

Remarks by Henry A. Waxman
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Introduction:

It's a pleasure to be here with you today.

I am particularly pleased that your organization has asked me to focus on Medicaid, because it is a program about which I care deeply. It is an essential program for over 52 million Americans. It covers 25 million children. It covers 8 millions persons with disabilities. It provides the critical supplemental coverage that makes Medicare work for 6 million seniors.

And it is a program that has been a virtual life saver for people suffering from mental illness.

As you all well know, Medicaid has become the primary payer of public mental health services. It is the payer for the low-income. It is the program where many suffering from these disabling conditions find the services and support that are all too often lacking in private health insurance coverage.

In the area of mental illness, as in many others, Medicaid has expanded and evolved to fill critical gaps in the health care system.

That is not to say that the program does not need to evolve further. In many areas, outdated limitations in the law or restrictive regulatory interpretations have kept the program from being as effective in addressing the problems of persons with mental illness as it could be.

The limitations on who can be covered in inpatient psychiatric facilities are very well known to you in this room. The shortfall in fully utilizing options for community-based care is another.

But despite all the areas where improvement is needed, what remains clear is what a tremendous resource the program remains for low-income people with mental illness.

Medicaid under Attack:

Yet in the guise of reform, Medicaid is a program that is clearly under attack.

The Bush administration and the Republican leadership in the Congress are determined to limit the Federal commitment to this program.

This has been a long-term goal, and one that is being pursued through many different avenues.

Some years back, we saw the direct approach: proposals to block grant the program. End the Federal commitment to pay its share. Give States flexibility to decide all the rules. Take away the rights of beneficiaries because when the pot of dollars is fixed, and costs go up, people just lose care.

Those were the proposals we saw in the Republican Congress in the 1990s. But the reaction was strong. People who previously hadn't known the difference between Medicare and Medicaid suddenly realized the critical roles Medicaid played.

And States, who long had pushed for flexibility in how they ran the program, started to get more than a little uneasy when they realized the price for that flexibility was a cap on Federal dollars.

So the direct assault on the program, the explicit call for a block grant, receded.

But it didn't end the threat.

This Administration has continued to pursue, through the waiver process, efforts to entice States into agreeing to a cap on the Federal dollars for their programs.

Sometimes they've used the carrot of allowing States more flexibility in areas that we all agree are positive, like more home and community based services.

Sometimes they've threatened to disallow State funding sources for the program that have traditionally been recognized as legitimate unless the State agrees to change their programs to conform to the directions that the Administration is seeking: more mandatory managed care, more cost-shifting to beneficiaries, more restrictive benefit packages, and a limit on the Federal contribution.

Sometimes they've even enticed States to these actions by holding out extra dollars in the short term in order to achieve their long-term goal.

And while they have been pursuing these changes through the back door with waivers, they have also mounted direct pressure on the program through legislative proposals to cut program expenditures, shift costs to beneficiaries, and take away benefits that have long been guaranteed.

Last year, the Administration capitalized on the desire of the Governors to have more flexibility in their programs. The cuts in Federal spending they called for in the program were mostly the result of changes that reduced both State and Federal spending by taking things away from the beneficiaries of the program.

They allowed more cost-sharing. They let providers deny benefits to a person who couldn't pay. They undermined EPSDT benefit protections for many beneficiaries. They allowed States to shift coverage to a model of what they called benchmark plans—benefits modeled on the private insurance coverage that has so often been inadequate for persons suffering from the kind of disabling conditions you are so familiar with.

About the only good thing you could say about the proposals that ended up in the Deficit Reduction Act was that the original Administration proposals were even worse.

But much damage will be done to many very vulnerable people because of the policies that were included in that bill.

So now we come to this year's budget. It represents what I call the old one-two punch.

Last year, the Administration justified the changes because they said the financial burden for the States in paying for their share of the program was too great, and we had to help them by taking away a lot of requirements that helped beneficiaries.

But suddenly this year, the bulk of the Administration budget proposals are ones that directly take away Federal dollars from the States. All of a sudden the concern about helping the States meet their financial obligations to the program doesn't seem the focus anymore.

The Administration budget proposes a reduction of nearly \$35 billion in Federal expenditures in Medicaid over the next 10 year period. Those cuts come both in the form of legislative proposals and regulatory actions.

On the legislative side, one proposal simply reduces the Federal share of the administrative costs of the Medicaid program, a cost shift pure and simple.

State administrative expenditures are used to determine eligibility, inspect nursing homes, and fight fraud—things that it hardly makes sense to ask States to cut back on.

In an even more short-sighted proposal, the Administration wants to reduce Federal matching funds for the cost of targeted case management services. These are the very services

that are critical for persons with mental illness and other disabilities. They are designed to help people access needed and appropriate services. This proposal makes no sense.

The proposed regulatory cuts are even larger--\$30 billion of the total \$35 billion in Federal cuts.

These go directly to the ability of the States to finance the program and to use Medicaid dollars to provide critical services.

They have targeted school-based services, particularly for children with disabilities. They also want to save Federal dollars by limiting the types of services that States can cover as rehabilitation services. This means, for example, taking away Federal matching funds for special instruction and therapy for Medicaid beneficiaries with mental illness.

I do not believe the Congress would endorse these cuts, even this Congress that is not Medicaid-friendly. So the Administration has proposed going around the Congress by simply taking these regulatory actions.

Only some very effective uprising in public opinion has any hope of stopping them.

While we are on the subject of regulatory decisions in Medicaid that have very negative impact on persons with mental illness, let me mention another one that is of great concern to me. Early last year it came to my attention that the Inspector General of the Department of Health and Human Services had taken the unprecedented step of auditing state Medicaid programs based on the premise that the federal government is not permitted to pay for the medical costs of children in institutions. As a result of these audits, Virginia, New York, Texas, New Jersey, and California were asked to repay over \$10 million spent on medical services for institutionalized children.

These audits were based on a mis-reading of the law. Under what is undoubtedly well-known to this group as the “IMD exclusion”, there is no federal funding for services provided in “institutions for mental diseases.” In 1972, Congress carved out the exception to the IMD exclusion that permits federal support for children to receive “inpatient psychiatric services”, which has long been understood to encompass medical treatment provided in accredited institutions.

Obviously, we should have done more, for all Medicaid populations, but at least this exception was established.

However, the HHS IG misread the law and regulations to permit federal support only for “inpatient psychiatric services.” Under this policy Medicaid would pay for psychiatric services for children in inpatient care, but not for their medical services. This is certainly not what Congress intended.

Sen. Susan Collins and I wrote to the HHS Inspector General as well as to the Administrator of CMS, Dr. McClellan, protesting these audits. To date, we received brief, albeit unsatisfactory, responses from both of them. So far, neither CMS nor the HHS IG has provided us with a solid legal basis for the position they are taking.

Before I leave the budget, let me just note that discretionary programs are also suffering under the impact of a budget philosophy that adds to the deficit with massive tax expenditures, and then cuts spending to address the deficit they create.

The President’s 2007 budget proposes a \$9 million cut to the National Institute of Mental Health, negatively impacting the ability of NIMH to continue to fund multi-year research grants.

The President’s budget also cuts \$72 million in funding to the Substance Abuse and Mental Health Services Administration. Funding for the Center for Mental Health Services (CMHS) would be reduced by \$25 million and many major activities would be frozen. These

activities include the Mental Health Block Grant, the Projects for Assistance in Transition from Homelessness (PATH) Homeless Formula Grant, and Children's Mental Health.

None of this makes sense.

But it is the inevitable result of a budget that can find over \$60 billion to spend encouraging HSAs and high-deductible health plans, and then cuts direct spending to make up for it.

Medicaid Reform:

What is represented in the budget is in fact a very clear view of the Administration's vision of what reform--or to use Mr. Gingrich's catchier phrase, transformation—of the health care system means.

That view is pretty simple: shift costs to the individual. Make them pay more out of pocket.

In the view of its proponents, somehow this will magically mean the market will work in health care. Patients will be able to analyze prices, and somehow negotiate a better deal for themselves. Patients will be able to easily judge the quality of providers and the services they deliver.

And this isn't just a vision of how we should design health care coverage for the wealthy—although that is clearly who would most benefit from the tax preferences built into these schemes.

It is seen as the way to cover even the poorest among us, people on Medicaid. So we see States pursuing waivers to put Medicaid beneficiaries in HSAs, as they are doing in South Carolina, or give them a defined contribution to their health care and let them figure out a private plan that will serve them better than Medicaid, as they are doing in Florida.

To me, this is exactly the wrong way to go, for the health care system in general, and certainly for Medicaid in particular.

It is beyond me when we have a system where nearly 46 million people are uninsured, and many millions of others have inadequate coverage, that we would think that putting more of the costs on the individual would make sense. Establishing a scheme that is likely to lead to less employer-based coverage is not just short-sighted, but dangerous. Assuming an individual is going to be more effective at negotiating prices than groups which use combined purchasing power like we have in employer plans is nonsense.

Ten percent of the population accounts for 70% of health expenditures. To talk about how we are going to empower individuals to get better deals on their “Lasik” surgery is focusing on exactly the wrong end of the problem.

All of you in this room know that we should be enacting legislation to guarantee mental health parity in insurance plans. I am a strong supporter of that.

But I don't think any of us had in mind that the way to achieve parity is to stop assuring coverage of other health care services, with high deductible plans that leave individuals on their own.

And lest we think this is just an exploration of a reform in the health care system, let's remember that in this budget alone, we are proposing to spend nearly \$60 billion over the next five years on new tax expenditures to encourage HSAs. That \$60 billion in lost revenue is money that can't be used to improve health care programs.

My argument is the same with Medicaid. Whatever dollars might be saved by addressing problems in the program should be turned back to Medicaid. It is a program that is clearly underfunded.

And if the burden of the program is too much for the States, then the answer is not to take coverage and benefits away from people who have no other source of care but to increase the Federal commitment to pay for its fair share of the program.

I want to cite just one instance of the unmet need that we already face with Medicaid, one that I know you are acutely aware of. I am thinking of the lack of accessible treatment for mental disorders that results in many young people ending up in juvenile detention centers. In 2004, a study by my staff on the Government Reform Committee revealed the juvenile detention centers and jails across the country are being used inappropriately to house children with mental disorders while they await community mental health services. Many of these youth are held without charges pending against them. They are in a situation that can only exacerbate their underlying problems.

When this is the reality of mental health care in this country—when children with mental disorders are kept locked up simply because they have no place else to go—I don't know how anyone can consider cutting the Medicaid funds that make treatment possible.

In the health care arena in general, and with Medicaid in particular, this wrong-headed approach that is being sold under the rubric of reform, will only be stopped if people who know better speak up and work tirelessly to expose this approach. Health care providers, like all of you, are in a position to do that.

And because of the issues you deal with, and the sensitivity you have to the particular problems that are faced by persons with mental illness, you can provide a unique and important perspective.

Medicare Prescription Drug Program:

Before I close, I just want to make note of one other issue: the Medicare prescription drug program.

In my view, the implementation of this program has been fraught with problems. And the problems we are seeing are not just start-up difficulties. They are endemic in the design of the program itself.

Assuming that people can deal with the complexity of 40 or more different plans makes little sense. But when they find that the formularies can change and the prices can change after they make their choice is a recipe for disaster. And we haven't even begun to see the problems that will occur when people start falling into the so-called donut hole, where their coverage stops.

The problems in drug coverage are particularly acute when we are talking about treatments that do not lend themselves to easy substitutions. Whether we are talking about AIDS drugs or mental health drugs, simply putting a drug in a protected class doesn't solve the access problems. When plans require a patient to fail one drug before they can use one that works—that poses a serious access problem, particularly for a vulnerable person already stabilized on a particular drug. Prior authorization requirements, or placing a given drug on a high cost tier, are barriers to effective treatment by mental health professionals like you for very vulnerable patients.

We saw these difficulties in extreme form with the transition for those people who had previously received their drugs from Medicaid. Nowhere was this clearer than with the estimated 2 million persons with mental illness in that situation.

While the Administration knew there would be difficulties with the implementation of Part D for these dual eligibles (that is the term we use for people eligible for both Medicaid and Medicare), the guidance they provided on how to deal with these problems proved woefully inadequate.

Certainly there were problems where people were auto-assigned to inappropriate plans, or where their enrollment couldn't be determined when they showed up at a pharmacy trying to refill their drugs.

But there were particularly serious problems because the CMS guidance failed to require that the drug plans assure the continuous coverage of a drug which had proven to provide beneficiaries with stable, effective treatment. Reports of scores of individuals who were forced to go without the drugs that managed their delusions, paranoia, anxieties or stress were all too common.

The CMS answer was to require a one-time refill.

But the point is, simply providing for a one-time transition supply is not enough. It is intended to provide an opportunity to go through a process of requesting a permanent exception from the drug plan for the needed medications. But that can be burdensome on the provider, confusing to the beneficiary, and potentially a system that will not work smoothly.

It is unfortunate that this most vulnerable population will face these problems. We face the possibility that countless mentally ill beneficiaries will be left without access to the very medications that had already proven effective in stabilizing them, drugs that they know work precisely because they have tried—and failed—with various other types of drugs.

But until we have the opportunity for a more basic reform of the Medicare Part D drug plan this is what you and your patients will have to deal with. I hope together we can work to minimize the problems this will cause.

Conclusion

These are very challenging times for people who care about health care coverage. I believe we must change the direction of the dialog and return to solving the problem of extending coverage to all of those who are without it, and improving the coverage we've got to cover the range of services that are so critical, including mental health services, for those who need them

I look forward to working with you on that challenge.