United States Senate
Committee on Finance

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Floor Statement of U.S. Senator Chuck Grassley of Iowa
Fiscal 2009 Budget Resolution
Medicaid Moratoriums
Thursday, March 13, 2008

The budget resolution proposes that Congress delay several CMS Medicaid regulations that are unpopular with states and advocates.

I know some people have concerns with the CMS Medicaid regulations. I'm not going to argue they are perfect. I have issues with some of them as well.

However, the regulations do address areas where there are real problems in Medicaid.

States don't have clear guidance and could be inappropriately spending taxpayer dollars. This leads to improper payments and wasteful spending.

We see this throughout the regulations in question. I have a CRS memo that shows some of the issues that exist under current law that I'm going to be quoting from shortly, and I'd like to ask unanimous consent at this time to enter it into the record.

Mr. President, I'll start with the public provider regulation.

We know that in the past, many states used to recycle federal health care dollars they paid to their hospitals to use for any number of purposes beyond health care.

It was an embarrassing scam that several Administrations tried to limit.

This Administration has gone a long way towards cleaning that up and the oversight of payments to public providers is part of that effort.

I have taken issue at times with the Administration's methods. I don't believe they have their public provider definition right in the current regulation.

That said, simply making the CMS regulation go away opens the door for a return to the wasteful, inappropriate spending of the past.

Quoting from the CRS report: “Under certain circumstances, a state can require providers to transfer funds to the state and because a provider's Medicaid receipts are indistinguishable from other receipts, effectively a portion of Medicaid payments may be included in those transfers.”

Intergovernmental transfers do have a legitimate role, but it is critical that states have a clear, correct understanding of what is a legitimate transfer and what is not.

If the regulation goes away, those lines will still not be adequately defined.

Now I'd like to turn to the new regulation on graduate medical education. I personally think Medicaid should pay an appropriate share of graduate medical education or GME.

But I'd like to see us put that in statute rather than return to the current customary practice because I don't think the taxpayers are well served by the way Medicaid GME operates today.

If we simply make the regulation go away, what are the rules for states to follow?

There are five different methods states use in billing CMS, eleven states don't separate IME from GME, and CMS can't say how much they are paying states for GME.

Let me quote from the CRS memo: “States are not required to report GME payments separately from other payments made for inpatient and outpatient hospital services when claiming federal matching payments under Medicaid. For the Medicaid GME proposed rule published in the May 23, 2007 Federal Register, CMS used an earlier version of the AAMC survey data as a base for its savings estimate and made adjustments for inflation and expected state behavioral changes, for example.”

To make their cost estimate for the regulation, CMS relied on a report from the American Association of Medical Colleges to determine how much they are paying for GME in Medicaid. That's because the states don't provide CMS with data on how much they pay in GME.

That is simply unacceptable.

You can disagree with the decision to cut off GME, but simply leaving the current disorderly and undefined structure in place is not good public policy.

Now let me turn to the regulations governing school-based transportation and school-based administration.

Is it legitimate for Medicaid to pay for transportation in certain cases? I think the answer to that is “yes.”

I do think it is legitimate for Medicaid to pay for transportation to a school if a child is receiving Medicaid services at school.

That said, we should have rules in place that make it clear that Medicaid doesn't pay for buses generally.

We should have rules in place that make it clear that schools can only bill Medicaid if a child actually goes to school and receives a service on the day they bill Medicaid for the service.

You can also argue that the school-based transportation and administrative claiming regulation went too far by completely prohibiting transportation, but if making this regulation go away allows states to bill Medicaid for school buses and for transportation on days when a child is not in school, we still have a problem.

It is also critical that Medicaid pay only for Medicaid services.

We all openly acknowledge the federal government does not pay its fair share of IDEA.

Quoting from the CRS memo: "States, school districts, interest groups, and parents of children with disabilities often argue that the federal government is not living up to its obligation to 'fully fund' Part B of the Individuals with Disabilities Education Act (IDEA, P.L. 108-446) (the grants-to-states program)."

We can also acknowledge that just because IDEA funding is inadequate, states will try to take advantage of Medicaid to make ends meet.

Again quoting from the CRS memo: "It is generally assumed that such transportation is predominantly provided to Medicaid/IDEA children."

We should define clear lines so that states know what is and is not Medicaid's responsibility.

Now I'd like to turn to the rehabilitation services regulation.

I certainly wouldn't argue that Medicaid paying for rehabilitation services is a bad thing. We want Medicaid to help beneficiaries get better.

But states must have a common understanding of what the word 'rehabilitation' means in the Medicaid program.

Again quoting from the CRS memo: "Rehabilitation services can be difficult to describe because the rehabilitation benefit is so broad that it has been described as a catchall."

Also, states need clear guidance on when they should bill Medicaid or another program.

Again quoting from the CRS memo: "There is limited formal guidance for states in Medicaid statutes and regulations on how to determine when medically necessary services should be billed as rehabilitation services."

You can say the CMS regulation went too far, but that doesn't mean there isn't a problem out there.

As CRS notes, billing for rehabilitation services between 1999 and 2005 grew by 77.7 percent. I'm far from convinced that all of that growth in spending was absolutely legitimate.

Finally turning to the case management regulation, I first want to point out the issues relating to case management are a little different than issues associated with some of the other Medicaid regulations I've discussed so far.

The provision in the Deficit Reduction Act of 2005 (DRA) relating to case management received a full review in the Finance Committee, along with Senate floor consideration and conference debate prior to enactment of the DRA. This regulation relates to a recently enacted statutory provision.

Certainly there is reason to believe that states have been using case management to supplement state spending. An example is child welfare. The income eligibility standard for the federal entitlement for foster care is linked to a pre-welfare reform standard. This means that every year fewer and fewer children are eligible for federally supported foster care. States must make up the difference for these children. This has caused some to believe that states are shifting some of their child welfare costs to the Medicaid program through creative uses of case management.

Concern about the inappropriate billing to Medicaid for child welfare services extends back to the Clinton Administration.

There are some that would disallow most child welfare case management claims from reimbursement from Medicaid. This goes further than I would support. Children in the child welfare system are arguably some of our nation's most vulnerable citizens, presenting with complex and multiple problems. Getting them the proper services requires thoughtful review, planning and management and I believe that Medicaid is the appropriate agency to support these activities.

On the other hand, driving a child in foster care to a court appearance and billing the caseworker's time to Medicaid is not an activity that should be billed to Medicaid.

Certainly, the regulations are not perfect. I am not convinced that limiting individuals eligible for case management to one case manager will contribute to the quality of their care and provide for access to services. Requiring case manager's to document their time in 15 minutes increments seems overly burdensome and inefficient. Eliminating the 180-day period to transition from an institution into the community is contrary to a number of provisions supporting home and community based services, including the “Money Follows the Person” program, also included in the DRA.

But again let me quote from the CRS memo: “Although there may be a number of issues related to claiming FFP for Medicaid addressed in these sources, at least two issues have been

sources of confusion, misunderstanding, and dispute. One issue where there has been misunderstanding is non-duplication of payments. Another area where there has been some disagreement is over the direct delivery of services by other programs where Medicaid is then charged for the direct services provided by the other program."

When CMS tried to come up with rules to increase accountability in case management, they had good reason to be trying to provide clarity and specificity for states.

Surely the answer is not to tell states they are on their own to interpret the case management provision in the DRA.

As CRS notes, billing for case management services between 1999 and 2005 grew by 105.7 percent. With spending growing that fast, we must make absolutely certain states understand how they should be billing CMS.

Mr. President, the budget resolution provides for $1.7 billion to address the regulations.

This is only to delay the regulations until the end of March of next year. I know supporters hope that the next administration will pull back and undo the regulations.

What would it cost if we tried to completely prevent these regulations from ever taking effect?

Not $1.7 billion that's for sure.

It would actually cost the taxpayers $19.7 billion over five years and $48 billion over ten years.

It is an absolute farce for anyone to argue that all of those dollars are being appropriately spent and that Congress ought to just walk away from these issues.

What we ought to do is insist the Finance Committee to REPLACE the regulations.

That's what this amendment does.

Instead of just making the regulations go away, the Finance Committee should replace them with policy that fixes the problems.

Mr. President, that's what we should be doing for the taxpayers.