for it with our own dollars, but if we call it Medicaid--and, Mr. Murphy, there are agencies, there are companies out there, that is their business, for helping States to maximize Federal revenue and helping States to say call it Medicaid. Now what was 100 percent State or local funded, we can now cut it in half because we have called it Medicaid.

Mr. MURPHY. With all due respect, sir, I don't think that is what is happening, at least in Connecticut and many other States, that there are these rampant abuses happening of things just being called Medicaid. There are, in Connecticut's case, legitimate rehabilitative services that

were covered fully with State dollars for years and now there is a choice being made to take advantage of what has, for a very long time, been an available Medicaid match.

I guess you continue to provide testimony this afternoon regarding all these abuses. The solution then seems to be to cut out eligibility of those services rather than to spend some effort and finances and resources to root out the abuses that are happening and make sure that we do not reimburse for those.

So it is a little hard to understand why we aren't here talking about ratcheting up the ability of CMS to root out abuse and fraudulent billing, rather than simply saying it is too hard to figure out whether these administrative costs are really being used for signing up kids or whether they are being used to build walls, and so we are just not going to cover it any more. Why don't we spend more time actually finding out who is abusing the system and allow those who are doing it right to still gain the benefit of the Medicaid match.

Mr. SMITH. Yes, sir. And we are trying to do both. I mean, we certainly want, through management reviews, through OIG audits, want to get the abusing also, but it is also everybody does want to know what the rules are and make sure all the rules apply to everyone. If in region one the Federal Government shouldn't be saying yes that is a

rehabilitative service in region one, but in region nine it is not. That shouldn't happen, and that is, again, part of the rationale for rule-making in the first place, to make certain everybody does have the same understanding.

Mr. MURPHY. And I think that this Committee and this Congress would look forward to engaging in a process by which we standardize some of those understandings rather than using the non-standardization as an excuse to simply cut off funding.

The last thing I will say, Mr. Chairman, is that I do think that there needs to be a little bit more real-world experience put into these rules, whether it is the reality of what these new foster care guidelines will mean for families that are now going to have to maintain very detailed and complicated billing standards, whether it is the statement that you made that you should settle this question for California by simply sending a social worker down with a laptop. Well, in my State we don't have enough money to give laptops to all of our social workers, and the fact that they have more and more to do means that they have less and less time to go down to the school.

The reality on the ground is that these school districts, these social service departments are stretched so thin, these parents who are taking on these very complex children with very complex illnesses are stretched so thin,

both emotionally and logistically, that this is going to be very, very hard to implement, and I think very, very hard to understand for people that have less and less resources to do it with.

I yield back the balance of my time.

Chairman WAXMAN. Thank you, Mr. Murphy.

Mr. Shays?

Mr. SHAYS. Thank you. Again, Mr. Chairman, thank you for having this hearing.

The sky isn't falling in. We are talking about $11 billion savings in the increase over five years. We will spend a grand total in the next five years of $1,258 billion, and it would be $11 billion more if you didn't make these savings. So there is a part of me that wants to know why you aren't doing a better job of getting savings, not to blame you for finding 9/10ths of 1 percent in a budget.

There is no undeclared war on the part of the Bush Administration. I voted for the health care bill, CHIPs bill for young people, but the President had legitimate arguments. He said it shouldn't go to illegal aliens, he said it shouldn't go to adults, and he said we should be trying to get those children who are the poorest of the poor that are still part of the program. So I think the President's position, while it is not one that I voted for because I want to expand the program, is not one that says we are declaring

war against kids.

Let me ask you, with regard to inter-government transfers, can you speak to what challenges the inter-governmental transfers involving public, non-governmental hospitals raises for CMS, both from a fiscal integrity of the Medicaid program point of view and from conducting oversight of the use of Medicaid funds?

Mr. SMITH. Yes, Mr. Shays.

Again, let me hasten to say there is an inter-governmental transfer recognized in the Medicaid statute that is permissible. What it means by that is the State can share its cost with local government. That is perfectly fine. We are not challenging that. But what has been termed inter-governmental transfer, we have generally been referring to it as recycling. With a provider in 1903, I believe, Congress put a limitation that says non-governmental entities cannot pay the State's share. I am simplifying it, but basically the taxes and donations provision.

What was happening with non-governmental entities were payments were being made and then payments were being returned. We are looking at that as recycling, because we are saying what should we match. If the bill was presented to us for $100, that a service was provided for $100 and in a 50/50 State like Connecticut State paid $50, we paid $50, but

we find out on the back end that the hospital or the nursing home returned, after they got paid, returned $25 back to the county or the State government.

Mr. SHAYS. So in essence the Federal Government was paying more of the cost than 50 percent?

Mr. SMITH. Correct.

Mr. SHAYS. Let me ask you another question. With regard to rehabilitation services, school transportation, school administrative costs, hospital outpatient services, and graduate medical education, the Chairman said, if I heard him correctly, that these programs were going to be discontinued. Is Medicaid eliminating these services for eligible beneficiaries?

Mr. SMITH. No, sir. Medical services that are medically necessary will continue to be covered.

Mr. SHAYS. And does CMS anticipate that these changes will result in the denial of services?

Mr. SMITH. There should not be being denied services because we clearly are saying we will pay our share for those services.

Mr. SHAYS. Let me ask you another question. On the first panel we heard from Ms. Barbara Miller about how important Medicaid rehabilitation services were to bringing her to where she is today. Can you speak to how, either under this proposed rule or under other aspects of the

Medicaid program, maybe through waiver authorities, such services as psychiatric rehabilitation will still be covered?

Mr. SMITH. Yes, sir. It will take a little bit of an explanation, if you will forgive me. Rehabilitative services in terms of what she spoke so eloquently about, what is called assertive community treatment--and I have stated publicly and to all types of audiences that assertive community treatment is a model of care and it is a model of care that we do presently support, and we have said we are willing to support. We recently released a State Medicaid director letter again that is very pertinent to people with mental illness on peers of saying that Medicaid reimbursement is available for peer counseling.

So, again, there are models of care that we currently support, that we believe we will continue to support under the rehabilitative services issue.

The habilitation side to where you are getting into--it is not rehabilitation, but habilitation, such as an adult day center, that really belongs to the other side of the Medicaid program of home and community-based waivers, which really is more of a social support mechanism to pay for those things to help people stay in the community, but they are not rehabilitative services. They are not medical services.

So States have that option, as well, for individuals to do adult--if you have a program for adult day program, that

belongs on over on the home and community-based services side of the program and we would continue to support that if that is what the State chose to do.

Mr. SHAYS. Thank you, Mr. Chairman.

Mr. SMITH. Yes, sir.

Chairman WAXMAN. Thank you, Mr. Shays. We give a lot of options to States and everybody else to come up with money that the Federal Government won't buy. Or States also have the option of saying no, they don't have the money.

Mr. Cooper?

Mr. COOPER. Thank you, Mr. Chairman. And thanks to all the witnesses on both panels.

I think the only thing we all can agree on is that no one would want Dennis Smith's job. It is a tough one.

Everybody here knows that this is not just a hearing on whether we have illegally aggressive regulations being promulgated. The hearing is really about the collapse of the U.S. health care system, and this is just evidence of it. Rather than focus on the negative, I think it is important to recognize that we all have a responsibility in this collapse.

I was struck by the testimony on the earlier panel of Drs. Gardner and Retchin, particularly the emergency room story, but Congress passed the law years ago and made it an unfunded Federal mandate. We require hospitals to see most all comers--you can go on diversion--and we didn't pay them

for it. We are surprised that the number of ERs in America have gone down relative to the needy population?

There are so many other aspects of this problem. We really need hearings like this every day for years to try to get to the bottom of it.

I am from a State that has been guilty of gaming the Medicaid system. I am embarrassed by that. As we took our legitimate 65 to 67 percent match, in some years we made it 92 percent. Why? Because we wanted to and we could get away with it. That doesn't make it right.

These six regulations, I don't think nobody here is defending them. You still have to because you work for the Administration, but it is amazing that in such a giant program that only $11 billion of savings was found.

I am not suggesting that these are the best ways, but this is such a fly speck of a larger problem. It is almost embarrassing.

The Comptroller General of the United States, David Walker, has written that we face $50 trillion in outstanding obligations, mainly health care. Today we have no idea how to fund those.

And not a penny of that $50 trillion is Medicaid, because we don't even have the analytical tools to describe the hole that we are in in Medicaid. Some analysts, like Hal Jackson of Harvard, say that these problems are getting worse

to the rate of $3 trillion or $4 trillion a year. Of course, the President denies that because he doesn't want the broader measure of our deficit problems.

But that means that any reform proposal that would gain ground on this problem would have to save more than $3 trillion or $4 trillion a year. That is unimaginable. I don't know of any group in this Country who has come up with a reform proposal of that scale.

Meanwhile, we are like the blind men of Hindustan. You know, we see a portion of the problem and each complain fiercely it looks like a snake to one, a tree trunk to another, a wall to another, and in fact it is an elephant. And we can get mad at each other and finger point and complain and all that, but meanwhile we are confronted by an elephant, and I don't see many people in Congress or outside of Congress that are doing much about it. We need comprehensive health care reform that looks at all aspects of the problem, because Medicaid is one of our most important programs.

The Chairman of this Committee helped build this program. Committee staff helped build this program. It is painful for them to see it dismantled piecemeal, because piecemeal solutions don't work for anybody--patients, doctors, law makers, families.

So it is hard to get at all these issues, and I know I

just have a short period of time, but one of the unspoken issues in this hearing is federalism. Under Medicaid we give States so much leeway. I can't help but know the irony that there is Dr. Retchin sitting behind you and he used to run Virginia Medicaid. Dr. Gardner has her former governor, now president of the United States, from Texas, and Texas is one of the States that has pioneered specialty hospitals that have no emergency rooms. The national case recently of the person who was dying in a Texas specialty hospital, had to call 9-1-1 because there was no emergency treatment in a Texas hospital because Texas law allows that to happen, why is that?

Now, do we need to override State flexibility? That is an outrage. Yet, it is happening more and more across our Country. And that is not technically a U.S. responsibility. The State did it.

Texas has more uninsured children, I think, than almost any other State in America, 25 percent. What an embarrassment. Texas is not a poor State, but they are not taking care of their own kids. Is that our fault?

So there are all these problems we are not beginning to deal with as a Nation, and I just have five minutes to make a quick statement, but, for the written record, I would like from you the policy choices that you could have made instead of these six regs, because there have to be other better ways

to save money in the Medicaid program. We spend $2 trillion on health care in America, yet no one wants to give up a penny of what they are receiving, and yet we don't have the best health care in the world. So I would just like to know, from the menu of choices, why you all came up with this $11 billion and which choices you rejected.

[The information to be provided follows:]

********** COMMITTEE INSERT **********

Mr. COOPER. I see that my time has expired, Mr. Chairman. Thank you.

Chairman WAXMAN. Thank you, Mr. Cooper.

Mr. Cummings?

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

Mr. Smith, it is good to see you again.

Mr. SMITH. Yes, sir.

Mr. CUMMINGS. As you know, on October 18, 2007, President Bush issued the Homeland Security Presidential Directive No. 21. You are familiar with that, are you not?

Mr. SMITH. [No audible response.]

Mr. CUMMINGS. Well, let me tell you what it says. You look a bit confused. This directive is intended to establish a national strategy for public health and medical preparedness that will ''transform our national approach to protecting the health of the American people against all disasters.''

Directive 21 instructs the Secretary of Health and Human Services to undertake several critical tasks. Among these are two of particular relevance to our hearing today. The first deals with medical surge capacity that we have heard a bit about during the first panel. Of course, that is the ability of the hospitals and the public health systems to treat large numbers of casualties in a short span of time.

The second instructs the Secretary to ''identify any

legal, regulatory, or other barriers to public health and medical preparedness in response from Federal, State, or local government or private sector sources that can be eliminated by appropriate regulatory or legislative action.''

Based on what we heard from the physicians on the first panel, it seems clear that your proposed regulations constitute a significant legal and regulatory barrier to public health and medical preparedness and response, and, as such, they appear to violate the President's own directive.

How do you respond to those concerns?

Mr. SMITH. Mr. Cummings, in terms of the cost regulation that we have proposed, as I have tried to explain, our policy says the hospital or nursing home or whomever is actually providing the service should get paid and get to keep the money for the service they provided. I don't see that as a conflict with what you have just described.

Mr. CUMMINGS. Did you hear I think it was Dr. Gardner's testimony when she talked about--

Mr. SMITH. I did, sir. Yes.

Mr. CUMMINGS. How does that strike you that anybody sitting in this room--we have got, I guess, about 100 people in here--anybody could get sick down there in Texas, I think it is, and be in a position where the patient that she talked about, not even able to get a bed. Does that bother you? I mean, when you hear things like that, does it make you think

about that when you go to bed at night and put your family to bed? Do you say to yourself, Boy, it is kind of hard for me to sleep thinking that there are people in the United States, some of them my own neighbors, who might be placed in that position?

Mr. SMITH. Mr. Cummings, I have devoted most of my career to public service. I do it precisely for people who need the support and help of their neighbors.

Mr. CUMMINGS. And so you sleep well at night?

Mr. SMITH. Yes, sir, I do.

Mr. CUMMINGS. I see. So you feel, as far as these directives are concerned, when it comes to the graduates, the graduate schools, does that concern you that we may have some problems there? You heard the testimony about them?

Mr. SMITH. Health care has many different parts to it, and I absolutely want to make certain Medicaid does its part, but to take on the responsibility of other functions, programs, et cetera, there are lots of different choices on how to address the graduate medical situation and the hospitals, themselves, that participate in it.

For example, in New York, as New York was one of the previous witnesses, New York has a $3 billion disproportionate share hospital system. They could use that entire amount for indigent care, but that is a choice that New York makes in the Federal-State partnership.

Mr. CUMMINGS. Well, I am going to conclude because I see we are running out of time and I see that Mr. Kucinich is here, but it seems clear that your agency's rule-making will harm disaster preparedness in many of our Nation's cities and undermine Federal efforts to strengthen medical surge capacity for pandemic flu, bioterrorism, and other public health threats. At a time when the Congress is providing the Department of HHS billions to enhance emergency preparedness, your agency, in my opinion, is undermining key elements of our Nation's preparedness infrastructure.

I have often said that when we come to positions that we should make them better. I know that you are going to leave here saying that you are going to probably make it better, but I am telling you, after your tenure I think it will be worse. I hate to say that. And I do pray for you as you sleep in peace.

Chairman WAXMAN. Thank you, Mr. Cummings.

Mr. Kucinich?

Mr. KUCINICH. Thank you. I want to thank my colleague, Mr. Cummings. I would ask him if he has a moment if he can stay, because these questions relate to something you and I have worked on together.

Mr. Smith, in May you appeared before the Domestic Policy Subcommittee of this Committee, which I am the Chair of the Subcommittee, at a hearing on the serious failures to

provide dental services to children in Medicaid in general and the resultant death of a child in Maryland, Deamonte Driver. At the time you said you would check on the actual services available in Maryland. Since that time, the Subcommittee did its own research, including an audit of United Health Group's claims records in the county where Deamonte Driver lived and died.

Here is what my Subcommittee found: that Deamonte Driver was one of over 10,780 Medicaid eligible children in Maryland who are enrolled in United Health's Medicaid Managed Care Organization and who had not seen a dentist in four or more consecutive years. Only seven dentists provided 55 percent of total service to United beneficiaries in Prince George's County, Maryland. Nineteen dentists listed in United's dental network provided zero services to eligible children in Prince George's County, Maryland.

Twenty-two dentists listed by United provided services to only one child merely a single time, and 45 dentists care for eligible children less than 10 times in Prince George's County, Maryland, and 7 dentists were unreachable by phone.

These findings are appalling, but at least one thing has changed: United Health no longer denies the truth about the inadequacies of their provider network in Prince George's County, Maryland. On October 18, they wrote a letter to me in which they conceded that my Subcommittee's findings were

accurate. They said, ''We concur with the majority staff's findings.''

My question for you, Mr. Smith, is, would you please tell this Committee if CMS had conducted an audit of United Health and was aware of the specific inadequacies of United's dental provider network prior to our Subcommittee hearing?

Mr. SMITH. Prior to your hearing we had not looked at the individual records.

Mr. KUCINICH. Since the hearing has CMS conducted an audit?

Mr. SMITH. I spoke with counsel beforehand. I would be happy to speak with you off the record, if that would be fine.

Mr. KUCINICH. You took an oath.

Mr. SMITH. I did take an oath.

Mr. KUCINICH. Has CMS conducted an audit?

Mr. SMITH. We are taking additional steps, Mr. Kucinich.

Mr. KUCINICH. What about the findings?

Mr. SMITH. The findings, sir, are not in at this point. We have not made a final determination.

Mr. KUCINICH. Will you provide this Committee all documents and findings within two weeks?

Mr. SMITH. I don't expect it will be completed by then, Mr. Kucinich, but when we are completed we will be happy to share the information we have with the Subcommittee, with the

full Committee.

Mr. KUCINICH. Will you provide them in four weeks?

Mr. SMITH. [No audible response.]

Mr. KUCINICH. Six weeks? Eight weeks? Three months? Four months? When will you provide this Committee with the information that you claim you are trying to get that reflects upon the death of a young man? When will you provide us with the information?

Mr. SMITH. I will furnish it as soon as it is completed. I will furnish you all the records that we have. I am not certain when this will be conducted. I expect it will be done before the end of the year.

Mr. KUCINICH. Mr. Chairman and Mr. Smith, Mr. Smith, we know how bad the problem is in the State of Maryland and we know where you were before our Committee hearing. We are wondering what a national audit would show. Has CMS undertaken a national audit in this regard?

Mr. SMITH. We are looking at other States, Mr. Kucinich.

Mr. KUCINICH. Will you provide this Committee all documents and findings on those audits?

Mr. SMITH. I am happy to provide what we find.

Mr. KUCINICH. How many other States, sir?

Mr. SMITH. We have just started another State. We are looking at States to look beyond that in terms of where to go after that.

Mr. KUCINICH. Mr. Chairman, I ask unanimous consent to have another minute.

Chairman WAXMAN. Okay.

Mr. KUCINICH. I would just say that our Subcommittee is going to be relentless on this, Mr. Smith. You are not going to be able to avoid--unanimous consent, Mr. Chairman, for another minute. My time has expired.

Chairman WAXMAN. I am sorry. The problem we have now is we have a vote.

Mr. KUCINICH. I just want to conclude then by saying that you are not going to be able to avoid the scrutiny of our Subcommittee or, I am sure, of this full Committee. There is a little boy in Maryland who died. We are not going to have any more children dying because CMS has not done effective oversight of these people who are providing care in the name of the Government of the United States, period.

Mr. SMITH. Mr. Kucinich, if I may, Mr. Chairman, I think the work of the Subcommittee was extremely helpful and important, and I hope that you would view us as working together on the problem rather than seeing us as an adversary on this issue, because I do not feel that way. I think that we share the same interest.

Mr. KUCINICH. I agree. We are going to work together.

Chairman WAXMAN. Mr. Engel, do you have some questions you want to ask in the short time we have left?

Mr. ENGEL. Yes, thank you. Thank you, Mr. Chairman. Let me thank you for allowing me to participate. I know there is a vote on, so rather than ask all the questions I just want to make a very brief statement.

I want to thank you for your leadership. Obviously, I have also been very troubled by the recent rules proposed by CMS and from what I consider their absolute disregard for Congress. Major Medicaid reforms require a Congressional role, and by rushing to publish these regulations CMS, in my opinion, has disregarded Congressional opposition and attempted to usurp Congress' role and, more importantly, CMS appears to have no regard for our safety net providers and the low income people whose health care would be decimated if these rules were allowed to come to be inactive.

As you discussed today, CMS issued a proposed Medicaid regulation that, in my opinion, threatens public hospitals' ability to deliver vital services and stand ready in the case of a natural disaster or public emergency. This regulation would cut at least $4 billion in Medicaid funding to safety net hospitals nationwide over five years, and CMS subsequently added and issued an additional regulation that would force billions of dollars in Medicaid payment reductions to teaching hospitals, many of whom are public hospitals, which hampers the ability of these providers to provide essential services, including the education of the

next generation of medical professionals, despite a shortage of medical professionals.

While we have a one year moratorium in place until next May on staying these regulations, if we don't act soon, States, hospitals, and safety net providers are going to have to prepare for the worse, which is catastrophic draft and funding. That is why I introduced H.R. 3533, which has been mentioned several times here today, the Public and Teaching Hospitals Preservation Act, which I am proud to say has 143 bipartisan co-sponsors. You, Mr. Chairman, have been instrumental.

Mr. Smith, I am just wondering if you could please submit to me for the record. It is not possible--some of our colleagues said it before--with the financial pressure these institutions face, these public hospital systems, to sustain these kinds of sweeping cuts, so I would like you to, in writing, tell me how you expect safety net providers that provide essential care to hundreds of thousands of patients that walk through their doors to continue delivering this care. It is just not possible. It is not possible.

And the second question is: the teaching hospitals in my home State of New York currently receive $1.2 billion in Medicaid GME, graduate medical education, payments annually. If your proposal to eliminate Medicaid GME payments is implemented, you will be essentially cutting medical

education payments to New York by 40 percent. We have 15 percent of the teaching hospitals in the Country, so it is simply a devastating cut to the teaching hospitals in New York; indeed, to the Country, and hospitals across the State. So I do not understand why the Administration is pulling support away from training America's future doctors, particularly at a time when there was a well-documented physicians' shortage looming.

If each payer isn't expected to contribute its fair share, who is expected to make up the difference?

I will take it in writing, but I just think these are unconscionable.

Mr. SMITH. We will be happy to respond, sir.

[The information to be provided follows:]

********** COMMITTEE INSERT **********

Ms. MALL. Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Engel.

Mr. Smith, as we conclude, your proposals would have the impact of reducing payment to the States by $11 billion over the next five years. The costs that these Federal dollars now pay for will not magically disappear. People with mental illness will still need rehabilitation services, school-age children will still need health care. But under your proposed rules, the Federal Government will no longer pay for many of these costs. In other words, what is being proposed is a massive cost shift from the Federal Government to the States, the largest Medicaid regulatory cost shift in memory, and Medicaid has always been a Federal-State partnership.

Secondly, these proposed rules will result in major disruptions in the State Medicaid programs. Some of these rules threaten key elements of our Nation's health care infrastructure and could harm emergency preparedness. These effects are not well understood because CMS has not done any State by State specific analysis of the impact of its regulation. Perhaps this is because CMS does not have the necessary information, perhaps it is because CMS doesn't want to know. In either case, it is very troubling.

I hope, Mr. Smith, that you or Secretary Leavitt will be moved by what we have learned today and direct CMS to withdraw these proposed rules. If it does not, it will be up

to the Congress to take the necessary measures to protect States, hospitals, physicians, and Medicaid beneficiaries from these reckless proposals.

I think you understand where we are coming from, what we feel about this. There is a great deal of intensity. I have to tell you, I don't recall your being elected to any office to write the laws. We were. If you are acting improperly, we will have to take appropriate measures to make sure the laws are enforced, not denigrated.

Thank you for being here. Thanks to the first panel, as well. That concludes our hearing. The meeting stands adjourned.

[Whereupon, at 2:05 p.m., the committee was adjourned.]