CHALLENGES FACING THE MEDICAID PROGRAM IN THE 21ST CENTURY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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CHALLENGES FACING THE MEDICAID PROGRAM IN THE 21ST CENTURY

WEDNESDAY, OCTOBER 8, 2003

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

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Greenwood, Deal, Norwood, Wilson, Buyer, Brown, Waxman, Pallone, Stupak, Green, Strickland, Capps, DeGette, John, and Dingell (ex officio).

Staff present: Patrick Morrisey, deputy staff director; Chuck Clapton, majority counsel; Jeremy Allen, health policy coordinator; Eugenia Edwards, legislative clerk; David Nelson, minority counsel; Bridgett Taylor, minority professional staff member; Amy Hall, minority professional staff member; and Jessica McNiece, staff assistant.

Mr. BILIRAKIS. Good morning. I now call this hearing of the Health Subcommittee to order. I would like to begin by thanking our witnesses for taking the time, one of whom is not here yet, but he is on his way from downtown, by thanking our witnesses for taking the time to join us and provide their perspective on the myriad of changes facing the Medicaid program at this beginning of the 21st century. This is the third hearing we have held in Congress on Medicaid and I look forward to a vibrant discussion this morning, and I am sure it is going to be vibrant.

Medicaid is a critical component of our Nation's health care safety net. Approximately 40 million low income children, elderly adults and people with diabetes rely on Medicaid, which is jointly financed by the Federal Government and the States. The title of this morning's hearing is Challenges Facing the Medicaid Program in the 21st Century, and I think that is a very appropriate title, especially when you consider that the Congressional Budget Office estimates that Federal spending on Medicaid will more than double over the next 10 years and consume an ever larger share of our GDP.

As we grapple with these realities, it is incumbent on us to carefully review how the program is working and whether there are opportunities to better focus our Federal investment than Medicaid. I like to think that is the gist of this series of hearings. However, I think we should remember that a comprehensive review of Medicaid should also reveal a number of opportunities for modernizing

this program. We should think critically about how we can provide States with the flexibility they need to design Medicaid programs that best meets the needs of their populations, while at the same time ensuring that Federal funds are targeted and used in the most effective manner possible. In terms of today's hearing, I am interested to hear our panelists' views on the open-ended funding stream available to States under Medicaid's financing structure and what incentives are inherent under such a system.

As many of you know I had strong reservations about providing States with temporary increases in their Federal medical assistance percentages, FMAP, as we did under the Jobs and Growth Tax Relief Reconciliation Act of 2003. While I supported providing targeted limit assistance to the States, I did not support increasing the Federal Government's share of the responsibility for a State's Medicaid program, especially since many States dramatically expanded their Medicaid programs during the 1990's. I have concerns with a system that encouraged many States to expand their Medicaid program during the 1990's and then draw down increased Federal funds, and then come to the Federal Government for additional funds when the economy was not as strong.

As we look toward developing strategies for reforming Medicaid, I also think that it is critical that we recognize that every senior citizen in America is entitled to coverage under Medicare and are, therefore, in my opinion, entitled to access any new prescription drug benefit that Congress might add to the program. H.R. 1, the Medicare Prescription Drug Modernization Act of 2003, recognized this and would allow every Medicare beneficiary, including the so-called, very important dual eligibles access to the new prescription drug benefit.

Again, I would like to thank our witnesses for joining us today and we all look forward to your testimony and we are going to go through our opening statements here and hopefully by then our first witness, Mr. Scully will be here. If not, we might have to recess for a few minutes until he gets here. But he was called to the White House very suddenly this morning as I understand it and he is on his way now.

I now yield to the gentleman from Ohio, Mr. Brown.

Mr. BROWN. I thank the chairman very much and appreciate his good work and genuine caring about people who have less advantage in this society. There are desperately poor people in America, and they can't afford health care and they can't afford long term care services. That is not Medicaid's challenge. It is the challenge of a caring society. I use the phrase "caring society" because President Bush used that phrase during his State of the Union address when he called Medicare the "binding commitment of a caring society."

Do we have that same binding commitment to Medicaid? Medicaid doesn't fritter away tax dollars. It operates with less overhead than private insurance. Its costs are growing more slowly than private insurance, and for good or for worse, it pays providers less than private insurance.

By any measure, that is a bare-bones system. Medicaid is not rife with fraud and abuse. There are strict controls on asset transfers. This and previous administrations have cracked down on other

abuses. Medicaid is supposed to serve the truly poor and it does. If we want to deny care to senior citizens, to disabled individuals, to children who are living in poverty, let's have a hearing about that.

But let's not imply that Medicaid is creating a funding crisis in this country. People in need and our willingness or unwillingness to assist those people is at issue here, not Medicaid. Medicaid spending growth isn't a sudden phenomenon. The President and the Congress knew about the increase on demands on Medicaid before we drained $3 trillion from the Federal Treasury and $16 billion from State budgets so we could give tax cuts for the most privileged people in our society.

In Ohio, you have to be—my home State, you have to be 64 percent of poverty to qualify for Medicaid. 64 percent. Is Ohio contemplating cuts in Medicaid eligibility and services? You bet it is. We toss off $3 trillion in Federal revenues, $16 billion in State revenues, again, to give tax cuts to the most privileged in our society, then we warn the Nation that Medicaid is headed toward a funding crisis. Our population is aging. Prescription and other costs are growing. We face budget, daunting budgets deficits. There are 43.6 million uninsured, and Medicaid is the insurer of last resort. Those realities aren't Medicaid's challenge or Medicaid's fault. They are our challenge, and in many cases, they are our fault.

Our challenge, not Medicaid's challenge, but ours is to finance Medicaid sufficiently so it can continue to serve people in need and confront the external factors, growing long-term care needs, rising drug costs, eroding health coverage and $3 trillion worth of irresponsible tax cuts. Those are the external factors we should confront directly. Before enacting those tax cuts, did we make sure that the lost revenue wouldn't affect our ability to protect the most vulnerable in society? Quite the opposite.

The administration tax cut proposal, $3 trillion, again going to the most privileged people in our society, was coupled with a program to block grant Medicaid, the program for the least privileged in our society, cutting off funding for optional populations and services. Think about that, 55 percent of seniors on Medicaid are optional. Should we kick these people off Medicaid? I want to read you a letter from one of my constituents, it is a fairly long letter in the last couple of minutes of my opening statement.

"I am printing this. I do not write good. My wife has Alzheimers. My wife is getting lousy care because they tell me you idiots of politicians, I don't care if you're Republican or Democrat, voted to cut these nursing homes. I go every day to my wife. One nursing home the light cord would not work so you could not call to the bathroom so you lay there in your body waste till someone does check which is hours away.

Shame on you people and shame on you who voted the cut. I hope your family experiences this some way and see how you like it. I have used up my Medicare 21 days. Insurance kicks in for 130 days. I pay $600 every 2 months for my wife. When that's gone they tell me I have to go to Medicaid which they will have to take everything away from us but our home and our old car. We were working people. My wife was an RN all her life. She took care of old people. I was an over-the-road bus driver. We are not rich. They

will steal everything we worked all our lives for. I hope somehow you will have to suffer like this and watch your wife lay in body waste.

Mad? You're damn right I'm mad. What a line of bull you give the people to get elected and turn around and shaft them. Every year, Medical Mutual raise my wife's rate, always 2 weeks before Christmas. Last year they raised it $80. The year before $105, taking it up to $600 every 2 months. Soon they will have all my Social Security check. She gets $840 a month. If we have to go to Medicaid they tell me they take all of her $840 and give her $40 back. I doubt you will ever see this. Your aide will shred this and I hope your aide has to watch his family lay in their body waste like I do for what you rotten politicians have done. And I served my country in World War II. What a joke."

The biggest challenge, Mr. Chairman, facing Medicaid is that we are losing sight of what it means to be a caring society. In the next couple of weeks, we are going to vote $87 billion the President asked for in Iraq, and now I understand Republican leadership has proposed another round of tax cuts. Thank you.

Mr. BILIRAKIS. I thank the gentleman.

Mrs. Wilson. No. Dr. Norwood.

Mr. NORWOOD. Thank you Mr. Chairman, and I thank you for calling this very important hearing today. I would also like to thank our witnesses, especially Mr. Scully, the esteemed administrator for CMS if he gets here, for being able to address this critical issue surrounding Medicaid and its implementation. Mr. Chairman, I think it is a good time and the correct time that we need to take a step back and take a look at the fundamental structure of Medicaid.

There are several issues that concern me with the current structure and the implementation of Medicaid. First, the cost of Medicaid already has exceeded all expectations and is only expected to grow exponentially as we continue to move forward. As our population gets older, and our care becomes more technologically focused and capable, the cost of health care is going to continue to rise. And I hope our witnesses will discuss possible strategies to contain expenses in the future.

Part of what we have done over the last 38 years is that we continually, as a Congress, increase the, or expand the categories in Medicaid, and we continually add more individuals on to the Medicaid lists for folks that are entitled, and we wonder why we have spent so much money, and we continually, the first step, is say well gosh, we are paying the health care provider too much, which was pointed out by Mr. Brown, is already below cost in many areas.

So I would like for us to just take a real serious look about why this cost has continued to grow particularly over the last 38 years. And I am concerned about the impact Medicaid has on our States. In Georgia, we are paying 20 cents of every tax dollar into this program. Medicaid leaves wide discretions to the States to craft individually tailored workable plans that address the needs of each State's own citizens within the Federal guidelines.

While this is a laudable principle, it has also spurred the history of State abuse that has plagued the Medicaid system. Today's Medicaid structure provides many perverse incentives for States to en-

gage in questionable and very worrisome behaviors about the increase in funding. And of course, States need to increase their funding because of the budgetary difficulties they face. Current budget crisis put States in the position of having to decide between roads, books for schools, health care for children and the poor or long-term care for seniors. I have said here before and I think we ought to have some serious consideration about moving long-term care which is about generally our senior citizens out from under Medicare and place that under—out from under Medicaid and place that under Medicare.

Mr. Chairman, I thank you for the hearing and Mr. Scully, we are delighted to have you today. And I look forward to your testimony.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Green for an opening statement, 3 minutes.

Mr. GREEN. Thank you, Mr. Chairman. And to follow up my colleague from Georgia, I think that is an outstanding idea if we would move it under Medicare, except I would hope we would cover more days than we do now under Medicaid for our poor seniors in nursing homes. Again, I want to welcome Mr. Scully, and Mr. Chairman, thank you for having this third in a series of hearings on the challenges facing the Medicaid program. The Medicaid program provides a critical safety net for 44 million low income Americans in the populations covered under the Medicaid the elderly disabled and children, some of our countries most vulnerable citizens. And as we know the health care cost for high risk populations such as these are expensive. Medicaid costs have been increasing dramatically in recent years, including a whopping 14 percent in fiscal year 2002. This is certainly a cause for concern, especially since Medicaid costs tend to go up during economic downturns, and we are certainly experiencing a protracted economic downturn.

Although I am weary of proposals that would block grant the program or substantially alter benefits, the benefits provided under Medicaid are vital, physician services, inpatient, outpatient hospital care, early periodic and screening diagnostic and treatment for children under 21, nursing home care and others that make life or death differences in beneficiaries' lives. And I've heard some critics talk about Medicaid, call it a Cadillac benefits program. But there is nothing extravagant about the benefits I have just listed. In fact, in the State of Texas, we don't do anything under social services that would be called extravagant, and we are even cutting back from there.

Reforming Medicaid or providing more flexibility means slicing into services that save people's lives. And Mr. Scully, I have a concern, I guess, in—our workforce commission in Texas is talking about voting on a Medicaid plan that would actually remove families from Medicaid if their children are truant from school. And my concern is if you can't get your child in school, you don't have health care. And it seems like that would be violation of our Federal rules, but what I am using that as an example is block granting, something like that, and they would use the Medicaid program not for the basic tenet of health care, but to use it to force people to do some other things.

Of course, I want children to go to school. But in Texas, we take away fishing licenses if you don't pay child support, which is pretty important, hunting licenses and even your driver's license. Maybe we ought to do that under Medicaid before we take away their health care. I know we will hear a lot today about flexibility and personal responsibility.

I would like to remind my colleagues we are talking about real people with real needs. As you heard my colleague from Ohio in his letter, I actually talked to a constituent last night who said his wife was receiving Medicaid in Texas in our district and she—and they are cutting her home health care benefits. And he said I don't know what else I can do. He said I am on Medicare and disabled and I can't do it. And I said well, the State of Texas actually cut Medicaid coverage for home health care on September 1 and so since—you are probably just getting the notice of it. But we are going to try and see if hopefully they fell through a crack. But again, Mr. Chairman, I thank you for the time today and I will put my total statement in the record.

Mr. BILIRAKIS. Thank you sir.

And by the way, I guess the opening statement of all member of the subcommittee will be made a part of the record. Mrs. Wilson, 3 minutes.

Mrs. WILSON. Thank you, Mr. Chairman. And thank you very much for holding this hearing today. I look forward to hearing the testimony. Medicaid is now the largest Federal health care program in the country. It is a $280 billion program with about 48 million covered lives. It is 7 percent of our Federal budget, and in most States it is between 15 and 20 percent of a State's budget. It has a huge impact on our—the health of our Nation as well as the funding of health care. We spent a lot of time in this committee over the last 5 years looking at Medicare. And I think that Medicaid is the next major health care challenge that this committee should undertake.

Mr. Chairman, you and Chairman Tauzin set up a Medicaid task force about 4 months ago and we have been meeting to examine a lot of the challenges facing Medicaid and we have listened to lots of people. People from the administration, doctors, people who run health care clinics and community health centers, people whose children are participants in Medicaid and there are some things that are beginning to emerge. And all of them are concerned about the future of Medicaid. We know that disabled adults want more control over their own care and who provides it, without having to wait for the State to come up with some innovative exception to the Medicaid rules.

We know that Medicaid does a poor job of managing chronic diseases like diabetes and asthma and heart disease. As one doctor said to me, the system only gets paid if people are sick. It is not set up to improve the health of poor people. I visit a wound care clinic in Albuquerque and the RN there, Barbara List, said to me why is it so easy for me to admit an indigent patient to the hospital to have their foot amputated and so hard for me to get a compression stocking to prevent the foot from having to be amputated in the first place?

We did a poor job in managing chronic disease and we know that Medicaid does virtually nothing to prevent disease or to reduce the risk of onset of disease. We know that under the pressure of expanding enrollment and increased costs, States have adopted some questionable financial schemes to maximize Federal dollars and that State agencies and hospitals, and doctors' offices follow the money stream rather than focusing on what is best for their patients.

And I know that because I used to be the cabinet secretary for children, youth and families in the State of New Mexico, and we often did things that didn't necessarily benefit the patients who are relying upon the care. Mr. Chairman, we have tremendous challenges facing Medicaid in this country, and I hope that the testimony today will begin to focus on some of those challenges, so that Medicaid can improve the health of those who depend upon it, rather than just paying the claims of the people who file the paperwork. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentlelady. Mr. Dingell for an opening statement.

Mr. DINGELL. Mr. Chairman, thank you. I commend you for holding this hearing. It is one which needs to be held. The subject of challenges facing the Medicaid program in the 21st century is an important one. One of the biggest problems that I see is the Office of Management and Budget, and quite honestly, some of the witnesses who will be testifying here before us today, because it seems attempts are being offered to shift much of the burden to the States in the form of block grants in a way which will adversely impact the well-being of those who are the beneficiaries of that program.

As all know, Medicaid is the largest source of health coverage in the Nation. It provides coverage to millions of families with children, 8 million people with disabilities. It is the largest source of coverage for people needing long term care. In other words, Medicaid provides health insurance to people who are uninsured or are uninsurable. Medicaid serves as a vital health care safety net for the least advantaged of our citizens, particularly during times of massive layoffs caused by a flawed trickle down economic plan.

Does it have flaws? Absolutely. Are these flaws correctable? Absolutely. In fact, flaws in the program have been subject to bipartisan corrections on a number of occasions over the past 20 years. Unfortunately, the administrations irresponsible tax cuts and failed economic policies have led to a fiscal crisis within the States. This has put additional pressure on Medicaid at the time that the Federal Government is trying to shift the burden of Medicaid to the States through the block grant mechanism. Medicaid roles have increased by about 4 million people since this administration took office.

In response, the administration has determined to substitute block grants for need-based Federal funding, thus putting the States at risk for raising Medicaid costs due to economic downturns or unforeseen cost increases. The people who will suffer are, of course, those who are the beneficiaries of it. I would note that this administration seems very much determined to move a lot of people

in the low income brackets from Medicare to Medicaid, thus imposing further burdens upon that group.

A block grant may reduce some opportunities for gaming the system, but it will create others and I intend to ask the witnesses today to please tell us what recommendations they have made to the Congress for eliminating opportunities to game the system by the States and others, and also what actions they have taken administratively to bring these problems to a halt. I think the answer will indicate that nothing has been done by the administration with regard to this matter. Shelling out Federal dollars under a block grant system with no accountability of the recipient is not an answer. It simply indicates to me that those who are hurting now will hurt more.

Moreover the burden for caring for vulnerable American families would be shifted to the shoulders of the States and their residents at a time when they can least afford to handle the additional responsibilities. It is unfortunate that fraud, waste, and abuse are not indicated on the basis of the Republicans' desire to end Medicaid as we know it, as millions of people have depended upon that program. I have long fought efforts by the States to game the Medicaid system, and I will continue to do so. I would note that under my chairmanship, we brought to a halt the raids upon DSH funds and the unseemly behavior of the States in inflating their claims under Medicare. That action has not prospered under the leadership of this administration. But the existence of fraud, waste, and abuse should not end need-based Federal funding for the most vulnerable amongst us.

What we should do is to address the problem which exists with regard to fraud, waste, and abuse and not come up here and seek the lazy man's way out. We can properly and vigorously address fraud, waste, and abuse, but I do not believe that it is a moral matter to do so at the expense of those in the Medicaid program, something which has been one of the shining glories of the Medicaid program in that it has provided a safety net for the most needy amongst us. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Buyer for an opening statement.

Mr. BUYER. I retain my time and waive.

Mr. BILIRAKIS. Mr. Waxman for an opening statement.

Mr. WAXMAN. Yes. Thank you very much Mr. Chairman. Today the subcommittee is holding a hearing titled Challenges Facing the Medicaid Program in the 21st Century. In my view, this hearing might be more appropriately titled Challenges Facing the Health Care System in the 21st Century and how the Medicaid program has stepped forward to provide coverage for persons that the rest of the system fails. That title might focus our attention on what the real problem is. It might be popular with this administration and the majority in this Congress to be critical of Medicaid and define it as a broken program.

I believe it is more accurate to describe it as a program which has been uniquely successful in providing services to millions of needy Americans with complex and difficult health care problems. Medicaid is now a program that is the single largest public program providing health care coverage, covering 51 million Ameri-

cans, significantly more than Medicare. It is a program that provides coverage for one out of five children. It is a program that covers 40 percent of the births in this country. Providing prenatal care and well baby care. And it is a program that supplements Medicare in uniquely important ways. It provides cost sharing for Medicare premiums. It makes Medicare affordable for low income seniors and disabled beneficiaries. It provides critical support supplements for services that Medicare doesn't cover, like prescription drugs, eyeglasses and hearing aids, and it provides long-term care services both in nursing homes and in home and community-based settings.

It is indeed the only program that has tackled this difficult problem. It is a critical program in providing services for the disabled. Indeed with the continuing development of technology and support services that allows severely disabled people to live productive lives, Medicaid has been unique in providing coverage for the range of services and supports that are necessary and expensive, and I should add, typically not provided by traditional private insurance plans.

Our witnesses today will do a better job than I can of elaborating on the populations and services that Medicaid covers and the critical role it plays, but I want to focus on the thread that runs through this picture. Medicaid is the program that serves the hardest to reach the cases that are most expensive and difficult, the services that are often otherwise not available when we are talking about people with AIDS, low income pregnant women who can't afford the basic costs of delivering their babies, or persons with physical and mental disabilities that need constant and continuing support.

Whether we are talking about aged people without family or resources needing long-term care services or persons needing expensive prescription drugs to treat multiple health care problems, in all of these cases it is Medicaid that has been the program that fills in the gaps of our health care system.

Mr. Chairman, I have additional comments I would like to put into the record with my opening statement.

Mr. BILIRAKIS. Without objection.

Mr. WAXMAN. But in the interest of time I want to say that the way to deal with problems is not to bash Medicaid for being successful at what we have asked it to do. We need to be better partners to the States in helping them to continue to meet the demands that have been placed on this program.

[The prepared statement of Hon. Henry A. Waxman follows:]

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

Today this Subcommittee holds a hearing titled "Challenges Facing the Medicaid Program in the 21st Century."

In my view, this hearing might be more appropriately titled "Challenges Facing the Health Care System in the 21st Century, and How the Medicaid Program Has Stepped Forward to Provide Coverage for Persons that the Rest of the System Fails." That title might focus our attention on what the real problem is.

It might be popular with this Administration and the majority in this Congress to be critical of Medicaid and define it as a broken program. I believe it is more accurate to describe it as a program which has been uniquely successful in providing services to millions of needy Americans with complex and difficult health care problems.

Medicaid is now a program that is the single largest public program providing health care coverage—covering 51 million Americans, significantly more than Medicare.

It is a program that provides coverage for 1 out of 5 children. In every State of the Union children below poverty are covered by Medicaid.

It is a program that covers 40 percent of the births in this country—providing prenatal care and well baby care assuring children a healthy start in life.

Medicaid is a program that supplements Medicare in uniquely important ways. With its payment of Medicare premiums and cost-sharing, it makes Medicare affordable for low-income seniors and disabled beneficiaries. It provides critically important supplementary services that Medicare doesn't cover, like prescription drugs, eye glasses, and hearing aids.

And it provides long-term care services—both in nursing homes and in home and community-based settings. It is indeed the only program that has tackled this difficult problem.

It is a critical program in providing services for the disabled. Indeed, with the continuing development of technology and support services that allow severely disabled people to live productive lives, Medicaid has been unique in providing coverage for the range of services and supports that are necessary, necessary and expensive. And, I should add, typically not provided by traditional private insurance plans.

Our witnesses today will do a better job that I can of elaborating on the populations and services that Medicaid covers, and the critical role in plays.

But I want to focus on the thread that runs through this picture: Medicaid is the program that serves the hardest to reach, the cases that are most expensive and difficult, the services that often are otherwise not available. Whether we are talking about people with AIDS, or low-income pregnant women who can't afford the costs of delivering their babies, or persons with physical and mental disabilities that need constant and continuing support, whether we are talking about aged people, without family or resources, needing long-term care services, or persons needing expensive prescription drugs to treat multiple health care problems—in all of these cases it is Medicaid that has been the program that fills in the gaps in our health care system.

Is the cost of Medicaid increasing? Of course. It pays for people who are sick and disabled and who use the most expensive services. It pays for prescription drugs where inflation has been the highest. And it serves an increasing number of people.

When we face a recession and see people losing their employment-based coverage, it provides coverage for more people instead of less. We may have more than 43.6 million uninsured in this country, but the figure would be considerably higher without the safety net of Medicaid.

The financial burden of Medicaid is difficult to sustain. As we look to the future and the continuing challenges that Medicaid faces, we need to recognize that the Federal government has an obligation to provide greater help to the States in meeting the cost of the program. The answer is not to find a way to limit the Federal obligation—to put a lid on it so our budget looks good. The answer is to find the best way to provide greater assistance.

We can start by helping with the costs of the dual eligibles, people covered by both Medicare and Medicaid. But we must do more.

The way to deal with this problem is not to bash Medicaid for being successful at what we have asked it to do. We need to be a better partner to the States in helping them to continue to meet the demands that we have placed on this program.

The needs of the people who depend on Medicaid require no less.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Deal for an opening statement, 3 minutes.

Mr. DEAL. I will reserve my time, Mr. Chairman.

Mr. BILIRAKIS. All right, sir. Ms. Capps for an opening statement.

Ms. CAPPS. Thank you, Mr. Chairman. I appreciate this opportunity to discuss the challenges facing Medicaid in the 21st century. I welcome Mr. Scully to this hearing and to the other witnesses as well. I want to reference a letter that my colleague from Ohio quoted from, one of his constituents and I hope that Mr. Scully has a chance to read that letter. It struck me as a nurse. I think each of us have had contacts with our constituents with similar stories to this. I wondered if your constituent, Mr. Brown,

realizes that the biggest challenge that Medicaid faces is the Bush Administration's proposal to dismantle it.

At a time when unemployment is so high, when the economy is in such dismal shape, when more and more people are losing their jobs and thereby their health insurance, this administration wants to arbitrarily cap Medicaid funding and change it to a block grant. It is an attempt to take advantage of the States fiscal problems to pass an ill-considered ideological proposal that will actually do more harm to millions of Americans.

This administration is trying to entice States into this program with a short-term boost in funding and the false promise of flexibility. But this is a siren song that many State Governors are already resisting, and I would urge the Nation's Governors to lash themselves to their masts, fill their ears with wax and resist this call so they do not crash their constituents on the rocks of the Bush Medicaid block grant plan. Right now, Medicaid guarantees health care to 42 million Americans who are struggling to take care of their families and to make ends meet.

Taking away that guarantee will pull the rug out from under working people who are just trying to survive in such a weak economy. Medicaid is not broken. In fact, it is working exactly the way it is designed to. As more and more Americans lose their jobs and their health insurance, Medicaid is there to help them. As more and more Americans find they cannot afford the growing expensive health care Medicare is there. It is the way it is supposed to operate.

The program helps to soften the impact of a slowing economy and it is a major means to speed the recovery to follow. But the block grant proposal would mean that in any given year, there would be an upper limit on what the Federal Government would pay. If that does not match the needs of Medicare beneficiaries, too bad. This means that States might be forced to help cut—forced to cut help to seniors in nursing homes, cuts to the disabled, support for pregnant women or to parents without insurance. This is not how to help the uninsured.

This is not how to revive a flagging economy. This administration does not seem concerned with either of these goals. All that seems to matter is that this is a means whereby to cut back on Medicaid, the program, so that more and more tax cuts will be available.

Mr. Chairman, I don't support the President's proposal, and I hope that this committee will not endorse it. In this hearing, and in those in the future, I truly hope that we can look at other solutions to the Medicaid funding challenges and carefully consider the consequences of this administration's proposal. I yield back.

Mr. BILIRAKIS. The Chair thanks the gentlelady. Mr. Stupak for an opening statement, 3 minutes.

Mr. STUPAK. Thank you, Mr. Chairman. It is long past time for this Medicaid hearing to take place. The Medicaid crisis has reached a fever pitch in this country, and our States and our low income families are hurting. All 50 of our States are struggling to provide health coverage for low income families at a time when enrollment is increasing due to a sluggish economy and escalating health care costs. A recent Kaiser Family Foundation report pointed out that over the past 3 years, 50 States have been forced to

make cuts in Medicaid to control drug costs. 50 States have reduced or frozen provider payments; 34 have reduced or restricted eligibility; 35 have reduced benefits; and 32 have increased copayments.

In Michigan where I am from, Governor Granholm has inherited a financial mess, and she has been doing everything she can to keep Medicaid program afloat, but it is a monumental task. Even after cuts to hospitals over the past 2 years, the State will cut another $110 million from hospital Medicaid payments in this fiscal year. The Federal Government must step in and provide more funding. It is as simple as that.

The administration block grant proposals are a cynical attempt to cap or reduce funding and will leave our States at the mercy of soaring health care and pharmaceutical drug costs. The Medicaid debate today is a matter of priorities. As this Republican-led Congress spends trillions of dollars to provide tax breaks to wealthy Americans and billions to pay to rebuild Iraq and provide Iraqis with universal health service, while leaving our most vulnerable citizens without health care. Let's redirect these priorities and take care of the ones who need it the most. Let's shore up the Medicaid program today, not tomorrow.

Mr. Chairman, I look forward to hearing testimony of our very distinguished panel, and I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Pallone, for an opening statement.

Mr. PALLONE. Thank you, Mr. Chairman. I want to use this morning's hearing to stress the importance of preserving Medicaid, and the way to do it is to reject the administration's proposal to block grant this program that is, in fact, the largest source of insurance in the United States today. In this hearing today, we will hear that by block granting Medicaid States will have flexibility necessary for expanding access to health care. But let's be clear.

In reality, this is a proposal that simply blackmails the States. The block grant proposal caps the Federal share of Medicaid dollars so the States cannot receive adequate funding as their Medicaid needs rise. By shifting fiscal responsibility to States, the Medicaid block grant encourages States to limit their liability by capping enrollment, cutting benefits, and increasing cost sharing for millions of low income people. In addition, any short-term relief that States receive up front under the block grant will have to be paid back at the end of the 10-year budget window. And if that's not a bribe, then I don't know what is.

By undermining access to care for the poor, the sick and the disabled, the President's proposal weakens the health care safety net and adds to the widening credibility gap that is putting him and Republicans that support his proposal further out of touch with the American people.

And Mr. Chairman, it seems that given the current atmosphere of erosion of employer-sponsored coverage and the dwindling economy, we need to strengthen and not undermine the Medicaid program. Supporting an increase in the Federal Medicaid contribution, the FMAP will shore up State Medicaid programs with an immediate increase in funding to offset reduced State revenues that are placing severe strains on State budgets nationwide, including my home State of New Jersey.

Now, if States are always amenable to flexibility and the FMAP is the type of Medicaid relief that States desire, not a budget neutral block grant. Mr. Chairman I just want to reiterate that I think the Medicaid, well, obviously the Medicaid program is an entitlement to the poor, the sick, and the disabled, and States cannot and should not be allowed to pick up and choose who they will and will not cover, which is exactly the type of flexibility that will be provided with this block grant.

Choosing to cutoff benefits to an optional population sounds easy and sounds justifiable. However, we must keep in mind when examining Medicaid, that optional looks like five out of six elderly nursing home residents, or a family at 60 percent of the Federal poverty level, and this is not population whose health benefits can be considered optional.

Now, you know last week the Census Bureau came out with a report that the number of uninsured rose dramatically and that we are now looking at a figure of 43.6 million uninsured Americans, and I am referencing this report, because were it not for the Medicaid program, an additional 4 million Americans would be added to the already overwhelming number of uninsured. And these 4 million people are comprised of working families with children who have unfortunately lost their jobs due to our economy, and as a result, have lost their employer-sponsored health coverage.

So again, we are in a crisis with regard to health care and access to health care. And for us to do anything but shore up the Medicaid program is a mistake. And the block grant is certainly not the way to go. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentleman.

I am hopeful that we will be able to get to Mr. Scully before too very much longer. But certainly I don't want to cutoff opening statements. I would appreciate it if we can keep them as brief as we can. Mr. Strickland.

Mr. STRICKLAND. Mr. Chairman, I want to reserve my time. But before I do that, I want to thank Mr. Scully for some help he gave me recently with Todd Children's Hospital in Youngstown, Ohio. Thank you.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. John.

Mr. JOHN. Pass.

Mr. BILIRAKIS. Pass. Ms. DeGette.

Ms. DEGETTE. I will reserve my time also.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Chairman Bilirakis, for holding this important hearing today. I also want to thank C-M-S Administrator Scully, Maryland Delegate Adelaide Eckardt, and Ms. Diane Rowland for taking the time to testify before the Health Subcommittee about the challenges facing the Medicaid program, and ways to respond to these challenges.

The Medicaid program serves a vital role for providing health care services for our nation's most vulnerable populations—including low-income children, seniors and people with disabilities. At the same time, Medicaid also faces serious challenges, due in part to certain structural flaws in the program. I believe that we owe it to the beneficiaries who depend on this program, as well as the taxpayers who pay for it, to examine these challenges and evaluate how we can improve this vital program.

One of the biggest challenges currently facing the Medicaid program is how federal rules often limit states' ability to provide the best care to the most needy beneficiaries. Under these rules, each state is required to offer the entire package of Medicaid benefit to all eligible beneficiaries. These rules create a one size fits all entitlement that does not make policy or fiscal sense.

The rules prohibit states from reaping any fiscal savings from tailoring the benefit package to meet the specific needs of certain eligibility categories, like private sector plans have been able to do. In contrast, Medicaid offers a broad benefits package that many beneficiaries typically will not fully need, and sometimes ignores the benefits of offering particular benefits to cover specific patient populations. States need more flexibility to tailor benefit packages to best suit the needs of their covered populations.

The State Children's Health Insurance Program (SCHIP) is an excellent example of how states can achieve great results when they have a greater degree of control in how they design their benefit package and provide coverage for eligible children. SCHIP provides grants to states to expand health insurance coverage for low-income uninsured children. States have broader flexibility to design and implement SCHIP programs—as opposed to Medicaid—resulting in more diversity across states. This program is viewed as highly successful and has helped millions of children gain access to needed health insurance. We should look at SCHIP as one example for how we could begin to improve Medicaid.

The contrast between SCHIP and traditional Medicaid also highlights another critical challenge facing the Medicaid program. SCHIP funding is based upon state specific capped allotments, rather than the open-ended entitlement structure used by Medicaid. This open-ended nature of Medicaid funding has helped contribute to the explosive growth in Medicaid spending in recent years. During times of budget surplus, states have had significant incentives to expand their programs, using generous federal match rates to provide new benefits and cover new populations. In times of budget shortfalls, states are forced to either trim back these new benefits, or come looking for additional Federal funding.

If Medicaid continues on its projected course, with growth rates in the double digits, states will simply not be able to bear the cost of the Medicaid program. They will have to further cut services, limit eligibility, or look to other budget priorities for savings. This is a serious challenge that both the States and the Federal government must take steps to address.

Let me also be clear: we are not planning to do any additional "temporary" increase in the Federal Medicaid matching rate to get states through any further short-term budget crises. We did that earlier this year and pledged that the assistance would only be truly temporary. I intend to hold the supporters of this policy to their word and ensure that the assistance remains only temporary.

An additional challenge facing the Medicaid program is the lack of a coordinated Medicare benefit. Currently Medicare does not provide a prescription drug benefit for its beneficiaries. Approximately 6 million Medicare beneficiaries, who are also eligible for Medicaid, must depend on the state programs to provide them with their prescription drugs. These dually eligible individuals often suffer from chronic illnesses, and thus are big consumers of prescription drugs within the existing Medicaid benefit. It is absolutely crucial that any legislation enacted this year to create a new drug benefit be created within the existing Medicare program, for all Medicare-eligible beneficiaries. This action would help states focus their limited Medicaid resources on their neediest populations and would also allow for improved coordination of care for beneficiaries.

There are serious challenges facing Medicaid today, and the program is clearly at a crossroads. If we are not willing to make some major changes in the current program, the long-term prospects will not be bright. States need more flexibility to respond to the unique needs of their Medicaid populations. We hope that some of the suggestions our witnesses offer today will help the Committee as we plan to move forward with Medicaid reform. We need to look for innovative solutions to the problems facing Medicaid. I believe that Medicaid beneficiaries and America's taxpayers deserve nothing less.

Mr. BILIRAKIS. The Chair appreciates your cooperation. We will just move right on to the first panel which consists of the Honorable Tom Scully, the administrator of CMS Centers for Medicare and Medicaid service. Tom, you have 10 minutes. Use that as you will, sir.

STATEMENT OF HON. THOMAS A. SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICE, ACCOMPANIED BY DENNIS SMITH

Mr. SCULLY. Thank you Mr. Chairman. I will go as fast as I can. And Mr. Brown, thank you for having me today. Thank you for having us here this morning and thank you for No. 1, being flexible. I had to go to a meeting at the White House this morning. Obviously came in a few minutes late and I apologize for that, and thank you also for allowing me to bring Dennis Smith, who runs the Medicaid program. We work a lot together, but he's far more knowledgeable than I am so I appreciate the committee's willingness to have Dennis come with me today, and obviously I will let him answer all the tough questions and I will take the easy ones.

Let me just start off by saying that I think Medicare, as a number of you pointed out, including Congresswoman Wilson, has been the focus of a lot of congressional attention this year. I spent a lot of time on it, including my meeting this morning. But Medicaid is obviously a bigger program, much more complicated, arguably much more in need of reform. And I would be anxious and hope Congress would be interested in engaging on any basis whether it is the administration's bill or any other on looking at the underlying Medicaid program. Medicaiid is much more complicated than Medicare. It is really 57 small programs between the different States and the territories. Every one of them is different.

Every arrangement is different. Every State program is different. It is a very, very complicated program. It is a wonderful program, as many of you have said. Medicaid covers 48 to 50 million people. And it does a lot of wonderful things. But it is a very complicated program that has gotten too little attention, in my opinion, from the Federal Government, including my agency. I have 4,800 full-time employees in my agency, and probably another 5,500 contract employees. We have about 500 people that work on Medicaid. Another 500 do survey and certification, but about 500 people actually work on Medicaid. We have 62 financial managers around the country that work on Medicaid.

So in many ways, given the amount of attention that has been given to this, by HCFA/CMS and by many people over the years, it is not too surprising we have ended up with a complicated, tangled amalgam of State programs.

So I would welcome a lot more attention to Medicaid, and I think that Medicaid, by virtue of the fact that it is actually run by the States and we are a relatively passive paying partner, has gotten far less focus than it probably deserves on the Federal policy level.

Let me just start quickly by going through the structure, which I am sure most of you understand. Many people think that Medicaid is a women and children's program. In fact, 73 percent of the enrollees in Medicaid are women and children. But there is a chart attached to my testimony which shows that only about 27 percent of the funding goes to women and children. A large percentage of the funding goes to the blind and disabled, which is obviously an important population to serve and obviously not something that probably can or will be changed very much.

But that's about 18 percent of the Medicaid population. Yet, it is about 45 percent of the funding. One of the things that has put

a lot of pressure on the States in recent years that a lot of people also don't understand and which I think Mr. Brown alluded to, is that almost 70 percent of people in nursing homes are on Medicaid. That puts an enormous amount of pressure on the States. This represents only about 9.5 percent of the beneficiaries, but 27 percent of the funding.

There are a number of studies out there that have shown that as many as 50 percent of the people that are going into nursing homes on Medicaid are not truly poor, that they transfer their assets to some of their family members. Eventually most of them do become poor and in fact do need Medicaid. But in many cases in many States you could make an argument that higher income people in some of these cases should use their own assets for at least the first few months if not years before they go on Medicaid. Yet there are very elaborate arrangements in many States to avoid that.

That puts an enormous amount of pressure on States, and if we are truly trying to help blind, disabled, truly poor women and children, and the truly poor that need nursing homes, I think, this is a source that a lot of people should focus more attention on to make sure that the people that are on Medicaid going to nursing homes are truly poor. There has been very little attention given to asset transfer issues.

One thing the administration is working on with HUD, is a small existing program in HUD for reverse mortgages. We have spent a lot of time working with the National Council on Aging, the AARP, and others, to find a way to enhance that program. Eighty percent of seniors have a paid-off home with an average asset value of $107,000. Yet very few of them think that it as an asset to be used to buy long-term care insurance; to pay for home health care.

Most seniors don't want to be in a nursing home. Most of them want to stay at home and they go to a nursing home as a last resort. Yet they have very little financial ability to find a way to finance that. We think we need to find clever ways, and we think we have some interesting ways to actually use their existing assets in their home to allow people to stay at home longer, then go to assisted living instead of nursing homes. And if they are not truly poor, we need to find ways without putting pressure on them to use their home as an asset, which is the No. 1 asset most seniors have.

Seniors have $1.5 trillion tied up in assets in paid off mortgages. One hundred percent paid off mortgages on their homes. Yet they rarely think of that as an asset they can use to help pay for their long term care. And I think it is something that the States and CMS should both look at and spend more time focusing on.

Secretary Thompson, Dennis Smith and I are spending a lot of time on that right now.

Let me just switch to talk about the focus of this hearing is. I have said repeatedly, but frequently misquoted, that if I were a Medicaid director in a State, I might very much do what they have been doing. I don't blame them. If the Federal Government sets up dumb rules in Medicaid and States use them to maximize the reimbursement, yes you can't necessarily blame them, but we need to police it better and do a better job of making sure that we treat everybody exactly the same. A number of you mentioned that Med-

icaid next year is going to be a $304 billion program, which will make it the largest Federal health care program.

But, out of the $304 billion, probably about $25 billion of that is attributable to intergovernmental transfers or taxes. We estimate that $304 billion is spent, but we really don't know how much of this might be attributable to inappropriate financing schemes. Our best guess is that about $25 billion of that is phantom matches that aren't actually put up by the States. So there's $25 billion of mythical care that really isn't given. That is a huge problem.

We really believe we need to turn this back into the State-Federal partnership the program was intended to be. In the last 20 years, I have spent a lot of time with many of you, including Mr. Waxman, trying to find ways to make sure this program actually works as a Federal-State partnership. I think that is critical. I think we should be able to look every Governor in the eye whether he is a Democrat or Republican and say they are getting exactly the same deal.

I attached a chart to my testimony this morning, and I think you will see that if you look at the statutory match rates which are based on poverty, Mississippi, being the poorest State in the country, has the highest statutory match rate. In at least 25 States, there is no real connection between what their match rate is and what the Federal Government is paying. Again, I don't necessarily blame a State budget director or a Medicaid director for doing that. But over the years, we have allowed it to happen and we have actually had very inequitable distribution among the States about what their actual match rates are. We have made a big effort to try to fix that.

Medicaid is the fastest growing program in the government. When I went into the first Bush Administration in 1989, Medicaid was a $60 billion a year program. This year it is $304 billion. It has grown 37½ percent, since I have been at CMS. That is pretty rapid growth. We have no problem with rapid growth, and I will get to that in a minute. We don't have any desire to spend less on Medicaid. But we want to spend more wisely.

We need to deal with long-term care costs. We need to deal with spend-downs for Medicaid. We need to deal with the problems we have State-by-State on extremely high spending on prescription drugs when it is not necessarily appropriate. We are very focused on trying to fix the program and make it work better. And a lot of that comes back to addressing financing problems. So let me just switch back to that for a moment.

If you look at the three big branches of financing gamesmanship that have gone on in the last 15 years, from 1988 to 1993, most of the States were trying to maximize disproportionate share hospital payments. We did limit that in the earlier 1990's, and it has worked fairly relatively effectively. The next transition beyond that, and this is illustrated in attached examples in the testimony was intergovernmental transfers. They exploded in the mid 1990's, and we have, to some degree, put a limit on them.

To me, the most disturbing development, which happened in the last 4 or 5 years, is upper payment limits. And the reason it disturbs me more than anything else is that in the earlier two sets of games, theoretically we were spending more money on health

care. With upper payments limits, States, in effect, have been able to cash out the State match, and get more Federal dollars without putting up any more money. And the most disturbing trend is the case where Medicaid is actually spending less money on health care because it is not with the Federal Government. The States are actually drawing down more Federal money and still putting up State money, and they are actually cashing out State money and displacing the Federal money, and we end up spending less on health care, which is clearly not the goal.

So I would argue we have done a lot in the last couple of years to slow down the States. I wouldn't expect them to be happy, but I do think that I can honestly tell any Governor from either party that in the last 3 years, to the extent we possibly could under the law, we have been able to look them in the eye and say they are getting exactly the same deal, and that we treat them exactly the same way. I will give one example. Regarding Missouri, which you can see in your charts. Two years ago we had a very large problem building in the Medicaid program. The normal course would have been to litigate it for 15 years.

Instead, we spent about a year and a half with a Democratic Governor, and their State's Secretary of Health working out a much more transparent financing schedule for Missouri. We settled most of the differences. All of them actually. We have what I think is a very clear model as a partnership where Missouri submits to us everything they are doing on Medicaid at the beginning of the year. We understand what they are doing. We understand their taxes. We understand their financing. We spend a lot more time working with them. As a result, they happen to have a very good Medicaid program.

We spent a lot more time working with them and trying to make Medicaid a better program, and a lot less time trying to figure out who can maximize their match rates, which is what happens in too many States, unfortunately.

So our goal here is to get back to the point where we spend a lot of time working on Medicaid, making Medicaid a better program and less time trying to figure out who can find the most clever accountants to maximize the reimbursement. I think that is a goal that probably all of us share. Let me just finally wrap up on the administration's proposal.

The administration's proposal, just to be very clear, is not a block grant. Our interest is not to save money. Our interest is to give the States a lot more flexibility. Secretary Thompson was a Governor. Obviously, he was not a big advocate of the current Medicaid structure in Wisconsin when he was a Governor. He, Dennis Smith and I spent a lot of time on this. What we were trying to do is give the States more flexibility without saving any money. It is not a block grant. It is limited only to optional beneficiaries. The Federal Government would still be required to cover all mandatory beneficiaries. The focus is to give States more budget certainty and to give us more budget certainty, while giving the States a lot more flexibility.

I was involved in negotiating the first TennCare waiver in 1990 in the first Bush Administration. I was involved in doing it again in the past year. I was involved with Senator, then Congressman

Wyden on this committee, when the first Oregon waivers went through.

We did a large waiver with Illinois last year. No State has to seek waivers. Even under the President's proposal, no State has to change a thing. What we are trying to do is give the Governors the maximum flexibility to come in and get a straight deal from us as far as how they can deal with their optional populations with far more flexibility, far more money in the baseline. They would get more money for flexibility and less hassle and a much more straightforward relationship with the Federal Government. And the bottom line is that nobody was required to do it. Any State that didn't want to didn't have to participate.

So I certainly understand people's concern. I think you know we are really interested in making the Medicaid program work better and we are not proposing a block grant. We are proposing giving the States greater flexibility and we would be very, very interested in seeing and working with the committee and with the Senate Finance Committee on trying to find ways to make the Medicaid program work better in the long term as a more efficient partnership that is going to continue to serve many, many millions of people. Thank you, Mr. Chairman.

[The prepared statement of Hon. Thomas Scully follows:]

PREPARED STATEMENT OF HON. THOMAS SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Chairman Bilirakis, Ranking Member Brown, distinguished Committee members, thank you for inviting me to discuss the challenges facing the Medicaid program in the 21st Century, and for allowing Dennis Smith, the Federal Medicaid director, to appear with me today. The Medicaid program faces many challenges. With more than 40 million Americans lacking health insurance, CMS has been pursuing a wide range of initiatives to expand insurance coverage, including working aggressively to improve the Medicaid waiver process. Through waivers and State plan amendments (SPAs), Medicaid eligibility expanded by more than 2.27 million people between January 2001 and September 2003. In addition, we are focused on outreach so that potentially eligible individuals know about the Medicaid program, and as in the Medicare program, we are working to ensure that Medicaid beneficiaries receive quality care. While all of these areas present challenges to the Medicaid program, today I am here to focus on Medicaid finances, perhaps the most immediately pressing challenge to the program.

Medicaid spending continues to rise each year—and this is no small concern. When I first went to work at OMB in 1989 during the first Bush Administration, total Federal and State Medicaid spending was $61.2 billion. By the time I departed in 1993, total Medicaid spending had grown to approximately $132 billion. Today, total Medicaid spending for 2004 is projected to be $304 billion—that's nearly a tripling in spending over 10 years and five-fold increase since 1989. Moreover, Medicaid—not Medicare—is now the largest government health program in the United States. In FY 2002, total Federal-State Medicaid outlays ($259 billion) exceeded Medicare outlays ($257 billion) for the first time. This trend is continuing, with Medicaid outlays exceeding Medicare by about $4 billion in FY 2003 ($281 billion versus $277 billion), and estimated to exceed it by approximately $26 billion in FY 2004 ($304 billion versus $289 billion). In addition, in May, Congress approved a temporary infusion of additional Federal funds as part of the Jobs and Growth Tax Relief Reconciliation Act of 2003. Under the new law, States will get a temporary increase in the percentage rate for Federal Medicaid matching funds (FMAP) for five calendar quarters, beginning April 1, 2003, and ending June 30, 2004. Thus, total Federal spending for Medicaid over the next ten years is estimated at $2.6 trillion. Combined Federal and State spending on Medicaid in this period is estimated at $4.5 trillion.

While some of this growth is due to expanded coverage and eligibility—positive growth for the program because so many more uninsured Americans are getting health care services—much of the increase in Medicaid spending over the past 10 years can be attributed to the ever-increasing costs of providing long-term care. The

Medicaid program primarily serves three groups of beneficiaries. Women and children comprise about 73 percent of enrollees but utilize just 27 percent of the Medicaid funding. The elderly and people with disabilities are the other two major groups that comprise just 27 percent of the Medicaid population, though the cost of their care consumes about 70 percent of Medicaid spending. In fact, almost 70 percent of nursing home beds are now Medicaid-financed, and State and Federal governments pay roughly 60 percent of all long-term care costs nationally.

Since Medicaid expenditures are a large and growing proportion of most State budgets, the Medicaid program is an area to which States turn to reduce costs. To reduce costs, States are feeling pressure to drop optional Medicaid benefits or to reduce optional populations. States also find other creative revenue enhancing mechanisms, including utilizing a variety of legal and regulatory loopholes to enhance the Federal funds they receive to provide health care for their citizens. Intergovernmental transfers (IGTs) are a prime example of such loopholes. While it is completely legal for States to share costs with counties and other local government bodies to recoup Medicaid expenditures, IGTs are only supposed to provide the statutorily determined match rate for a State. However, States often find ways to use IGTs to avoid paying the statutory match rate and effectively shift a larger portion of Medicaid costs to the Federal government. The Federal government should only match real expenditures for the Medicaid population at the real matching rates, but in recent years, IGTs have been used to draw billions in Federal funds with no true State or local spending.

As Federal and State Medicaid spending continues to grow rapidly, it is increasingly important for CMS to ensure that taxpayer dollars are serving their intended statutory purpose of improving health care quality and access for Medicaid beneficiaries. There are many opportunities for improving the fiscal integrity and management of the Medicaid program. I would like to discuss some of the problems we have seen, and some strategies that might refocus the program away from financing gamesmanship and back to delivering health care to America's vulnerable populations.

BACKGROUND

Medicaid is a partnership between the Federal government and the States. While the Federal government provides financial support to the States and is responsible for overseeing the Medicaid program, each State essentially designs and runs its own program. States have great flexibility in administering their programs, and the Federal government pays States a portion of their costs by matching certain spending levels, with statutory matching rates currently ranging between 50 and 77 percent. This creates a natural tension in which States strive to maximize Federal matching dollars. The Federal government has a responsibility to ensure that funds are matched appropriately. However, through various financing and funding mechanisms, including the use of donations and taxes, the Disproportionate Share Hospital (DSH) program, and Upper Payment Limits (UPL), many States manage to inappropriately draw down more Federal Medicaid dollars with fewer State dollars, resulting in an effective FMAP that is higher than the statutorily determined matching rates, creating inequities among States. CMS has begun to close these loopholes and ensure that States receive appropriate matching rates, but it is a long, complicated and politically unpleasant battle.

To prevent inappropriate funding mechanisms now, and in the future, it is important that we understand the various types of loopholes that States have exploited in the past and continue to exploit today. We must remain vigilant in closing and avoiding all of these loopholes. President Bush, Secretary Thompson, and I take this very seriously. We want to continue to work with you to correct current inappropriate State funding mechanisms to ensure the fiscal integrity of the Medicaid program and to ensure that Federal dollars are used to pay for Medicaid covered services for Medicaid-eligible individuals.

INAPPROPRIATE FUNDING MECHANISMS

As I mentioned, over the last two decades States have developed innovative ways of enhancing Federal matching dollars. In 1985 the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), changed the regulations governing the way the Federal government provides matching funds to States when they received private donations to help cover administrative costs. This rule change was merely intended to reduce record keeping and provide States more flexibility for accepting philanthropic donations.

Additionally, regulations at the time allowed States to impose special taxes on specific provider groups. These regulations led States to impose taxes and receive

donations from providers that led to new ways to finance States' share of Medicaid expenditures. In 1986, Congress was concerned that States were not reimbursing Disproportionate Share Hospitals (DSH) for their uncompensated care costs. Legislation was passed that eliminated any limit on DSH payments. The combination of new revenue sources from donations and taxes and the ability to pay unlimited reimbursement to Disproportionate Share Hospitals (DSH) led to a significant increase in the Medicaid expenditures claimed by States. Once these exploding loopholes began to be limited, States pursued the Upper Payment Limit (UPL) loophole more aggressively. These scenarios, which I will describe in greater detail, provided opportunities for States to creatively draw additional Federal matching funds.

Provider Donations and Provider-Specific Taxes

An early maximization strategy States employed to enhance Federal Medicaid matching funds without using additional State resources was the use of provider donations and taxes. Typically, a State would either arrange for providers to "donate" funds to the Medicaid program, or it would establish special "taxes" on certain provider groups. Once these funds were collected from the affected providers, they were then repaid to those providers through increased Federal Medicaid payments, largely in the form of DSH payments. Since States had a great deal of flexibility in how they made DSH payments, they were able to raise DSH rates to compensate providers for the costs associated with the donations or taxes. As the DSH payments were raised, the effective level of Federal matching funds increased correspondingly. In the end, the providers were repaid their donations or taxes, and the State was left with the Federal matching funds to either return to the provider or to keep for whatever use it decided. The only party that incurred any new cost was the Federal government. It was a no risk, no cost, free money mechanism for dozens of States.

I spent a considerable amount of time on this issue while I was at the Office of Management and Budget in the first Bush Administration. I can tell you that the widespread use of these financing mechanisms contributed to extraordinary increases in Federal Medicaid expenditures in the late 1980s and early 1990s. For example, in 1989 we found that three States were drawing a combined total of $23 million from Federal funds through provider taxes and donations. This number increased to eight States drawing an additional $300 million in 1990, and by 1991 more than half of the States were drawing an incredible $12 billion.

In 1991, Congress passed the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991," the first piece of stand-alone Medicaid legislation in the program's history. This law set out strict conditions that States must meet in order to use taxes levied on health care providers as part of their State dollars eligible for Federal Medicaid matching funds. The law said the taxes must be:

- Broad based, or applied to all members of a definable group. For example, they must apply to all hospitals, not just psychiatric hospitals;
- Uniform, with all providers within the group being taxed at the same rate; and
- Not part of a "hold harmless" agreement where the funds are returned to the providers either directly or indirectly.

The law also eliminated Federal Medicaid matching payments for provider donations, except in very limited circumstances. After significant consultation with the States, CMS published a final regulation implementing this law in 1993. The rule laid out a process for States to request waivers of certain provisions for tax programs that are not broad based or uniform. The "hold harmless" provision, however, cannot be waived. In an effort to improve State compliance with the law, in 1995 CMS issued detailed regulatory guidelines explaining the Donations and Tax rules.

In 1997, CMS notified States that if legislation explicitly ending the use of impermissible taxes and resolving outstanding State liabilities was not passed, CMS would have no choice but to ask the Department of Justice to pursue enforcement measures to resolve States' liabilities. Also in 1997, the Balanced Budget Act (BBA) banned States from using Federal Medicaid matching funds for purchases unrelated to health care, such as building roads and bridges. In 1998, CMS proposed legislation to allow the Secretary to work out compromises with States regarding large unallowable funds States received, rather than having to refer these cases to the Justice Department. Although this proposal never became law, due to the other restrictions I discussed, it appears that today States generally have stopped attempting to exploit this particular loophole.

Disproportionate Share Hospitals

Another financing mechanism commonly used by States has its roots in the early 1980's. In 1981, Congress recognized that some hospitals were treating a large number of uninsured patients thereby increasing their uncompensated care costs (UCC). As a result, these hospitals were taking in far less revenue per patient and experi-

encing difficulty remaining open. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981, Congress allowed States to pay more to hospitals treating a disproportionate share of uncompensated care cases as a way to encourage these hospitals to continue treating needy patients. Although this program concept clearly represented a good idea, the States were slow to embrace it.

A major change to the DSH law took effect in OBRA 1986, which prohibited the Federal government from putting any limit on payments made to hospitals that serve a disproportionate number of low-income patients with special needs. Then, in OBRA 1987, Congress created DSH payment rules and qualifications in law, specifically defining Disproportionate Share Hospitals and requiring States to pay additional funds to certain qualifying hospitals. OBRA 1993 further restricted State use of DSH revenues by limiting the amount that States could pay to specific hospitals to 100 percent of their uncompensated care costs, further limiting abusive DSH practices.

As OBRA 1993 took effect, States began looking for new ways to maximize Federal funds. One way States financed their share of Medicaid expenses was through IGTs. States have always been allowed to shift funds among the different levels of government to reduce administrative burdens. For instance, a County can transfer funds to the State, and States can use this money as their share of Medicaid expenditures. However, States provided DSH payments to public facilities that exceeded their Medicaid costs, receiving more Federal matching funds in the process, and these facilities could then refund some of the money to the State through IGTs (see attached chart 1). To end this practice, the Balanced Budget Act of 1997 mandated State-specific caps on the total level of Federal matching payments to State DSH hospitals.

Upper Payment Limits

As Congress mandated limits on DSH payments and restricted States' ability to use donations and taxes, States began exploring other creative ways to enhance their Federal Medicaid funding, such as maximizing their "Upper Payment Limit" calculations. In 1987 Congress had established Upper Payment Limits for State owned or operated inpatient facilities, in an effort to remove the inherent incentive for States to overpay themselves. However, under the revised rules, States still were allowed to exceed these UPLs for certain publicly owned providers. By calculating the maximum amount that Medicare would have paid to each Medicaid facility—the Upper Payment Limit—States were able to obtain extra Federal matching funds. Under this scenario, States could calculate the upper limit for both public and private hospitals and nursing homes in the aggregate, rather than separating public from private. This gave them the flexibility to pay public hospitals and nursing homes more than private facilities. As a result, public hospitals could then return money to the State. The State, in turn, could use these funds to obtain more Federal matching dollars. The State could then return a portion of its share of the money to the public facilities, and keep the Federal share for its own use (see attached charts 2 and 3).

The Agency saw the first indications that States were using Upper Payment Limits in publicly owned providers to raise revenues in the early 1990s, although the dollar amounts and the number of States were limited. At that time, aggressive consultants began advising States to use Upper Payment Limits as a way to increase Federal Medicaid revenues flowing to the States. In 1999, at CMS' request, the Health and Human Services Office of the Inspector General performed audits in six States that confirmed the abusive nature of these payment arrangements. To close this loophole, CMS published three regulations establishing Federal upper payment limits (UPL) that limited the ability of States to increase their share of the Federal payments under Medicaid without actually spending State funds. Generally, the new UPL rules prevent States from paying each type of hospital and nursing home in Medicaid more than 100 percent of what Medicare would pay for similar services.

The final regulation, which took effect May 15, 2002, included provisions for a gradual phase out of excess Federal funds drawn down by States using these funding schemes. There are three phase-down periods: two, five and eight years, and States are assigned to each depending upon the length of time they had operated the funding schemes. The longer a State relied on the excess funds, the longer they have to phase out the use of those funds.

In early 2002, CMS notified 24 States determined by CMS to be qualified for a transition period under the upper payment limit (UPL) regulations. CMS provided the States with its preliminary determination regarding the length of each State's transition period and requested that each State submit the necessary UPL calculations to support its preliminary findings. CMS is presently evaluating the UPL calculations provided by each of the 24 States and the associated Medicaid spending,

both of which are necessary to make final UPL calculations. The first transition period of the two-year phase out ended on September 30, 2002.

CMS OVERSIGHT ACTIVITIES

CMS has a strong interest in strengthening financial oversight and ensuring payment accuracy and fiscal integrity. Federal matching funds must be a match for real State expenditures, not a match of phantom dollars. At the Federal level, our primary role is to exercise proper oversight and review of State financial practices and to provide guidance and support for States' efforts to ensure program and fiscal integrity. While we have made substantial progress in helping States identify and reduce improper payments, we are now turning our attention to strengthening Medicaid Federal financial management activities.

We have taken some initial steps to improve our financial management processes, but we know that more work can and must be done. As part of the President's FY 2003 Budget, we have dedicated $10 million from the Health Care Fraud and Abuse Control (HCFAC) account to develop a comprehensive Medicaid program integrity plan. The FY 2004 Budget proposes to allocate $20 million from HCFAC for this initiative. We are increasing attention to, and emphasizing the importance of Medicaid financial management at all levels of our Agency and across all of our regions. This effort involves improving Federal oversight capabilities of State Medicaid financial practices, and focusing attention on program areas of greatest risk, so that our resources are targeted appropriately. The following are examples of improvements and progress we have made as part of our Medicaid financial management and program integrity redesign.

Creating National Reimbursement Teams

In an effort to improve national consistency in the issuance and application of Medicaid reimbursement policy, we have put together a team of Central and Regional Office staff, the National Institutional Reimbursement Team (NIRT), who are responsible for reviewing all institutional reimbursement State plan amendments, providing technical assistance to the States, and developing Medicaid institutional reimbursement regulations and policy. For example, the team is currently using a standard set of questions that must be answered by States before a State plan amendment will be approved and will help ensure that the payment methodology is clear. Questions include issues such as, "Do providers retain all of the Medicaid payments including the Federal and State share (including normal per diem, DRG, DSH, supplemental, and enhanced payments) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization?" As a result of this effort, we will better know what we are paying for and how we are paying for it. The team's work will help ensure consistency in the application and review of our Medicaid policies. We also have established a Non-Institutional Provider Team (NIPT), which functions similarly to the NIRT, but for non-institutional providers, namely physicians. The NIRT and the NIPT have been working together on UPL transitions for those States with both inpatient and outpatient UPL phase-outs.

Upfront Reviews of State Funding Sources and Expenditures

We will be redirecting and adding resources this year with the goal of changing the emphasis of the Financial Management (FM) review of State Medicaid/SCHIP programs from an after-the-fact review to an upfront and proactive review. Our new emphasis would be primarily to review the non-Federal share amounts and related expenditures prior to the beginning of the fiscal year so that any problems or issues can be resolved before any claims are submitted. This process would provide an approval of the State's operating plan for the upcoming year, with the goal of eliminating the need for CMS to intervene and disallow Federal Medicaid funding after it has already been spent by the State and to identify any unallowable funding schemes or expenditures before they actually happen. Now is the best time to start this effort—while States are currently developing budget plans for next year. That way, we can examine spending before States are locked into a budget, and avoid disallowances that disrupt the State budget cycle.

Making Federal Matching Payments Only When State Plan Amendments Are Approved

In the past, States have been allowed to draw down Federal matching payments for State plan amendments that were submitted, but not yet approved. This allowed States to assume a financial risk if their plan amendment was subsequently disapproved. Since Federal matching payments were readily available while their State plan amendments were being considered, States had little incentive to ensure their

plan amendments were approved. In fact, some State plan amendments were pending for years while the States continued to draw down Federal matching payments. In January 2001, we issued a State Medicaid Director letter informing the States that we would no longer make Federal matching payments until State plan amendments were approved, thus removing the previous incentive for States to keep plan amendments pending. For our part, we have changed our policy so that we will either approve or disapprove plan amendments within 90 days.

Partnership with State and Federal Oversight Agencies

Another key element of our new financial management strategy is to strengthen our working relationships and our exchanges of information with several State entities. Every State has one or more audit entities responsible for ensuring that State expenditures, including those in the Medicaid and State Children's Health Insurance Programs, are properly made and documented. Furthermore, every Medicaid Agency has a surveillance and utilization review staff to pinpoint and pursue questionable provider claims and Agency payments. Finally, as you know, virtually all States operate a Medicaid Fraud Control Unit, typically housed in the Attorney General's office, to pursue instances of suspected Medicaid fraud. By better cultivating our relationships with State agencies that perform these types of functions, we believe we can continue to enhance our oversight of the Medicaid program nationwide. In addition, over the last several years, at the Federal level, we have developed a close collaboration with the Department of Health and Human Services' Office of the Inspector General. We intend to continue this relationship.

FUTURE ACTION

CMS has several efforts underway to improve Medicaid's financial oversight and management. For example, both the General Accounting Office and this Committee's Oversight and Investigation Subcommittee have begun investigations into potential waste, fraud, and abuse in Medicaid State plans. Additionally, the Medicare reform legislation currently in conference, also addresses Medicaid with the inclusion of a provision that would require a State, as a condition of receiving DSH payments, to submit an annual report that:

- Identifies each DSH hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding year;
- Includes such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

These are all temporary solutions, and Medicaid financing needs fundamental structural reforms that will return the program to a Federal and state partnership. The Administration has demonstrated its commitment to increasing states' flexibility in administering their Medicaid programs. The HIFA, Independence Plus and Pharmacy Plus waiver initiatives have given states significantly more flexibility to expand eligibility and to tailor their programs to meet the needs of their beneficiaries.

However, reform of the financing structure of Medicaid is needed if we are serious about reducing waste, fraud and abuse. Because state governments are facing budget pressures, they will seek creative Medicaid financing strategies. The financial incentives in the program exacerbate this problem. Under the current Federal-state matching mechanism, if a state cuts one dollar of its own spending, then the state forfeits between one and two dollars in federal funds. Under current law, states may eliminate coverage of optional populations and drop optional benefits. They are doing so. In the past year, over two-thirds of states have reduced services or eligibility and most states are currently considering other benefit or eligibility cutbacks. This puts the health coverage of thousands of Americans at risk because when states can no longer afford to pay their share of the costs, they may lose the Federal funding as well.

We want to give states another option so that they can manage their health care budgets, while preventing further service and benefit cuts and while actually expanding coverage for low income Americans. Our proposal builds on the success of the State Children's Health Insurance Program (SCHIP) and the Health Insurance Flexibility and Accountability (HIFA) demonstrations in increasing coverage while providing flexibility and reducing the administrative burden on states.

Under this proposal, states would have the option of electing to continue the current Medicaid program or to choose an alternative global financing option. States electing this alternative would have to continue providing current mandatory services for mandatory populations. For optional populations and optional services, the

increased flexibility of these allotments would allow each State to innovatively tailor its provision of health benefit packages for its low-income residents. For example, states could provide premium assistance to help families buy employer-based insurance. States could create innovative service delivery models for special needs populations including persons with HIV/AIDS, the mentally ill, and persons with chronic conditions without having to apply for a waiver. Another important part of the new plan would permit States to encourage the use of home and community-based care without needing a waiver, thereby preventing or delaying institutional care. The Administration has been engaged in discussions with the governors aimed at creating a proposal that both accomplishes the desirable goal of reform and addresses some of the major concerns in Medicaid.

An additional avenue for addressing Medicaid funding challenges is to encourage consumers to buy long-term care insurance. For example, the President has proposed to expand the four State programs on Long Term Care Partnerships, as well as two important tax relief measures for care givers and those who purchase long term care insurance.

CONCLUSION

Through complex, creative financing schemes States have artificially maximized Federal Medicaid matching funds. This practice is simply unacceptable. The Medicaid program must be a Federal-State partnership, not an exercise in financing gamesmanship. We must continue to ensure that beneficiaries receive the high quality care they deserve, and that we are appropriately matching State Medicaid funds. The last two decades have demonstrated that States can be extremely resourceful in creating innovative funding mechanisms that do not comply with the intent of the Medicaid program, which requires States to certify that they have the appropriate funding to pay their matching Medicaid share. We all need to work harder to ensure States are able to help pay for high quality health care for their residents through appropriate means, but we need to be vigilant in order to prevent further loopholes before they become set in law or regulation. We appreciate your support in these efforts and the opportunity to discuss this important topic with you today. We are happy to answer your questions.

Chart 1

Intergovernmental Transfer Financing (DSH)

County Provider and State Profit Example

Statutory Match Rate is 60/40

Claimed Expenditure	$100
CMS pays	$60
County Provider IGTs	$60
(amount equal to federal share)	
State pays Provider	$100
Net to CMS	($60)
Net to State	$20
$ 60 from CMS	
+ $ 60 from Provider	
- $100 payment to provider	
Net to Provider	$40
$100 from State	
- $ 60 IGT	

Effective Match Rate is 100%

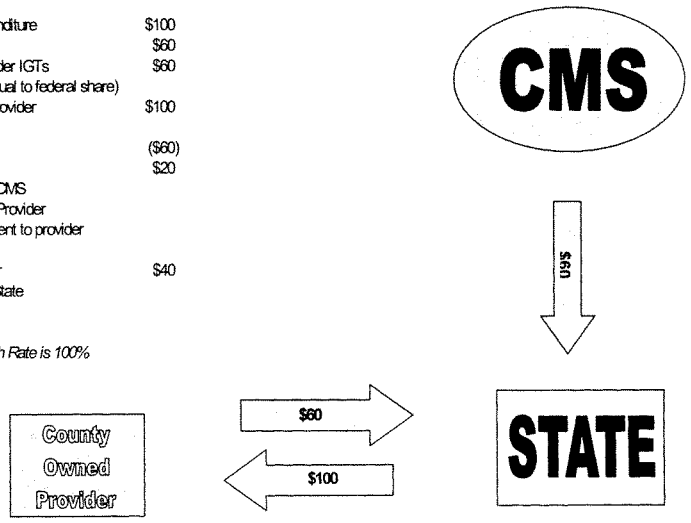


Chart 2

Intergovernmental Transfer Financing

IGT from Physician Group Example

Statutory Match Rate is 50/50

Claimed Supplemental Payment E	$600
CMS pays	$300
Physician Group IGT's	$300
State provides	$0
State payment to provider	$500
State retains	$100 (1/3 of Federal Share)
Net to CMS	($300)
Net to State	$100
Net to Provider	$200

Effective Match Rate is 100%

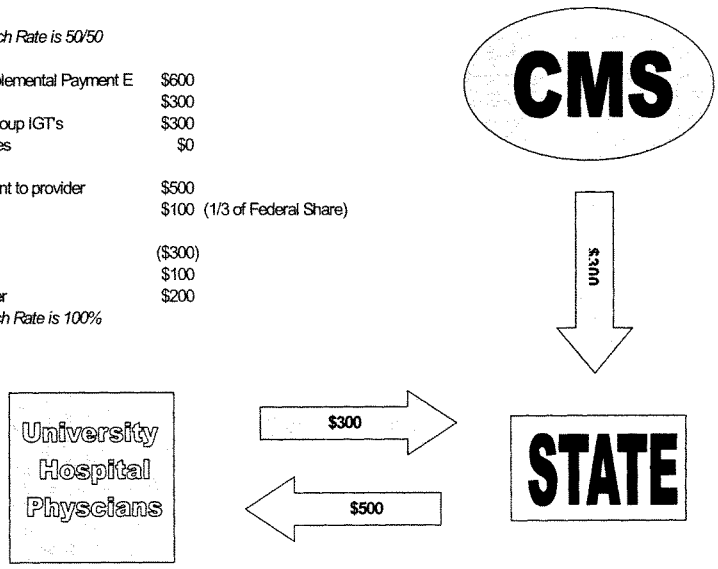


Chart 3

Intergovernmental Transfer Financing

Bank Loan to County-owned Provider Example

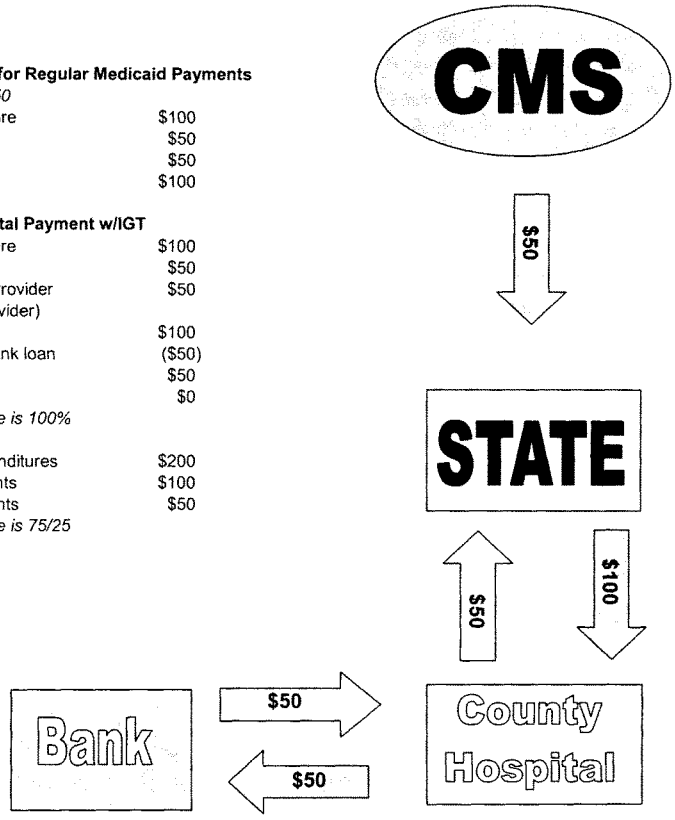
Claiming Process for Regular Medicaid Payments

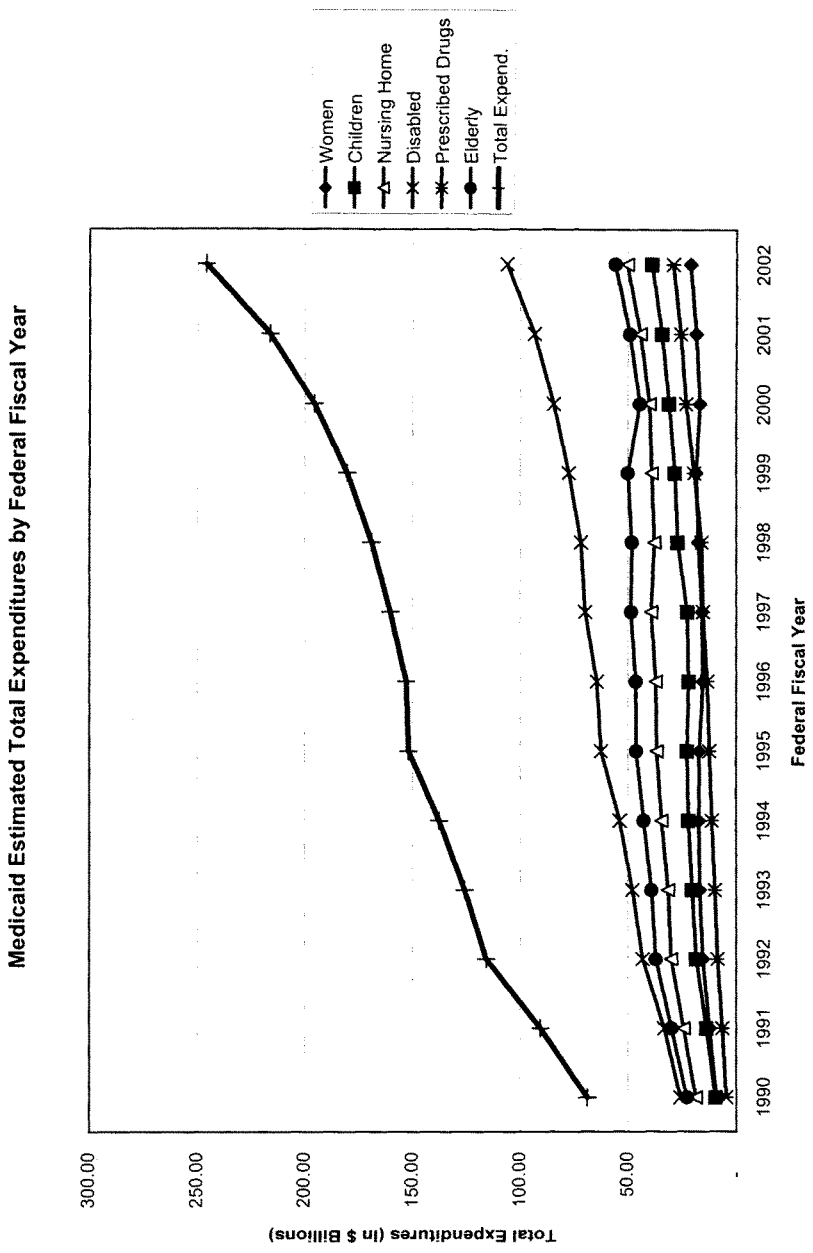
Match Rate is 50/50	
Claimed Expenditure	$100
CMS Match	$50
State paid	$50
Provider gets	$100

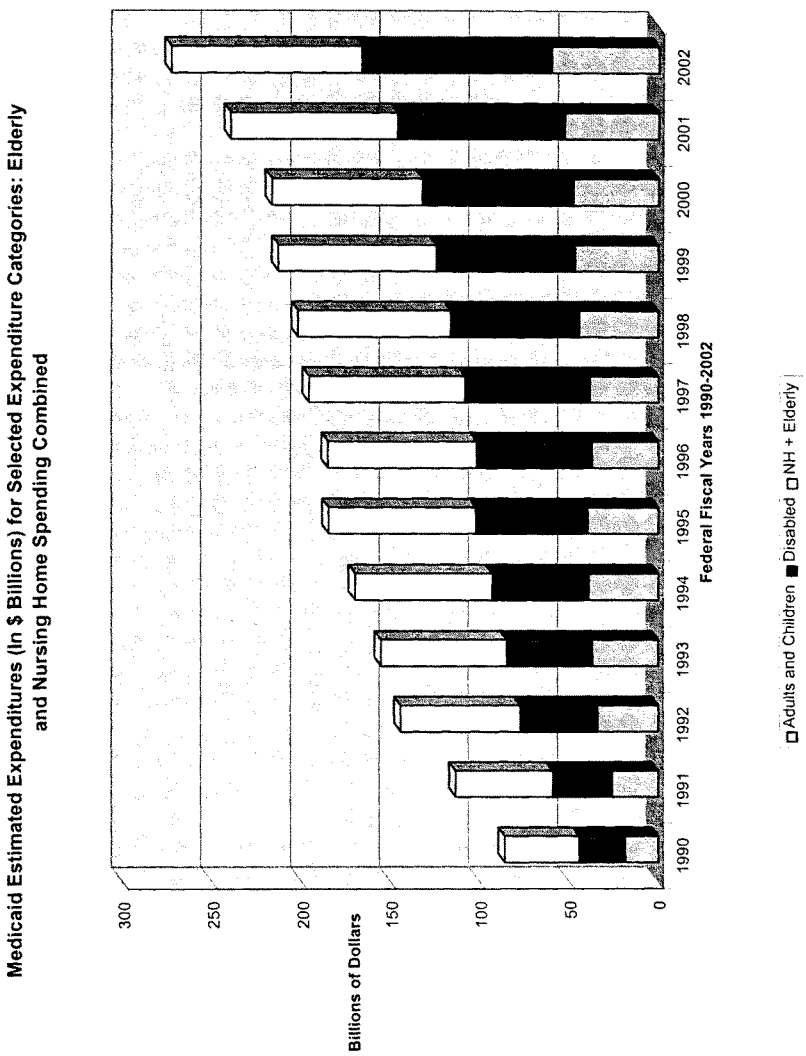
Add In Supplemental Payment w/IGT

Claimed Expenditure	$100
CMS Match	$50
IGT from County Provider	$50
(Bank loan to provider)	
Provider gets	$100
Provider repays bank loan	($50)
Provider nets	$50
State paid	$0
Effective Match Rate is 100%	

Total Claimed Expenditures	$200
Total CMS payments	$100
Total State payments	$50
Effective Match Rate is 75/25	

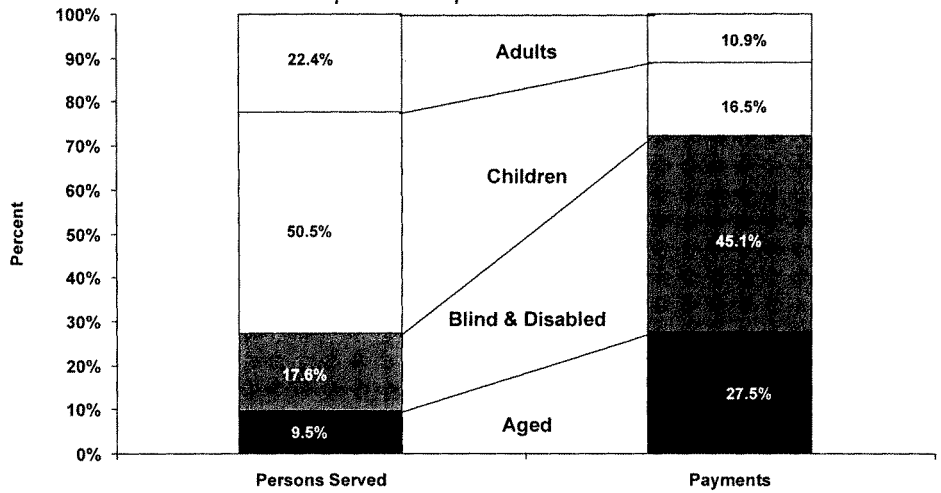



Medicaid Estimated Total Expenditures by Federal Fiscal Year
Women
Children
Nursing Home
Disabled
Prescribed Drugs
Elderly
Total Expend.
300.00
250.00
200.00
150.00
100.00
50.00
-
Total Expenditures (In $ Billions)
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
Federal Fiscal Year


Medicaid Estimated Expenditures (In $ Billions) for Selected Expenditure Categories: Elderly and Nursing Home Spending Combined
Billions of Dollars
300
250
200
150
100
50
0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
Federal Fiscal Years 1990-2002
Adults and Children
Disabled
NH + Elderly

Distribution of Persons Served Through Medicaid and Payments by Basis of Eligibility, Fiscal Year 2000

Payments for the elderly, blind and disabled account for 73 percent of total payments and only 27 percent of persons served.



Note: (1) "Payments" describe direct Medicaid provider payments and Medicaid program expenditures for premium payments to third parties for managed care, as well as cost sharing on behalf of persons served who are dually enrolled in Medicaid and Medicare, but exclude DSH payments and Medicare premiums. (2) This chart excludes 3.7 million persons served with "unknown" basis of eligibility and 6.5 billion expenditures on behalf of persons served with "unknown" basis of eligibility in FY 2000. If included in the total above, "unknown" Medicaid persons served would have comprised about 9 percent of total persons served and about 4 percent of total expenditures.
Source: CMS, MSIS.

Mr. BILIRAKIS. Thank you very much Mr. Scully.

In your testimony, I guess particularly in your written testimony, you focused more on how some States have used a variety of schemes to obtain billions of additional Federal Medicaid dollars. You know, if all that additional Medicaid dollars, Federal Medicaid dollars were used for health purposes for those people in the States, I don't know that that would upset me too very much. But I guess what would really upset me would be if some of those dollars were being used for purposes other than health care. Can you maybe respond to that? How much would you say, and I don't mean in terms of dollars, but percentages or whatever the case may be, do you feel of those dollars are used for purposes other than health care?

Mr. SCULLY. I would say that is very hard to say, Mr. Chairman. I think a rough estimate. I think we have done a lot better in the last 2 years about, you know, it used to be that when the State applied with a State plan for more Medicaid money we used to approve it and then generally, and I mentioned this in my testimony, the tradition had been to approve it when States had spent it and then we'd try to get it back later, which obviously never works. We have, in the last couple of years, got to the point of saying we are not going to give any States the money until they explain where it is going and it is spent on health care and not on building roads.

There are lot of examples in the early 1990's, I won't pick on any States, where some States got billions of dollars for the Medicaid program and didn't use it for health care. I think we have minimized that to some degree. But the money is very fungible. And in many cases, especially through upper payment limits and intergovernmental transfers, the States, in fact, take quite a bit of money off the top and don't use it for health care, which is extremely troubling to us. I don't think we have a problem matching real State expenditures and carrying more people on health care. The concern we have is two-fold. There is an awful lot of Federal dollars being drawn down when States aren't putting up any money at all.

And second, giving everybody the same deal. I mean there is nobody here from Alabama, so I will pick on them, although we have been working cooperatively with them, the poorest State in the country is Mississippi. They have, I think, a 77 percent match rate.

Alabama next door has a statutory match rate of about 70 percent and in recent years, they have gotten as high as 93 percent. So to me, it is a matter of, you know, the poorest States should get the best deal, and everybody should work on the same sets of rules, and if States have been clever enough to draw down money inappropriately and we haven't called them on it, which in the past we hadn't always done it, is not a fair deal under the statute. And I think that that is the primary issue.

Mr. BILIRAKIS. I know the same thing has been taking place over the years regarding dish money too. Can you give us some examples if you know, I know you have been at this for a long, long time, and you are certainly familiar with some of the excesses and some of the fraud that has taken place. But can you give us some examples of how some of their money has been used in the past aside than for health care?

Mr. SCULLY. Well, once again, it is, I mean, I would say it is fraud. On the other hand, I would say that as I said repeatedly, if you are a State budget director, or you are a State Medicaid director, and you can get away with it. I think many of them tried to do it.

Mr. BILIRAKIS. I would suggest that fraud is probably not as strong a word as should be used in a case like that.

Mr. SCULLY. Yeah, I believe some of this behavior has been outrageous. But I think part of it is the agency has to crack down. We have been doing that. It has not been fun. It is not politically pleasant. And I think we have been doing equitably among all States. But I think it has to be done. Yeah, I can give you examples of lots of things. But, you know, I would start off with the tax in my home State of Pennsylvania years ago. What happened was every nursing home in the State paid a tax for one tenth of a second, sent it to a bank in Harrisburg. The State raised $500 million, put it up and got an immediate match of $500 million from the Federal Government and transferred it back to the nursing homes. That was the original way donations and taxes worked.

There are many ways intergovernmental transfers work, but intergovernmental transfers, for example, generally State hospital would transfer its entire budget to the State for a split second. That would be put up as a Federal match, would be transferred back to the public hospital.

Obviously there is no State money involved. It is all—it is all a wire transfer and there is no money put up. There are many ways to do intergovernmental transfers and that is one. Disproportionate share of hospital payments I will pick on just to pick one particular State in the upper Midwest, they actually had—were paying a particular public hospital 870 percent of their actual rates.

So, for example, if you had a hip replacement that cost $10,000, the State would allow itself to be billed $87,000 by the hospital so the Federal Government would then match its percentage of that. In that particular State it was about 60 percent. So you can imagine the State then picked up on a Federal match for that procedure roughly $50,000. They only paid the hospital 10. So the State put up nothing, got $40,000 in cash. Paid the hospital 10 and the only person left unhappy is the Federal Government.

So the upper payment limits basically allowed States to come up with outrageously high reimbursements that were far more than anybody would pay.

That is a quick example of all three mechanisms. There are many, many different ways to do it. There has been almost no limit on the legal cleverness of various——

Mr. BILIRAKIS. Not to condone anything like that, but certainly if that money at least was used for health care it would be—not to be condoned, but certainly something we would understand and maybe sometimes look the other way. But when it is used for roads and for infrastructure and for purposes other than what it was intended for, that is what really gripes me.

My time is up. I would now yield to Mr. Brown. Thank you, sir.

Mr. BROWN. Thank you.

Mr. Scully, welcome. I am glad you are here.

As you know, the number of Medicaid enrollees in the U.S. between 1996 and 2000 stayed at around 33 million. In 2001, that number jumped to 36 million. Today, it has climbed to 40 million, 40 million in the next year. Given the state of the economy, that would seem to be a good thing. After all, even with the safety net, the percentage of uninsured Americans, we learned last week, rose from 14.6 to 15.2 percent of the population, now 43 point something million uninsured Americans. Do you see the increase in Medicaid spending as a positive phenomenon?

Mr. SCULLY. I think it is a positive phenomenon in a lot of States. Especially that started 4 or 5 years ago when they had surpluses, were expanding SCHIP, and they were using the money, they were expanding through waivers and other mechanisms to cover more people. We encouraged that.

We have covered, I think, 2.27 million more people under Medicaid since we have been at CMS. I think that is a good development. For instance, in Illinois, we just covered 340,000 people up to 200 percent of poverty on a waiver of prescription drugs. So in the States that had the financing, they were trying to expand coverage, and we were all for it. I think it was great.

The problem obviously now is the States are feeling a contraction, and they are starting to reduce their coverage, and that has us concerned, obviously. Our concern is, when the spending is going up, it is very easy for States to expand coverage when they are doing it 100 percent Federal dollars and no State dollars. Our interest is making sure that the expansions are partnerships and that, obviously, when the States contract, Congress appropriate quite a bit of money in the tax bill to the States to get them through, hopefully, the next year and a half. That may help. But our concern now is to try to find a way to sustain the expansions we have.

Mr. BROWN. Mrs. Capps in her opening statement talked—and I think I am reading somewhat between the lines and somewhat directly what you said—that Medicaid has been a success because—in some sense measured in part that we are spending more money because we are taking care of more people in recessionary times.

If we agree that an adequate safety net is a minimum requirement of a just society, that a program like Medicare works that way, I am not sure I understand why capping funding would be expected to maintain or improve that safety net. In other words, given that the 2001, 2002 explosion of Medicaid applicants from the 33 million constant for 4 years up to 36 million and then to 40 million, given that that correlates with the rise in unemployment, the loss of 2.5 million or so jobs in the last couple of years, how do States handle recession with capped funding? How are we going to be able to sustain that safety net?

Mr. SCULLY. We didn't look at it as a cap, first. It is totally voluntary, so no State has to do it.

Second—and I think if Secretary Thompson were sitting here he would tell you that every one of his Governor colleagues would be back here in 2 years kicking themselves for not doing this—the reason is because the current Medicaid baseline, when we proposed this in the spring, Medicaid was growing at about 11.5 percent a year. Most States were still looking at rapid growth in Medicaid.

What they were going to get from this—and we were negotiating with them whether it was a 3-year, 5-year, 10-year baseline. They were going to get budget certainty to lock in the Federal spending at a 10 percent plus a year inflated level.

Now they are going to come back—because the States on their own accord are cutting their spending, you are going to find that current Medicaid spending baselines have dropped down to 4, 5, 6 percent.

We essentially were telling the States, we are worried about some of these games. We are worried about budget certainty. We are going to give you a 10 percent a year inflated baseline and total flexibility. We were talking about 3 years, 5 years, 10 years with the Governors and lock that in. And they are going to come back 6 months later and say that 10 percent baseline no longer exists because they have been forced themselves to cut it back to 3 or 4 percent a year growth. So it was totally voluntary.

I can tell you, from Secretary Thompson's point of view as a Governor, he said to many of his colleagues, you guys are nuts not to come in and lock in 10, 11 percent a year growth for 5, 10 years and run your program more flexibly.

What we get out of it was budget certainty. We didn't have to worry about upper payment limits or intergovernmental transfers. What the States got out of it was locking in a baseline that was based on the growth projections of 2 years ago which are clearly coming down. For most States, we believe it would have been a terrific deal for them. If they didn't think it was, they didn't have to do it.

Mr. BROWN. But a cap means less money to them, ultimately.

Mr. SCULLY. No, a cap—we were going to build in a 10-year baseline and were discussing with the Governors, before they decided they weren't interested this year, 5-year numbers, 3-year numbers, 10-year numbers. We were going build in a current baseline with current beneficiary growth plus medical inflation on a per capita basis, give them exactly what they were going to get, projected over the next 10 years, and it was from an artificially high baseline.

What we would have gotten out of that is we wouldn't have had to worry about all these different mechanisms that have over the years turned out to have artificial inflation. What the States would have gotten out of it was a lot more flexibility with a lot more money. If they came back today for the same deal, every State would be looking at a much smaller pot of money than they would have had 6 months ago because they have been forced to reduce their spending.

Mr. BROWN. Are you implying that the States wring out waste and inefficiencies better than you have and better than Dennis has?

Mr. SCULLY. No, I am implying that if you give the State—let's say hypothetically Ohio, and I should know their Medicaid budget, but I don't. But let's say we have a $20 billion program in Ohio. It is $12 billion Federal and $8 billion State. The States are spending an awful lot of time trying to figure out how to not spend their $8 billion and get more out of our $12 billion. Whereas, if we just gave them a static amount of money, they would run their program

better with a lot more flexibility and they would spend less time trying to worry about how to game the match.

We were going to lock that $20 billion in at an artificially high baseline, because they used to have an 11 percent growth rate. I believe the Medicaid growth rate with the new numbers that come out in the budget is probably going to be 6 or 7 percent. We have been trying to find ways to make the financing work better; and, State by State, this was a voluntary effort. Any State could have said no or said yes.

If the Governor wanted to come in and lock in a baseline and say I want—this is essentially what Tennessee has done since 1990. Tennessee has come in on an annual, purely capitated basis. They have to cover all their beneficiaries, but we give them a waiver, and they have much more flexibility in their program when we negotiate the bulk number. But it is purely voluntary on Tennessee's part. But this is the way Tennessee has worked since 1990.

I am not advocating Tennessee's program, but I think they would argue it has given them a lot of flexibility.

Mr. BILIRAKIS. Mrs. Wilson.

Mrs. WILSON. Thank you, Mr. Chairman.

Tom, thank you for your testimony. You have quite a bit of information on the financing and eligibility and so forth. But I wonder what kind of data and information do you have on how Medicaid has affected the health status of patients? Does CMS gather that data? Can you tell us about how Medicaid has improved control of blood sugar levels for diabetics, for example, or how immunization rates have been improved by Medicaid?

Mr. SCULLY. I think we have done quite a bit of immunization and preventive care. But it is obviously a State-by-State program.

I have spent a lot of time, for instance, in Mississippi. The Mississippi Delta probably has the most acute diabetes problem in the country. We have tried to find ways to have Mississippi manage it better. We have done everything imaginable in the last 5 years. I am not sure we have made much of a dent in it.

Your question is it very much varies State by State. Some States do a great job in disease management. Some do virtually nothing. I am not sure—one of the things that we think we would get out of waivers is to give the States the ability to do quite a bit more of that.

Mrs. WILSON. How do we know, funding this huge health care program, whether we are helping anybody or not? We all know it increases coverage and so on, but how would we say we have a broader goal of improving the health status of folks who depend on it in preventing the onset of disease if we don't have the data?

Mr. SMITH. If I may add, we are working with the States on some specific performance indicators that are based on children and adults; and we are looking at things like improvements for children who have asthma. There are a number of different indicators, performance indicators that we are building into the system. The SCHIP law itself, the States have to report on performance.

But I would say we do—and we have some States on a State-by-State basis that have been reporting different types of outcomes. Missouri, for example, even goes down to how it has reduced the number of days a child has missed from school.

It is very uneven. Some States do a lot more than others do.

We also have a national performance-based initiative that we are working with the States on to tell us more. Oftentimes, immunization rates, for example, it is hard to peg down because people move in and out of Medicaid. So if you are looking only at immunizations that Medicaid has paid for, you are probably not seeing the entire picture because a child has moved on and off of the program.

I think Massachusetts did an extensive tracking system and again pretty much found out just tracking Medicaid does not give you an accurate picture of the overall health care because people move on and off of the program. But we are trying to improve that.

Mrs. WILSON. Does CMS, the Federal Government, pay for 100 percent of the information systems in order to gather this data and find out whether we are helping people, improve people's health status, or is that a shared priority as well?

Mr. SCULLY. It depends on the program. Some of the matches are at the State match. A bunch of them are at 90/10, technology matches, and there are some we actually pay almost 100 percent of.

Mr. SMITH. 90/10 for new Medicaid Management Information Systems, the MMIS systems. In terms of if you are making improvements into your system, much of that would be matchable as high as 90 percent. The regular match rate, just the ongoing administrative rate, though, is a regular match rate. There is an administrative match rate of either 50 percent or 75 percent.

Mrs. WILSON. How many of the 57 programs would you assess have an exceptional tracking program for health indicators?

Mr. SMITH. For health indicators, that is not the way the information systems have really been used at this point.

Mrs. WILSON. So it is still about payments, it is not about health?

Mr. SMITH. You are absolutely correct.

Mr. SCULLY. There is no standardized format for the States to use as far as tracking diabetes patients or any other chronic diseases.

Part of the problem, as Dennis said, is a lot of people—the transition in and out of Medicaid is pretty rapid as well so it is not a static group of patients like Medicare is generally.

Mrs. WILSON. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentlelady.

Mr. Dingell to inquire.

Mr. DINGELL. Mr. Scully, there is nothing in your testimony about what you are doing to fix the problems in nursing homes raised by recent GAO studies. Also, there is nothing in here about how you would make it easier for people to get enrolled in the Medicaid program so you can get services. What are you doing in both of these instances, please?

Mr. SCULLY. I think we have expanded—encouraged the States to do a lot to enroll new beneficiaries. I mentioned I think there are 2.27 million new Medicaid beneficiaries in the last 2½ years. I think we have pretty aggressively encouraged the States to do more outreach, both in Medicaid and in SCHIP. Obviously, under the current economic environment, States are probably slowing that down a little bit, which is a concern to us. But I think we have

been pretty aggressive in the outreach for new beneficiaries on this.

Mr. Dingell, I am not sure which—GAO sends me a lot of studies on nursing homes. I am not sure which one—on nursing home quality?

Mr. DINGELL. I am sorry?

Mr. SCULLY. I am sorry. Your question was about a GAO study on nursing homes. Which one?

Mr. DINGELL. What are you doing to bring these new beneficiaries into the program?

Mr. SCULLY. To enroll new beneficiaries? I think we have done a lot of SCHIP and Medicaid outreach State by State. I think the numbers show that there has been a pretty significant expansion in the population the last couple of years. On the nursing home issue, I have been probably the most rabid advocate of nursing home quality.

Mr. DINGELL. I note, for example, you tell us that 2.27 million people were added to the Medicaid rolls between 2001 and 2003 who were previously uninsured. How many of these were not previously covered under Medicaid and SCHIP?

Mr. SCULLY. I think those were almost all new.

Mr. SMITH. Mr. Dingell, those are new people.

Mr. DINGELL. Those are really new people who had never been covered under Medicaid before?

Mr. SMITH. They were not previously eligible under the rules that the State had been working under at the time.

Mr. DINGELL. Were they covered or not?

Mr. SMITH. They were not covered by Medicaid when the State submitted those expansions, whether through an income disregard or a waiver. Those were people who were not previously eligible.

Mr. SCULLY. Those were not just the people that may have been expanded by an economic downturn. Those are the people that were covered by virtue of the fact that we gave States waivers to expand their coverage.

Mr. DINGELL. They then were covered under waivers under previous circumstances?

Mr. SCULLY. There was an increase in the base level population of the people that came on because of economic changes.

Mr. DINGELL. I want the broad numbers of new people covered, not covered because you changed a person who was under a waiver to a person who was regularly covered.

Mr. SCULLY. Those are people that could never have been covered under current law but for the waiver, so we expanded it by 2.27 million people by virtue of giving waivers.

Mr. DINGELL. I have 2 minutes and 18 seconds, and I note that the record now indicates that you have a lot of these people who have been moved from waivers to permanent coverage, but your indication to me is they have not gotten additional coverage. I will submit to you a letter requesting the answer to this particular question so that we can get this more clearly.

The Clinton Administration published a final regulation that would have prohibited approval of any new State UPL plans. HCFA told States that no new plans would be approved. This administration came into office, the administration reversed that po-

sition and allowed new States in under the wire. It has approved their UPL proposals. What were those States and why were they approved and why were others not approved?

Mr. SCULLY. I will ask Dennis. He probably knows the details. But the answer, I think, is there was a transitional issue with three or four States.

Mr. DINGELL. Two were approved, Virginia and Wisconsin. Why were they approved?

Mr. SCULLY. Because of the timing of the law, I believe it was.

Mr. DINGELL. Pardon?

Mr. SMITH. Mr. Dingell, if I may, at the time that rule was promulgated, we believed that more States in fact would have been eligible.

Mr. DINGELL. But only two came in. Why were those two States approved and why were others not approved?

Mr. SMITH. I will be happy to follow up with you.

Mr. SCULLY. In fairness to Dennis, because Dennis, as you probably know, was the former Medicaid director in——

Mr. DINGELL. Would you submit to the committee, please, the answer to those questions dealing specifically with each of the States?

Mr. SCULLY. Yes.

Mr. DINGELL. We were told that we should restructure Medicaid because States have abused the system. Aren't we best served to abate the abuses, stop the abuses and be on guard against future problems, rather than changing the system? Isn't that the way we should proceed?

Mr. SCULLY. Yes, and I think we have pretty aggressively, and I think most of the States would tell you that——

Mr. DINGELL. No, that I note to you goes rather less than converting Medicaid to a block grant system which is what this administration is now proposing. Block grants are quite different than a system of shared responsibility and shared expenses. Why are we going this route to address the problems of abuses?

Mr. SCULLY. We have been very aggressive. I don't think any State Medicaid director would tell you we haven't been extremely aggressive in trying to make them play by the rules. I think, as I said previously, we don't believe it is a block grant. We believe it is a simplified version of a waiver, much like Oregon and Tennessee and other States have worked under for years; and any State that doesn't want to do it doesn't have to. We believe we are trying to improve the State-Federal partnership, not block grant.

Mr. DINGELL. I heard my time is up. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. SCULLY. Mr. Bilirakis, could I just for 1 second add, just for Dennis, the two States you mentioned, I should remember the details. I was the one that made the decision on Virginia and Wisconsin. GAO spent a lot of time looking into this because of Virginia where Dennis used to work and Wisconsin where my boss used to work. I made both of those calls personally, I was very involved in it, GAO did a very detailed investigation, and I believe they were convinced I did the right thing.

Mr. BILIRAKIS. I also was somewhat confused regarding your answer that Mr. Dingell referred to that the record now shows regarding the 2.27 million that he referred to. Those were completely

new beneficiaries, is that right? They had not previously received or were eligible for Medicaid?

Mr. SCULLY. They are additional new beneficiaries that came in. Those 2.27 million are people that, under the current State laws, had we not given the waivers, could not have gotten coverage. By virtue of us giving a waiver—they were additional people that would not have been covered but for the waivers.

Mr. SMITH. Those were specific expansion numbers based on a State plan amendment that the State submitted to us for new coverage. So we have tried very hard to count them correctly so they—that does not reflect people who came in, they were previously eligible but then they came in.

Mr. BILIRAKIS. But the bottom line is they were purely new beneficiaries?

Mr. SCULLY. But, as Mr. Brown noted, the other population of Medicaid beneficiaries has also grown as more people have gotten on the Medicaid rolls due to poverty thresholds and other things.

Mr. WAXMAN. Mr. Chairman, would you yield on this point just so we can get a clarification?

Mr. BILIRAKIS. Very briefly.

Mr. WAXMAN. I think it would be helpful for us if we get in the record what the populations are. Because it is my understanding that many of these people could have been put into the Medicaid program through a State plan. They didn't need a waiver to add that population. So we ought to find out exactly how many were added because of the waiver and how many would have been added had the State decided to cover them under their ability to submit their plan.

Mr. SMITH. Mr. Waxman, you are correct, and that number does reflect both waivers and State plan amendments. But the point was that they were new people that the State opted to cover on their own.

Mr. WAXMAN. And the State could have opted to cover them on their own without a waiver?

Mr. SMITH. Yes, sir.

Mr. WAXMAN. So we need to have the differentiation of the populations.

We will submit a question in writing, Mr. Chairman; and we would love to get a response.

Mr. SMITH. But they were all new people, regardless of whether they were under a waiver or a plan amendment.

Mr. BILIRAKIS. Mr. Buyer is recognized to inquire. Mr. Buyer, 8 minutes.

Mr. BUYER. Thank you.

All of us, we represent our districts, we represent our States, and we try to look at a system of the totality. But there are also then numbers, and in particular there are Senators that then will try to do their own little rifle shots to protect their own little hospitals based on their own circumstance.

So you here are trying to manage an overall system while you feel the political pressures of individuals who may be even in power positions to do XY with regard to their own little hospital. That is a given in the political environment. You here are providing some testimony on what to do to best help a system and, at the same

time, in the U.S. Senate in the Medicare bill, S. 1, Senators put in some rifle shots with regard to how to assist specific hospitals. And I don't question they are having difficulty. I want to ask you, do you think this is an appropriate way to assist public hospitals with large uncompensated care costs and has Congress done this for other hospitals? And do you have any concerns about establishing this type of precedent?

Mr. SCULLY. Yes, we do, obviously. I am guessing the one you are referring to in the Senate is the one that just happens to be in a Midwestern State.

Mr. BUYER. Yes.

Mr. SCULLY. I think Indiana. Obviously, people concerned about individual hospitals are concerned about that provision as essentially it draws down a huge amount of additional Federal dollars for one hospital without putting up any additional State dollars. Obviously, there are many hospitals that we have a number of programs, Medicare disproportionate share, Medicaid disproportionate share, other cross subsidies. We have $32 billion of total cross subsidies that take care of indigent care both in Medicare and Medicaid at hospitals. To single out one particular hospital to—I believe they are talking about statutorily raising the upper payment limit to 175 percent of Medicare, we think is obviously not good policy, and we are opposed to that particular provision. We don't like rifle shots generally, but that particular——

Mr. BUYER. This is in reference to Wishard Hospital in Indianapolis. Are there others out there in this bill that we don't know about or is this the only one in S. 1?

Mr. SCULLY. It is the only one I am aware of. I am spending most of my life on this bill right now.

Mr. BUYER. The difficulty here is for these hospitals—not just whether it is Wishard but other public hospitals—are the high level of uncompensated care, is the uninsured. Here in Indiana we have a Governor that cut the Medicaid by 10 percent and then we have an escalation in the uncompensated care and people are less apt to—why seek individual responsibility or why take my health care offered by the employer? I can turn it down and take the cash instead and just go get care at Wishard. I don't know what has happened to responsibility in the system if all we are going to say is, well, let's just let the government fund these types of things. What is your sense?

Mr. SCULLY. I should correct—apparently, I have been corrected. There is a psychiatric hospital in Michigan that also has a rifle shot in the Senate bill. I think we spent an awful lot of time in this bill working on Medicare disproportionate share, indirect medical education and other things that are supposed to take care of inner city hospitals' indigent care needs; and to pick out one particular one and give it a turbocharged advantage is not a good——

Mr. BUYER. Let me be clear here. So then the administration opposes the rifle shot with regard to Wishard and the one in Michigan and you prefer making these substantive changes to help an overall system for the country?

Mr. SCULLY. Absolutely.

Mr. BUYER. Let me ask about the—you keep using or the words are thrown out about financing schemes. Obviously, these States

have been seeking some type of advice here by some consultants or associations on how to game the system. You made reference to that in your testimony.

Mr. SCULLY. And then they bill us usually for 70 or 80 percent of the cost to the consultant. That is even better.

Mr. BUYER. So tell us, obviously, people can do—this is sort of—this is dancing on the edge here. They can stay within the law and give their advice, but what are you doing with regard to working with outside groups to prevent the gaming of the system?

Mr. SCULLY. Dennis was a Medicaid director for many years in Virginia. I have been working on this through two administrations. It is like deja vu all over again. I had spent a lot of my time from 1989 to 1993 working on the same issues.

I think we have been trying to be straight with the State Medicaid directors. As I have said repeatedly, if I were a State Medicaid director, I am not sure if the law allows that some people shouldn't push the edge of the envelope.

We have been trying to be very clear about the rules. We have been ratcheting down on them pretty drastically. The primary thing we have done is told the States that when they apply for a new service or new expansion for upper payment limit or anything else, they are not going to get the money until they explain it to us.

What had happened in the past in many cases is we give them the money—and I went through this with Nancy and with Paula, who is a good friend. They faced the problem in the past. I am sure Tim would tell you this. You give the States the money and then go back later and say we would like our $2 billion back or our $500 million back and all of a sudden you are on the front page of the newspaper telling that State, instead of them overbilling you, you are now trying to re-collect from the State for money that they have already spent.

The primary mechanism we have used is basically say you have got to get—we're not going to give you any money until we understand the financing and until we agree with it and it is a legitimate service and legitimate match and the money is being spent on health care.

Mr. BUYER. Why would we reimburse States if we would pay individuals to scheme against the Federal Government?

Mr. SCULLY. I think the primary reason is for many years it was not widely understood, the Medicaid program was understaffed, and it was generally a partnership where the Federal Government trusted the States for sending in legitimate bills and we sent in our matches and the consultants in the States were way ahead of us.

Mr. BUYER. Is this something whereby it is within your discretion or is this something that Congress needs to change the law?

Mr. SCULLY. It is painfully within my discretion, generally. Congress could change the law, but it does not fund having—obviously, when the States are having the budget pressures they have, the primary source of any State budget director is to call up his Medicaid director and say, can we get a few hundred million dollars out of Medicaid? Generally, over the years, they have. But we started saying no, and particularly in this environment it is difficult.

Mr. BUYER. Are you willing to tell the State Medicaid directors that you will not reimburse for their outside consultants?

Mr. SMITH. Actually, we already have provided guidance to the States that—often, these are relied upon as contingency fee contracts; and we have told the States, if those are for Medicaid maximization, we would not pay and they would not be allowable in that respect.

Mr. SCULLY. They can still bill us for the fees, but if somebody happens to get $500 million for their State, they used to be able to get a percentage of that. We obviously——

Mr. SMITH. There are a number of specific——

Mr. BUYER. You obviously have—you can finish the sentence. You have stopped that?

Mr. SCULLY. We have stopped that, yes, to the extent we understand it. The money is very fungible and extremely hard to track.

Mr. SMITH. There are a number of specific areas where we have seen a lot of this in the past on school-based administrative services, for example, so we have provided—we have made final a claiming guide on administrative costs. They pop up in several different specific areas. As we find them, we do provide specific guidance to the States and tried to be very clear about what is allowed and what is not, but a lot of it is traced back to finding the flow of the dollars.

Mr. BUYER. All right. Thank you. I yield back.

Mr. BILIRAKIS. Mr. Waxman to inquire.

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

Mr. Scully, I am pleased to see you. Your presentation about Medicaid seems to be a complaint that the open-ended matching funds inevitably result in States trying to maximize use of Federal dollars. That is not all bad, because what the Federal Government did in the Medicaid program was to use Federal dollars to encourage them to do things that they wouldn't otherwise be able to do or wouldn't be able to choose to do on their own.

For example, we adopted recently an increased match for States to provide breast and cervical cancer treatment services. We specifically designed that to encourage States to use that money, and we used a carrot of Federal matching funds to achieve that coverage. In fact, that is what most of Medicaid does. It encourages the States by using a carrot to cover the optional services and optional populations which is most of the Medicaid spending. We designed the program to encourage the States to use the matching funds to take up these options.

No one is going to defend games being played when funds are being used for other purposes, but the vast majority of the funds Medicaid gets from the Federal Government is for very legitimate purposes, some of those optional services and optional populations that would be under a block grant, whether they be the breast and cervical cancer program, the prescription drugs, home- and community-based services, programs for disabled people, particularly the working disabled, the coverage of kids over 100 percent of poverty, most people in nursing homes, eyeglasses and hearing AIDS for adults.

So if you look at the Medicaid program as simply a program for States to get funds in an open-ended way and we are going to close

it, if we close the amount of money they can get they are not going to cover some of those services, in my opinion.

You have raised the DSH problem and you have raised the UPL problem. The DSH system now exists in statute. The Congress said exactly how much money it wants to spend on DSH in each State. The UPL regs are closing down the abuses in the system. So let's put those things aside and look at the problems of the Medicaid program.

Seventy percent of the costs of the Medicaid program are to serve lower income people who are elderly or disabled. The largest and fastest-growing Medicaid services are for those people in nursing homes and for prescription drugs. Where will these people turn to for long-term care and pharmaceuticals if Medicaid is not able to serve them?

Mr. SCULLY. Mr. Waxman, I agree with you. There are a lot of things we try to incentivize in the Medicaid program. We have done a lot of them over the years. I think that is exactly right. We have incentivized technology in 90 percent, some new coverages at 90 percent. The problem is when it is a 100 percent Federal match, and that has happened in many cases. I think we have tried to minimize that. We have capped DSH. We have limited UPL.

Mr. WAXMAN. I am not asking you what you can do to limit it. If you limit it, if you leave the program as it is, if you limited the program and you couldn't cover long-term care in nursing homes and prescription drugs, where are these people going to go?

Mr. SCULLY. What we have looked at is—I believe what we have done is totally voluntary for any State. What Oregon decided to do, I think they have done a fairly good job. Some people don't like the TennCare model, but I think Tennessee has covered an awful lot of uninsured people.

Mr. WAXMAN. Many States are turning to strict limits on the number of prescriptions a Medicaid beneficiary can get a month for drugs. Many of them are allowing only three drugs per month with no exceptions. Many elderly and disabled people need more than three prescriptions per month. What can these people do if Medicaid won't pay for the drugs if they need it for such chronic conditions as diabetes, heart disease or even HIV?

Even with open-ended funding they are cutting back on these programs. Charity hospitals don't provide outpatient drugs. It seems to me that they are going to be having to go to the drug companies for assistance programs, if that is possible. I think they are going to run into big trouble.

Mr. SCULLY. As I said, this is totally voluntary for any State. But I think, on the contrary, States have covered new populations. There are plenty of places where, if you are at 35 percent of poverty and if you are not in a category that is eligible, you can't get any coverage. In a State like Illinois, we covered 340,000 seniors up to 200 percent of poverty with new drugs. On the contrary, I think we have given States flexibility to cover more people.

Mr. WAXMAN. They have more flexibility if they get those matching funds, in my view. That is why they have been able to cover a lot of these populations that are optional to them. But if we limit the amount of matching funds the States get, then seems to me we limit their flexibility. We have a disagreement about this, but I be-

lieve we limit their flexibility to how to cut back on services for people; and the services that are most expensive are services for very, very vulnerable people who have nowhere else—my point is they have nowhere else to turn.

Governor Schwarzenegger in California is going to face this problem, and he is not going to buy in if he has any sense to the idea that he is going to get a little bit more money up front and then have the choice to get that money now but get the State stuck in a situation where they are going to have a limit on Federal dollars, especially when States end up with the brunt of a poor economy, which has happened under the economy that is suffering under the Bush Administration's economic policies.

Mr. SCULLY. I was about to say something nice.

Mr. Waxman, I would just say I appreciate—your comments on this have been very reasonable this morning. We would like to work with you and get by the rhetoric of block grants because that is not what it is to make the program work better. As you know, I spent a lot of last winter working with Governor Davis to come up with an extremely flexible waiver.

Mr. WAXMAN. A lot of good it did him.

Mr. SCULLY. I think the L.A. County public hospitals will tell you it did a lot of good for them. I think it took a lot of burden off L.A. County and southern California. We spent a lot of time working with them on their waiver to give them a lot more flexible use of their money or they would have had a lot of problems.

I think the issue is—I understand this is politically sensitive. We would like to find a way to make the States work as reasonably and as flexible as they can. We have done a lot of work with California and let them do a lot of creative things on their waivers that I think has provided a lot better health care for California.

Mr. BILIRAKIS. Mr. Deal to inquire for 8 minutes.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. Scully, during your statement and also in opening statements by members here, references have been made to the SCHIP program. I think we all generally recognize this has been a fairly successful program in providing health coverage for low-income children. As I understand that program, it has a capped annual expenditure back to the States.

I have two questions. First of all, is this a similar model to what was being proposed for Medicaid in general, that being an annual capped program; and, second, has it been successful in eliminating some of the gamesmanship that the States have tried to play in a noncapped approach?

Mr. SCULLY. I guess yes and no. SCHIP is a supplemental program beyond the Medicaid program. It does have a lot more flexibility than Medicaid. There is much more budget certainty for us in the Federal Government. So to that extent, the fact that it is a model for giving the States greater flexibility to use a clearer pot of funds, that is the case.

But, clearly, we were not trying to cap the Medicaid program and come up with—obviously, no State had to do this. We were only looking at the optional populations the States could have dropped tomorrow to give them more flexibility. The mandatory populations

in Medicaid would have had to have been covered exactly as they are today.

I guess the argument, and maybe Dennis can clarify, is that I think it probably includes some of the better aspects of SCHIP, but obviously Medicaid is an entitlement program. People that are categorically entitled to the Medicaid program would continue to be categorically entitled to the Medicaid program.

Mr. SMITH. If I can add—and SCHIP was very much the model that we were looking at and pursuing. People I believe would say that SCHIP has been wildly successful. But you touch on another point in that there are caps in Medicaid today. There are eligibility caps there. If you don't meet—even at 35 percent of poverty, if you are an uninsured adult male, you aren't going to qualify for the Medicaid program. So there are eligibility caps in Medicaid today. The QI-1 program for low-income seniors is a capped funding program. The caps are not all that foreign.

As Mr. Scully referenced, States dealing with 1115 waivers are negotiating capped Federal liabilities. So they are not all that foreign to the Medicaid program as in fact these types of financing arrangements between the States and Federal Government have grown in the last several years.

Mr. SCULLY. I would like to just clarify this as somehow I think it is perceived as a block grant or some type of way to save Federal spending. This was Secretary Thompson's idea. He was a Governor, and I think he was one of the more creative Governors on welfare and Medicaid. He came back and said, if I were a Governor still, what deal would I want, and he was the one that was pushing this. I think he is incredibly frustrated that his fellow former Governors have not understood more about what he is trying to do.

Mr. DEAL. Let me ask you about another area that has attracted a lot of attention recently, and that is the issue of dual eligibles, a significant portion of the population now and projected to be an even significantly larger portion of the population in the future. What is the administration's position with regard to these dual eligibles as it relates to long-term care and prescription drug benefits?

Mr. SCULLY. Obviously, we are in the middle of doing the negotiations right now. We are determined not to take sides between the House and Senate, certainly not in public, anyway.

I guess the long-term care issue is a little different, but I think the prescription drug issue in Medicare is complicated. I think the one thing we have said publicly is that the President is determined to spend every marginal new dollar covering a new person, and we believe the money in the Medicare benefit should go to cover predominantly low-income seniors with a new drug benefit and should not go to basically pay for an existing senior who has an existing drug benefit.

So one of our concerns whether you look at either bill is just spending money to buy out existing coverage whereas we should be covering a lot more people. We have said, I guess, publicly, the Senate—there is no question the Senate drug benefit covers a lot more people, low-income people than the House benefit does. Some would argue the Senate benefit may have a little too generous coverage. We think we need to find the right mix. But our concern is

covering as many new low-income Americans as we possibly can with a drug benefit. I don't believe we are talking at this point about making any changes in long-term care.

Mr. SMITH. Mr. Deal, to sort of put it in perspective of the other spending on duals, prescription drugs are only 15 percent of the Medicaid expenditures on duals. Once you start moving into other areas, you are talking about considerably even greater sums.

Mr. DEAL. I yield back, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mrs. Capps to inquire.

Mrs. CAPPS. Mr. Scully, recently, Surgeon General Carmona argued for the United States taking a more aggressive role in preventing violence through proven public health strategies. We spend in this country close to $6 billion annually on domestic violence. I am urging you—this is a little plug for some legislation I have to ensure that providers in our health programs include screening for domestic violence and follow-up services for women, and I hope that is some legislation you can support. It is not unrelated to our topic at hand.

But I want to continue this discussion of lump sum payments capped that would be the proposal by the administration for Medicaid. The administration predicted economic growth for fiscal year 2002. Instead, we saw more job losses and, more importantly, rising numbers of uninsured; and so we have also seen Medicaid having a rapid expansion. Doesn't it seem likely that from time to time estimates of what a State will need or States will need for Medicaid would be inaccurate? I would like you to kind of, I guess, continue some of Mr. Waxman's questioning about what happens to States when such an estimate discrepancy occurs, what happens if the States, as is the case today in almost every State, are already themselves in budget deficits and cannot afford to pick up excess costs?

Mr. SCULLY. That is one of the primary reasons that we proposed our plan to begin with. All this is negotiable. As I have said, with Tennessee and any other State that we negotiate a waiver with, we negotiate the per capita amounts, we negotiate the inflation, we negotiate the assumptions about how fast beneficiaries are going to grow.

I did that with Governor Davis last winter in California. We negotiated a whole new waiver for the California system. I think it was $1.9 billion. We had to make lots of assumptions about growth rates.

One of the things that we thought—that Secretary Thompson thought was a benefit to the States when we did this last winter was that we were looking at projected growth rates State by State in Medicaid that were probably artificially high. We knew they were coming down, and we were willing to let the Governors lock those in for a few years which would have been beneficial to them. They didn't have to do it if they didn't want to. I think most of them are realizing now that they may have not made the correct judgment on that call.

One of their biggest concerns we started with was we had talked about locking it in for 10 years. The Governors came back and said, that's too long. How about 5 years? How about 3 years? We had

just started talking to them about making those kind of midcourse adjustments when they decided, I think, due to the rhetoric of this is a block grant, which it is not, that it wasn't a safe thing for them to do this year. I think when you look at it purely on the merits, it was a no-brainer for them.

Mrs. CAPPS. Let me just ask you, though, if the States had locked into estimates based on predictions that we would have economic growth that were made last year and then we have seen in many States a very sharp downturn in employment and rising needs, then what?

Mr. SCULLY. Actually, that benefits them. Because a lot of them were looking at predictions of Medicaid growth, because they had the money, of 10, 11, 12 percent. We would have locked that in. And because they have been forced to voluntarily drop their optionals, they are now looking at having 2, 3, 4 percent growth rates. We were essentially going to let them lock in their prior growth rates for the Federal spending that didn't exist anymore. That exact trend actually would have helped them.

Mrs. CAPPS. I guess maybe I need this to be clarified more. You are expecting them to expand during economic good times?

Mr. SCULLY. They had expanded in the late 1990's, in the last couple years. Let's say, California, just for example.

Mrs. CAPPS. That is true. What if it were capped at last year and California now faces the situation we are in?

Mr. SCULLY. They would have been in great shape. Because what has happened State by State is that California—most of California's program is under waivers, by the way. A lot of this already is happening in California.

Let's pick California. California's program runs about $33 billion this year, I think, roughly. Let's say we have taken that $33 billion and inflated it at 12, 13 percent a year, because that was what we projected last year. California and every other State—I guarantee you in the next 6 months, California is going to have to come in and drop optional benefits to save money. Their growth rate, which used to be projected at 13 percent, which would have been locked in, we would have written them a check for that, they now drop to zero or 2 percent. They are going to lose the Federal match. All the Federal money will be gone, whereas they would have had it locked in.

Mrs. CAPPS. I guess I am thinking of those people, when they are dropped, what happens to them?

Mr. SCULLY. We don't want them to be dropped. That is what we were trying to avoid. California would have locked in an artificial—even though they would not have spent the money, they would have locked in the Federal money for 3, 5, 10 years at an artificial growth rate of 10 percent. We would have gotten the certainly of not having to argue about this gamesmanship every year, and they would have gotten the Federal money even if they didn't have their own. We would have locked it in.

Now what happens, because we only match real spending, is California comes in and has to make decisions about dropping optional beneficiaries. If California's spending rate drops to zero or 1 or 2 percent, they are only going to get matched for those dollars. They are going to get less Federal money.

Mrs. CAPPS. I guess my question is maybe even more basic or simple. What happens if the demand for Medicaid exceeds the locked growth rate?

Mr. SCULLY. If the demand—it is just like it does in Tennessee. Theoretically, the State has to eat the difference. But if you look at the Tennessee experience, which is by far the most—that is the one I have had the longest experience with. I just spent a lot of time renegotiating TennCare with the new Democratic Governor in Tennessee. I would think that it would be very hard to find anybody in Tennessee in either party that doesn't think that it was a very good deal. We have adjusted it a number of times when they had good arguments.

Mrs. CAPPS. They wouldn't lose their care?

Mr. SCULLY. It hasn't happened in Tennessee.

Mr. BILIRAKIS. Mr. Greenwood to inquire.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. Scully, you and I are both from Pennsylvania. You made the reference earlier to Pennsylvania's scheme with regard to nursing homes. It is my understanding that at this moment moving through the Pennsylvania legislature is a bill that they are calling the granny tax, wherein they tax nursing home beds. The nursing home providers pay that tax to the State, the State then uses it to match—would use it under this legislation to match Federal funds, thereby increasing the per diem to the nursing homes. Given what Pennsylvania has been through now, what would make Pennsylvania and its new Governor Rendell think that they could get away with that?

Mr. SCULLY. I hope they don't think they can.

Mr. GREENWOOD. They must. They are moving a bill through.

Mr. SCULLY. I did a teleconference with the State Senate committee overseeing this about 3 weeks ago in Pennsylvania. They asked me that question. I basically said—under the parameters, I said we would turn it down and not match it.

There is a provision in the bill which a number of Members were involved in, including you, I believe, that essentially you can have provider taxes if they are broad-based and redistributive. That means there would be winners and losers.

For example, if you wanted to tax every nursing home in Pennsylvania, you would have to make sure they aren't all held harmless and get all the money back because then it is not really a tax. So if you want to tax every nursing home in Pennsylvania at 5 percent and guarantee they are going to get every penny back, it is not a legitimate tax. If you tax them all at 5 percent and they have different levels of indigent care, some get back 2 percent, some get back 8 percent, then that is a redistributive tax, works like a tax and we will match it. But we won't match it if it is just a hold harmless tax because the money is just there. If they send it off to the State, raise the money and get it all back and they are all guaranteed to be held harmless, we will not match that and we will take a long look at it, if that is the way Pennsylvania's tax works.

That was largely the discussion I had with Missouri. Missouri restructured their tax structure on their providers so that there were winners and losers, and we actually do match their taxes. They

used to be hold harmless taxes, and we did not match those. It depends on how Pennsylvania's is structured.

Mr. GREENWOOD. It isn't a policy that even allows for a tax to be explicitly or specifically on the health care providers. It would seem to me, as a matter of policy, if you want to tax the people of Pennsylvania, all of whom are eligible for nursing home care, and then use those tax revenues to match Medicaid dollars, that is a fair and widely distributed tax as a policy, even though, given the caveat that you have just explained, that there is no guarantee that they would get it back. It still strikes me as a relatively phony taxing scheme.

Mr. SCULLY. I am with you, but I lost that fight 12 years ago in the first Bush Administration when these provider taxes came up. I personally think all provider taxes are bogus, that is my own personal opinion, but Congress when we were trying to slow this down in the early 1990's passed a law and said you can have provider taxes but they have to create winners and losers and be broad based and redistributive. I personally think it should be general revenues. But current law says that if the taxes are broad based and redistributive, and there are even more complicated rules than that. You can use provider taxes, but they have to create winners and losers.

Mr. GREENWOOD. I believe the new Medicaid director in Pennsylvania is one who was in the Medicaid department in Pennsylvania, left and became a private consultant to States to create these schemes and now is back running the Medicaid program under Governor Rendell. A great system.

Mr. SCULLY. I promise I won't do that.

Mr. GREENWOOD. One of your graphs that shows the growth rates of various components of the Medicaid program shows, I believe, expenditures on the disabled increasing very rapidly. In 1993, it was about $50 billion a year expended. It is now over $100 billion. Why has that been what seems to be the fastest-growing component?

Mr. SCULLY. It is. Some of that maybe has not been publicly debated but, and Dennis may jump in here, probably a good social policy. I would guess the bulk of that or a lot of it is the fact that we have done a lot of home- and community-based waivers so that we have deinstitutionalized a lot of disabled people. So there are more people eligible for benefits. States have covered more, and that is probably a good thing, but it has clearly caused an enormous demand increase on the Medicaid program from the disabled population.

Mr. GREENWOOD. Does it reflect any change in the eligibility by the States—who determines what the eligibility is to be called disabled?

Mr. SMITH. In some respects, States have expanded beyond who they are required to cover under Federal law. It is a combination of population expansions and the growth in home- and community-based waivers in particular, which again we think is a good thing.

Again, as we are talking about the future of Medicaid and how to change the program, we think that respect of changing the dynamics in where people are served for their long-term care needs has a great deal of promise to focus the dollars more clearly on the

individual rather than what we often find are provider-driven services and coverage. We think giving people more control over their own services has a great deal to offer, improving services and holding down the rates of growth.

Mr. SCULLY. There has been a lot like Arkansas as a cash and carry. There are a number of States that have done those type of things.

The answer to your question, Social Security makes the core determination, SSDI, of who is disabled statutorily under Medicaid, but many States have expanded that as an optional benefit beyond that to other categories, and we have encouraged that to places where it has provided much less institutionalized care generally.

Mr. GREENWOOD. Thank you.

Mrs. WILSON [presiding]. Thank you.

The gentleman from Texas, Mr. Green, for 5 minutes.

Mr. GREEN. Thank you, Madam chairman.

Mr. Scully, I am going to ask my staff to give you a copy of the letter we sent last week that was signed by a number of Members from Texas on the issue of Medicaid coverage for TANF recipients in Texas for a child who skips a class. Because I know tomorrow, I think, the State workforce commission is actually going to make a decision on that.

I appreciate what CMS is doing to ensure States are in compliance with Federal law and not restricting benefits to an individual if their teenager skips a class.

You state in your testimony the elderly and people with disabilities comprise just 27 percent of the Medicaid population and note the cost of their care consumes about 70 percent of Medicaid spending. You also state that almost 70 percent of the nursing home beds are now Medicaid financed and State and Federal Governments pay roughly 60 percent of all the long-term costs nationally. I am concerned that increased flexibility and benefit design or eligibility requirements might throw these individuals who are no doubt among the frailest and most vulnerable into the streets. Managed care doesn't appear to work for this population, particularly in a nursing home setting. So I am curious as to how flexibility would do something about that 70 percent of the Medicaid spending. I didn't realize those percentages were that high, in all honesty.

Mr. SCULLY. First, I would say a lot of people don't realize in Medicare—the percentage of managed care in the Medicare population is probably 11 percent. I think we have a little more than 5 million people in managed care. Dennis probably knows the exact number. We actually have something like 27 million people in Medicaid managed care. It is growing very rapidly, and many States are going in that direction.

I actually think you can make a good argument that it has been a very good, positive trend for care in the Medicaid program, but when you get in the nursing home setting, it is totally different. I think very little nursing homes, almost none that I know of State by State, has managed care.

The most disturbing trend in the nursing home setting that I see, and this gets back to Medicare, is I believe the average per day Medicaid reimbursement, it obviously varies greatly by State, is about $115 a day, whereas in Medicare we pay as much as $325

a day. I think the average is about $280. You get 70 percent of the people in the nursing homes in this country in Medicaid and, depending on the State, there is a huge cross-subsidy for Medicare and Medicaid. We only cover about 12 percent of the beneficiaries in Medicare, but we basically massively overpay in Medicare which we know because the States chronically underpay in Medicaid.

As the population grows of people in nursing homes on Medicaid, the ability to cross-subsidize, which probably isn't a good idea anyway in Medicare, it is a huge public policy problem. We are consciously cross-subsidizing Medicaid in nursing homes, but the nursing home rates, depending on the States, are generally chronically low and cause huge problems. So you have very little managed care in Medicare, but you have got a huge nursing home problem in Medicaid.

Mr. GREEN. And Medicaid pays the full monthly, the 30 days, whereas Medicare just has that benefit for once a year.

Mr. SCULLY. No, we pay for the first 60 days post-hospitalization.

What happens is, if the patient gets out, if you are a senior and you get out of the hospital, we pay for the first 60 days. If you are there longer than that generally, and there are many other rules around it, you switch to Medicaid after a certain period of time. If you are chronically in a nursing home for good, that is where most of the Medicaid patients—most of the nursing home patients are eventually paid for by Medicaid.

Mr. GREEN. Again, with those high percentages that are taken care of, or the 70 percent cost of the care consumes the 70 percent of the Medicaid spending, my next question is, could you point to an option where States might be able to use Medicaid funds as a type of premium support model for individuals who can use their Medicaid coverage to buy into their employer-sponsored plan or to purchase health insurance in the private market?

Again, looking at the percentages that you talk about, 70 percent of Medicaid spending is for that elderly and frail—so we would only be talking about 30 percent that could actually possibly be in the private sector; and you take out disabled, we are talking about such a small number of people. I find it hard to believe that Medicaid spending on a monthly basis—if I had the option, I could go find an individual policy with the Medicaid expenditures, for example, in Texas that you could find an individual policy knowing what I would be quoted for an individual policy in my 50's.

Mr. SCULLY. You could buy a terrific individual policy. In many States, it depends on where you are, the Medicaid spending per capita is enormous; and one of the reasons—you are right. We believe we need to take pressure off the long-term care sector.

I mentioned reverse mortgages and other things, but if you look at the per capita spending in Medicaid, obviously there is a core population of low-income people that need a full Medicaid benefit, but in many cases the per capita Medicaid spending is, in many cases, $6,000, $7,000, $8,000 a person, in some cases higher. One of our concerns is if you give States flexibility like Tennessee has had that they will take some of the relatively higher income people in the State—we obviously have a significant problem with the uninsured—and start using some of those resources to buy a basic Blue Cross plan or to buy other private insurance.

Because one of the problems you have with State Medicaid plans in my opinion is State legislatures. Every benefit in the universe is covered for every specialist in the world when you get in the State legislatures, mandating benefits State by State and especially—it may be appropriate in low-income populations, but as you get relatively higher up in the income stream we have found States like Tennessee, when they can buy people policies that are private policies without all these mandates, that they can cover a lot more ground for a lot more people.

Mr. GREEN. Again, I know, having served in the legislature and seen those mandates, and granted there is an argument for it, but oftentimes you also have problems with having a plan that has no benefits or very limited benefits that people aren't accustomed to.

But getting back to the issue in the private market——

Mrs. WILSON. Mr. Green, I think you are out of time. If you have got a quick question here——

Mr. GREEN. Obviously I didn't realize I was out of time. Thank you, Madam chairman.

Mrs. WILSON. Thank you.

Mr. Stupak is recognized for 5 minutes.

Mr. STUPAK. Thank you; and, Mr. Scully, thanks for being here.

When I was reading your written testimony, you spent about 16 pages with charts and that, showing some of the tactics that the States used to maximize their Federal contribution. Just listening to the testimony here, let me ask a question this way. Do you see any irony in your argument that we can't trust the States with financing Medicaid so we should give them nearly complete control over access, quality and data about the health of their recipients? It is almost like you are saying, we can't trust them, but yet you are willing to block-grant it to them.

Mr. SCULLY. No, the money is fungible. The Federal problem with the Medicaid program—and I don't mean to beat up the States too much. I mean, the fact is—Tim and others have been through this—there is no way to—the money is fungible when you are in a matching program. It has almost been too easy for the States to do this.

I guess our experience in places like Tennessee or Illinois and other places, when you actually come up with a matching program, if you took the $33 billion in California and said, our expectation is to spend $18 billion or $20 billion and you spend $13, whatever the rate is, it is a lot easier to monitor. The States are not putting up real money. In the States that choose to do it, and this is purely optional by State, it would be a much easier ability to both fiscally manage it and to give the States more flexibility. We think it was a much better deal for the States.

Obviously, even if our proposal had passed, any 1 of the 50 Governors didn't want to do it didn't have to do it, or the State legislature. It was purely voluntary.

So I guess I do think that the fact is an enormous amount of effort—and I skipped 8 years in the middle, but I can tell you between 1989 and now, my now 7 years in the government in that period, I spent a huge amount of my time, both when I was in the White House and OMB, on this program trying to work with the States, State by State, to figure out who is going to maximize rev-

enue, who is going to get what match, and not enough time trying to figure out how to provide better benefits. And so I personally think it is the right set of incentives.

Mr. STUPAK. But it sort of seems like you trust the States with the patients but not with the cash.

Mr. SCULLY. No. I think we trust the States to do it. It is just human nature. If you are in a budget squeeze as a State Medicaid director or State budget officer, and you can figure out a way to draw down Federal money without putting up State money, you are going to do it. And if we don't tell them they can't, they are going to do it.

So it is not that we can't trust them. They are doing what they are incentivized to do, and we provide a lot of the wrong incentives. I would rather provide incentives to say you know what you are going to get from us. We know what you are going to put in. Let's focus on providing better care.

Mr. STUPAK. But even if you did your cap program that you want to do with that 10 percent increase and all that to take up for growth, it really wouldn't have made any changes in the last 3 years. As I said in my opening statement, just about every State has had to reduce benefits. The prescription drug cost has skyrocketed out of control. Thirty-five States have had to reduce benefits. Even if they got that extra 10 percent, the States would still be faced with the same situation, wouldn't they?

Mr. SCULLY. I actually think most—if any State looked at what they could have gotten last spring versus what they are likely to get next year, it is hard for me to imagine a State that would have had a much better deal. It is hard for me to imagine for a State budget office that wouldn't see that. And we had a lot of pressure on the State.

One of the things that I think, which we haven't gotten into, it is very frustrating to me, I won't pick on—I picked on some drug companies about this. It drives me crazy to see what the States are spending on prescription drugs in some cases. You know, we have got a lot of wonderful drugs that poor people need. We have also got a lot of drugs that have generic equivalents or have come off patent, and we spend a huge amount of money in Medicaid buying drugs because they run on TV ads, and low-income people have a 1 and $3 copayment, and they go out and buy $80-a-month prescriptions with a $3 copayment because they just saw it on television even though the drug is identical to the one that is generic or just came off patent.

Mr. STUPAK. Well, if you are talking about prescription drugs, then you wouldn't agree with the provisions in the House-passed bill, Medicare prescription drug plan, where the Secretary of HHS can't negotiate drug prices. There is a bar against it in the bill. They said the Secretary of Health and Human Services shall not negotiate drug prices. So if you want to bring down the price of drugs and use the purchasing powers of whether it be the States or the Federal Government, you would be barred against it from the legislation.

Mr. SCULLY. Well, that is a very—this could take a couple of hours. I will take 30 seconds. I was one of the inventors of Medicaid drug rebates in the 1990 legislation, I think. I am not sure

it works perfectly, but the volume of States' drug spending then was about 8 percent of the market, and that was enough, arguably, to give the States the ability to centralize their purchasing power.

If I started buying—if Secretary of HHS started negotiating drugs through Medicare, I would be buying well over 50 percent of the volume of all the United States. It just doesn't work.

What we basically did in our program is we essentially have tried to split the country up into drug purchasing plans so that we would be buying in volume for seniors, but we would be doing it locally through the market, rather than—you wouldn't have a market if Secretary Thompson and I sat out there for 60 percent of the drug spending and just decided to negotiate prices. We would be fixing prices, not negotiating prices. We would be the market.

Mr. STUPAK. Yeah, but you still have——

Mr. SCULLY. It doesn't work.

Mr. STUPAK. Yeah, but the bill still doesn't allow the Federal Government to buy at any kind of reduced rate.

Mr. SCULLY. What we try to do in the bill is split the country—in our proposal is split the country up into 10 regions for PPOs and for prescription drug purchasing plans, get 41 million seniors buying in bulk and put them in huge groups to buy in bulk. But if I bought for all 41 million seniors, I would be the market. What we are trying to do is coordinate—the same thing with the prescription drug discount card, which I have been advocating from the first day I walked in the door, is the goal is to get seniors organized into huge purchasing pools to have the leverage——

Mr. STUPAK. But even your senior discount card, I remember asking a question, did not encourage the use of generics. In fact, I asked you the question on the 80 percent discount. I forget the one drug it was, the one for stomach concerns.

Mrs. WILSON. Mr. Scully, if you could answer this question and then——

Mr. STUPAK. Even the prescription drug plan has——

Mrs. WILSON. Your time has expired.

Mr. STUPAK. The Bush card never encouraged any kind of generics. I really think that the whole situation, whether it is the House-passed Medicaid plan that we have where Tommy Thompson can't negotiate or the one that the President put forward that you came and talked about before this committee, neither one of them did anything to drive down the price. In fact, you actually protected the price of drugs, and basically you left the prices to the poor seniors to try to pay for.

Mr. SCULLY. I think what you see—and let me finish quickly. You notice we got sued in your original drug card and didn't do very well. We now in this bill will have clear statutory authority to do it, and I think you will see in the regulation that they will be very helpful toward generics.

Mrs. WILSON. Thank you.

Mr. Strickland has 8 minutes.

Mr. BROWN. Mr. Strickland, could you yield 30 seconds to me to start?

Mr. STRICKLAND. I will happy to yield more than 30 seconds to my friend.

Mr. BROWN. I thank the gentleman.

Mr. Scully, I am unclear on something you said in response to Mr. Stupak on the purchase of what you said, expensive drugs. My understanding is that Medicaid can buy—if there are two generics, two or more generics that Medicaid can buy, that you can order the purchase to be paid for the cheapest of the three, or at least of the two generics; isn't that correct?

Mr. SCULLY. That is correct with generics. What I was—I think I was referring to something else. I don't want to pick on particular drugs, but, you know, there are some drugs where there is a generic equivalent now, and there is still a name brand that is slightly different, extended time, and we pay $80 a month for that prescription, the beneficiary pays a $3 copayment, where there is a generic that might cost, you know, $16 a month. And the fact is we are spending an awful lot of Medicaid dollars on those types of drugs. And to give you an example, which I probably am not going to get invited to their Christmas party, but my most common complaint, and this is Nexium versus Prilosec, which are extremely similar, and we are spending $300 million last quarter on——

Mr. STRICKLAND. Reclaiming my time. Thank you.

Mr. Scully, it seems as if we may be talking past each other, because is it my understanding that you are saying that your proposal is not a block grant, and it seems as if everyone on this side is saying it is a block grant. Is it a definitional problem, or is there a substantive difference between a block grant and what you are proposing be done?

Mr. SCULLY. No, there is a huge difference, and I was—there were block grants for Medicaid proposed 15 years ago, where basically you take the State's Medicaid allocation, give to the State, and let them run the program themselves. This is totally different. The mandatory beneficiaries in the program were required to be covered so the States would have to match it. We would have to cover it. It is only for the optional populations.

Mr. STRICKLAND. So would it be a block grant for the optional populations? Is that what you are saying?

Mr. SCULLY. It would be a negotiated per capita payment amount that the States could voluntarily do. So no State would have to—it is essentially TennCare. If you look at what TennCare did, what Oregon did, it is a simplified bulk waiver for your optionals, which it is just a simplified way for Tennessee to do what they have already done with a lot less hassle.

Mr. STRICKLAND. So if I think I heard you correctly, you said it is capped per person?

Mr. SCULLY. The calculation is a per capita spending on all three of the various populations.

Mr. STRICKLAND. So how does that differ from a block grant?

Mr. SCULLY. Well, the block grant proposals were, first of all, 20 years ago where the entire population—where they were static populations, didn't grow. In this case it is a per capita amount, so if you happen to have a recession, and the number of people grew in Medicaid, your State gets more money per person. The block grants generally said if we are giving you $10 billion now, we will index to that inflation.

Mr. STRICKLAND. But the requirements associated with those resources would be the same type of requirements or lack of requirements that would be associated with a block grant; is that correct?

Mr. SCULLY. I really don't think it is. I think the—again, if you look at most of California's population in the Medicaid managed care plans, they are already in exactly this type of per capita spending cap. So the States have already come in State by State and negotiated these arrangements in many cases. A State like California has done it for about a third of their program, and we are just trying to simplify it and make it easy to understand and actually give them a better deal.

So I just—I think, unfortunately, and this just happens, that the rhetoric kind of overtook the reality, and I think it has been counterproductive.

Mr. SMITH. Mr. Strickland, if you look at other programs like the Maternal and Child Health Block Grant, Social Services Block Grants, the SAMHSA Block Grant, those are block grants in that they are discretionary. They have to be reauthorized, reappropriated.

Mr. STRICKLAND. If I could just interrupt here. I have here a document from OMB which indicates that by 2013, there will be a cut of more than $8 billion. How do you—how do you explain that? That is, understand, an actual cut in amounting to about 2 percent, but——

Mr. SMITH. Well, again, that is 8 percent, $8 billion off what is already in the baseline. But the baseline is already growing. Under the administration's proposal, the Federal Government would have spent $2.7 trillion on Medicaid over the next 10 years. In our proposal we still would have spent $2.7 trillion because there is growth built into the baseline, the 8 billion that you are referring to——

Mr. STRICKLAND. But excuse me for interrupting, but Mr. Brown took some of my time, so I have to hurry.

Isn't it accurate to say that the States will be getting less money as a result of what you are trying do?

Mr. SCULLY. Well, if you went back and looked at that projection which was under the arm of giving the States the option, and we assumed half of them would do it from last January, and went back and looked at the midsession review budget which shows real State spending, what you will find is that $8 billion is swamped many times over because the fact is the States have to reduce their spending anyway. We are trying to lock in higher levels. The Medicaid baseline for next year, if you take that 10 years of numbers, will be way below what our proposal is.

Mr. STRICKLAND. But, Mr. Scully, you said the baseline projection included projected growth in the number of people——

Mr. SCULLY. It did.

Mr. STRICKLAND. [continuing] did you not?

Mr. SCULLY. We made some assumptions about the States when they got those projections and about what the behavior would be.

Mr. STRICKLAND. So if you cut $8 billion, you are cutting $8 billion from what the States would have been expected to receive.

Mr. SCULLY. No, because we put it in on the front. What we basically required was that the States that got more money in the first

7 years would have to come back with lower rates of growth in the last 3. And there was almost a rounding error in $8 billion. When you look at the $2.7 trillion—I guess my point is if you looked at the $2.7 trillion and that baseline projection last January, I would bet if you looked at reality right now, it is probably down to $2.6 or $2.55, because the fact is the States are being forced to spend less.

Mr. STRICKLAND. I just want to get for the record, though, according to OMB, it is an $8.285 billion cut. Now, that is OMB's conclusion.

I want to move on to just——

Mr. SCULLY. That may be correct.

Mr. STRICKLAND. You know, I have got a minute and 30 seconds. The administration opposed the FMAP Federal increase in funding for Medicaid for the States; is that correct?

Mr. SCULLY. Yes.

Mr. STRICKLAND. Now, you have said, and I think others have said, in fact, the Kaiser Commission indicated that the State Medicaid directors were strongly in favor of the additional resources of about $10 billion. Every State surveyed indicated this was a needed relief. Twenty-one States indicated that FMAP would provide general relief within their Medicaid programs. An additional 19 States said the enhanced FMAP was going to be used to soften or prevent cuts. In Ohio the fiscal relief provided by FMAP prevented a cut that would have affected 60,000 low-income parents. In Missouri the fiscal relief avoided cuts to parents and cuts to seniors and people with disabilities.

How would reducing the long-term Federal commitment to health care for low-income vulnerable Americans by capping Federal funding of the program through the administration's approach help if the economy of States continues to struggle? This being my point: If that FMAP relief was not there, States would have cutoff vulnerable people. Will the administration support continued enhanced funding for future years if the economies of these States continue to struggle and they simply are faced with a choice of either cutting off people or the other option is to getting additional Federal resources; what will your response be?

Mr. SCULLY. Well, we will have to wait until it comes up, but I will say that my major objection to the enhanced match, which I think was about $10 million in the fall, was—and I put a chart in my testimony—is there is no correlation between the FMAP now and the FMAP then. I am not picking on Ohio, but by our calculation Ohio's real FMAP is 4.5 percent higher than the statutory FMAP. And if you want to pick on a State like Mississippi, which is the poorest, that hasn't been quite as clever, I mean, spending more money on it, my argument last winter was you are going to split the money in the pot and put $10 billion in, you ought to give it to the people that haven't fudged. Why should we be handing it out to everybody whether they have played under the rules of the program or not? And we have essentially handed the money out across the board. And my argument would have been let's look at the real FMAP and see what they are getting.

Mr. STRICKLAND. So is Ohio fudging?

Mr. SCULLY. Ohio is on the margins of being——

Mr. STRICKLAND. Is Ohio fudging?

Mr. SCULLY. [continuing] on relatively good behavior.

Mr. STRICKLAND. If Ohio is fudging, I invite you to come in and solve the problem.

Mr. SCULLY. I have spent a lot of time talking to them, and they have been very straightforward with us, but the fact is that over the years there are about 27 States that have successfully enhanced their match. Ohio is probably not in the world champion category.

Mr. STRICKLAND. You just said Ohio was fudging, and I want to get to the bottom of that.

Mrs. WILSON. Okay. Thank you, Mr. Strickland.

Ms. DeGette is recognized for 8 minutes.

Ms. DEGETTE. Thank you, Madam Chairman.

Mr. Scully, I share your concern and repulsion for people, States or institutions who are gaming the system, but I share some of the skepticism of some of my colleagues about this as a solution, and I think we should try to work together to try to find ways to stop this kind of behavior. You may not have the answer today to some of the questions I would like to ask, but I would like you to supplement it if you can in writing.

You were talking about—one thing you talked about was senior citizens gaming the system by transferring assets, and we certainly have heard about that anecdotally over the years. I am wondering if you are aware of any studies or evidence to see how extensive this is.

Mr. SCULLY. There are a number of studies. I looked at some last night. There were a couple—I think it was Colorado actually has and Connecticut has a fairly extensive one. And this has been debated in a lot of State legislatures with great pain about what the look-back should be, what the asset level transfer should be, how much is excluded from your assets. But it is a fact, as a former lawyer, there is a significant bar in this country with regard to transferring assets.

Ms. DEGETTE. Do you know how extensive it is?

Mr. SCULLY. Very extensive.

Ms. DEGETTE. I know a lot of States like Colorado have enacted legislation to try to make it more and more difficult to do this, so that is why I like—I mean, I think people recognize it is a problem and——

Mr. SCULLY. I guess my solution to this, just to be clear, is not necessarily to ratchet down this to make it tougher. You could have a good argument about what this should be. My—one of the suggestions that Secretary Thompson and I are working on is that a lot of these people that are transferring assets to their kids—for example, my mother is not wealthy.

Ms. DEGETTE. I am sorry. I only have a few minutes.

Mr. SCULLY. Okay. I will answer it after you are——

Ms. DEGETTE. Thanks. And something else, and this is an issue I work on a lot, you probably know, is the disproportionate share of hospitals. And you were talking about hospitals gaming the system by putting in huge amounts of bills to the State for operations that should cost less, and I was really puzzled by that. And the reason was, as you might know, Ed Whitfield and I have been

working for a number of years on trying to fix DSH reimbursements, and what I am wondering if there is not some incidence of safety net hospitals putting in these types of reimbursement requests just because they are so desperate to get funds.

And let me just give you a little background. One analysis recently found that hospitals lost over $9 billion on Medicaid and uninsured patients in 2001 even with DSH funding. And if you look at the recent statistics, DSH funding has gone down since 1998 from $10.3 billion to $8.7 billion nationally, and yet the number of uninsured, as we have just seen, is increasing.

I will tell you, the DSH hospitals in my district, I don't think they are trying to game the system. I think they are trying to get some reimbursements for all of the uninsured people that they are trying to treat, and I think Ed would say the same thing if he was here.

Mr. SCULLY. If we could find a way to make sure they kept the money, that would be great, but what happens was I used to run a hospital association for 7 years, and what happens in many cases, the hospitals transfer the money to the State. They put it up for DSH. They get the match back, and the hospitals either get nothing back or a small percentage, and the State keeps the rest for other purposes. So if we can find a way to make sure it is actually going to indigent care, I would be all for it.

Ms. DEGETTE. Well, do you think we should just eliminate DSH funding?

Mr. SCULLY. No. I was involved in capping. What happened——

Ms. DEGETTE. Well, what could we do to give the hospitals the money they actually need?

Mr. SCULLY. Well, make sure they actually get the money, and it doesn't get——

Ms. DEGETTE. Well, how are you going to do that if you block grant all the money to States——

Mr. SCULLY. Well, we wouldn't block grant——

Ms. DEGETTE. [continuing] and make this optional?

Mr. SCULLY. I would be happy to work with you on trying to make sure that the money actually goes to the hospitals because that is where it is supposed to go. When I first discovered the Medicaid DSH program was in evidence in 1989, it was $200 million in West Virginia and Alabama. By 1991, it was $13 billion, $12.5 billion. And we have capped it, and we have limited it, and it is actually pretty flat.

Ms. DEGETTE. But that is going down. DSH reimbursements have gone down, but the number of uninsured have gone up, and the people at the DSH hospitals in Colorado tell me—their problem isn't getting the money back from the State. Their problem is the caps we have put on it through the 1997 BBA.

Mr. SCULLY. Well, I believe that if you actually went to the hospitals and said to them—and they are scared to death of this question——

Ms. DEGETTE. I do go the hospitals. I do ask them that, and I also asked the hospital association that.

Mr. SCULLY. I been to every hospital in your district, I believe, and I think you are right.

Ms. DEGETTE. Did you ask them that question?

Mr. SCULLY. Believe me, I am intensely familiar with this question, and I would be happy to ask that question, but I can almost guarantee you would find that none of them get every dollar back that they put in.

Ms. DEGETTE. Let me talk to you for a minute about the States' situation, because in your written testimony and today in your verbal testimony, you said that one of the big problems is States use this Medicaid money and then divert State funds off to other purposes like highways and stadiums. And I think that was probably true in the 1990's. But I have a State right now where last spring the legislature faced a $900 million deficit, and they cut—what they did then was cut $61 million for medical programs for the poor, including Medicaid. I am going to guarantee you they weren't saying, ha, ha, let's take our Federal dollars and then put our State dollars somewhere else. They don't have the money. And I think this is true in all 50 States because according to a Kaiser report, all 50 States executed cost-containment plans in fiscal year 2003.

And so my question is instead of a complicated proposal that we would call a block grant proposal, you would call something else, to try to cap Federal money in the States, wouldn't it be better for us to try to work with States on waivers and other kinds of ways where they could really give relief to poor people and seniors and not have to worry about it rather than this brand new scheme?

Mr. SCULLY. Well, I would argue we haven't tried to cap it. We have had a 37 percent increase in Federal spending on Medicaid since I have been in job. So it is not like—we have expanded coverage, we have encouraged more enrollment, we have done everything to expand the program. What we are asking from the States is that they actually match with matching real dollars, and I don't think that is an unreasonable request. And I know for a fact that Colorado is not one of the—I think you can look at my chart. Colorado has not been one of the States that has maximized reimbursement. They have actually generally played very much by the rules.

Ms. DEGETTE. Well, we are all fiscally conservative out there. But the point is in a place like Colorado, I think under a scheme like this, they may actually suffer in reimbursement; certainly some of the reimbursements for SCHIP and other discretionary programs, but the State does not have that money, or for DSH. They don't have the extra money.

Mr. SCULLY. This is purely voluntary. If Colorado looked and said this is not a good deal for us, and we don't want to do it, they don't have to do it. Even if our proposal passed as it was, we assumed half the States would say this is a good deal and take it. If they don't think it is a good deal, they don't have to do it.

Ms. DEGETTE. And then I guess this is one problem a lot of us on this side have is then you get into a real patchwork of 50 different States saying 50 different things.

Mr. SCULLY. It can't get to be more a patchwork than it is now.

Ms. DEGETTE. Well, I think I might disagree with you on that, because at least under current law, there is some guaranteed benefits, and I am not sure that that would happen under your proposal.

Mr. SCULLY. Every guaranteed benefit, if you are a mandatory beneficiary under the current law, all this is optional coverage. No State could have dropped one single beneficiary that they are required to cover now. That was part of the proposal, the mandatories had to be covered and had to be matched. Any one of these two we are talking about any State could drop tomorrow if they wanted to. We are trying to give them the flexibility not to drop them and have more flexibility in how they covered them, and if they didn't want to do it, they didn't have to.

So I just think that in fairness—and I understand, you know, I used to be a Senate staffer. I probably would have come up with the same talking points. But in fairness, this is not a block grant, never was, and has been largely misrepresented, and we would be happy to start from scratch and talk about ways to fix the Medicaid program.

Ms. DEGETTE. I would like to spend some time talking particularly about DSH because I think it is being unfairly characterized, and it really is the safety net that is keeping sick people who are not even on Medicaid alive. And I think we need to really figure out a way to make that system work.

Thank you, Madam Chairman.

Mr. SCULLY. Thanks.

Mrs. WILSON. Thank you very much, and thank you both very much for joining us this morning. We very much appreciate your being here, and we look forward to continuing this dialog.

Mrs. WILSON. I would at this point like to introduce and ask to come forward the second panel that will be testifying today. Delegate Adelaide Eckardt from the Maryland State House, and Dr. Diane Rowland, the Executive Vice President of Health Policy for the Kaiser Family Foundation.

Mr. BROWN. Madam Chair, could I ask unanimous consent to offer these letters from various groups in the record about the whole issue of block granting and caps and all of that?

Mrs. WILSON. Without objection.

Thank you. Thank you both very much for joining us today. We have—your entire statements will be put into the record. And I would ask you each to summarize your remarks and share with us the high points of your remarks, and then we will open it up for questions.

STATEMENTS OF HON. ADELAIDE ECKARDT, REPRESENTATIVE, MARYLAND STATE HOUSE; AND DIANE ROWLAND, EXECUTIVE VICE PRESIDENT, HEALTH POLICY, KAISER FAMILY FOUNDATION

Ms. ECKARDT. Good afternoon. I am Delegate Addie Eckardt from the Eastern Shore of Maryland, and I am here today to share with you my thoughts on Medicaid reform.

I would like to start by saying we really are in the best and worst of times. We are very fortunate because we do have a Medicare program, and we do have a Medicaid program. The Medicaid program, I would say, has been very successful in attempting to provide health insurance, health coverage for those most vulnerable citizens in our constituency and our States. But I would sug-

gest to you, and I am going to kind of cut to the chase, that there are a couple of things that we need to keep in mind as we proceed.

I believe, Mrs. Wilson, you suggested that we need to look at the elements of wellness, of personal responsibility, of caring for families as we proceed, and I am going to underline a number of the strategies to facilitate reform that have already been stated.

First of all, I believe that there does have to be continued flexibility for the States both to give them a better way to deal with eligibility and with the benefit structure. And I am going to use one of the examples that happened to us in Maryland. We had a program a number of years back called Kids Count, which we attempted to use some Medicaid funds to be able, along with State funds, to provide some health care for kids, but we did that before the SCHIP program. When the SCHIP program came along, then we kind of were penalized because we thought we could just roll our Kids Count program into the SCHIP program, and because there were certain requirements for both eligibility and benefits, we weren't able to do that. And we thought that may have been a more cost-effective way, while providing an essential benefit package to more kids.

What happened is that we had to go back and look at a number of different options and waivers to be able to then do the SCHIP program. We expanded that program to go way above the Federal poverty level to above 300 percent a number of years back. And, in fact, we were so diligent with our enrollment that we funded—I projected funding for about 60,000 children, and we wound up having over 100,000, which left us with a little bit of a shortfall.

This past year in our legislative session, we went back to revisit how we looked at that program, and, in fact, we did limit the enrollment for the high end for those people at 300 percent of poverty while we left open the lower-end program, which was for those people below the Federal poverty level, which we thought was important.

The reason I am sharing that with you is that I think there—because we need that additional flexibility because we have found that even as we expanded the program, we weren't enrolling all of those people who are most vulnerable and most poor. And I suggest that we might use the SCHIP program in thinking about our seniors.

Maybe we need an SCHIP program to include our dually eligible population, which is presented as, you know, another dilemma because of the high cost of the increasing cost of long-term care. If we could look at the dual-eligible and maybe get some pilot programs, as you have done a lot of the demonstration waivers, both with funding from Medicare and from Medicaid, to be able to then institute a truly managed care program—and I say managed care in quotes because I don't mean a managed cost program. You are exactly right when you talk about a lot of our health care delivery system is based on what is reimbursed, not what is in the best interest of the populations that we serve—in States I believe are truly genuine in their attempt to provide the best care, the most cost-effective care to our most vulnerable populations. And I think they, in fact would be able to do that.

I think we also need to take a look at the life span. If you are talking about kids and you are talking about senior care, you have everybody else in between. We fund low-income pregnant moms and kids, but there is no provision for low-income dads. And so you get a very difficult situation, particularly when it comes to things like dental care and other kinds of care.

We would like to treat the family as a whole, and we have tried to figure out in Maryland where is the best place to do that and how is the best way to do that. So even though we are putting a lot of energy into the SCHIP program, which I think is good, and it is almost like a front-loaded program, we need to put our dollars there right now and make sure we have efficient programs in the States, giving the States the flexibility, because my premise is that over the long haul, those individuals in those programs will value medical care.

We have instituted some copays and some premiums at a nominal level, because my experience, my 30 years experience in working in psychiatric and mental health care, is that when people are able to pay a little bit, then they take some personal responsibility and some ownership. If you look at our federally qualified health centers, they will tell you that if individuals pay a little bit on a copay when they come into the center, they think twice about calling the center and walking in for every cold, every sniffle, every concern that they have with their kids or with their families.

So I think we do have to institute measures along the way to help people, A, value health and wellness and be able to maintain an element of self-sufficiency as they move forward and not to erode the existing private health insurance market. So all of these things have to be taken into consideration when you move forward and take the Federal program and figure out how you provide the most—the best resources or resources to the State so that they can get out of the patchwork quilt business.

One other way I think we need to move forward is to provide tax deductions for long-term care insurance. I would like to see, personally, tax deductions for any health insurance because I think that again builds those incentives, but long-term care insurance would be a place to start.

The other thing that has been talked a lot today has been the way that folks divert their financial resources when you have to go into a nursing home, and that is a very prevalent practice, and it is spread by word of mouth, and it is spread sometimes by well-meaning organizations. And I think why that happens is because many people find that the kind of care that they need, because they wait too long, is through the Medicaid system and through the Medicaid reimbursement.

My mom had a stroke a number of years ago. She was healthy most of her life. So I agree with the fact that most of the health care dollars are spent in the last year or two of an individual's life. She had a stroke. She had some financial resources, but she had a stroke in one State. She was sent to another State for health care. And then it became like an assembly line. Whoever pays for what is what she got, not what she needed. And I would say to you that ultimately we brought her back to Maryland. She did have the financial resources, so we were able to provide a degree of care for

her, but it was not what I would have desired. It was choppy, it was insensitive, it was disrespectful, I think, of her, and of the family, and we were left on our own.

And I am a health care provider, and I hear the story over and over again. I have worked diligently for over 30 years to be able to make a contribution to health care so that all of our citizens have access to health care, and I will continue to champion that. So I would urge you, and I would suggest, that now is a good time to look at reform. It is good to look and take an evaluation of the programs that we have because you have a very daunting task. Are the States in budget crisis? Yes, they are. But I think, again, this is a good time to look at that because I believe States are going to be very conscious about how they deliver health care to their citizens, because it will be too costly if we don't do otherwise. Thank you.

[The prepared statement of Hon. Addie Eckhardt follows:]

PREPARED STATEMENT OF HON. ADDIE ECKARDT, DELEGATE, MARYLAND STATE HOUSE

Medicaid the government program that pays for the costs of providing health care coverage to 44 million low-income individuals continues to be a significant program across the country. Over the years efforts continue to provide for the most vulnerable citizens. States and the Federal Government fund the program jointly, with the respective percentages for each state determined by the use of the FMAP (Federal Medical Assistance Percentage) formula that is based on the state per capita income. In the fiscal year (FY) 2001, total Medicaid expenditures totaled $228 billion, with the federal share equaling approximately 57 percent of the total. The federal share of the Medicaid expenditures currently represents 7 percent of all Federal outlays, while the state share of Medicaid spending accounts for between 15 and 20 percent of states' total expenditures.

Medicaid covers health care expenses for four primary low-income populations: 1) children, 2) parents of children and pregnant women, 3) the aged, and 4) the blind and disabled. Approximately three quarters of the current Medicaid population consists of children and other adults, with the remaining quarter consisting of the aged and disabled persons. The aged and the disabled, however, consume two-thirds of all Medicaid expenditures, principally through their use of long-term care, pharmaceuticals and related services. Statutory mandates require that states cover certain populations, e.g. children under age 5 with family incomes below 133 percent of the Federal Poverty Level (FPL), while states may elect to cover other "optional" populations, such as children age 6-19 with family incomes at or below 100 percent of FPL.

Medicaid covers two distinct types of health care services: those that are statutorily mandated and those that are optional. Statutorily mandated services include inpatient and outpatient hospital care, physician services, early and periodic screening, diagnostic and treatment services and immunizations. Optional services include outpatient prescription drugs, dental care and vision for adults. About two-thirds of all Medicaid expenditures are attributable to services for optional populations and benefits.

According to a report by the Kaiser Commission on Medicaid and the Uninsured, States are beginning what is for some the fourth consecutive year of fiscal stress. State tax revenues declined significantly in 2002 and remained at that low level throughout 2003. As they completed their 2003 fiscal year and developed budgets for the fiscal year 2004, states faced total budget shortfalls of at least $70 billion. To close these large budget gaps, states reduced planned spending and some began to raise taxes and fees. After the beginning of fiscal year 2003, states reduced budgeted spending levels for the year, and many states proposed to reduce fiscal 2004 spending.

These fiscal conditions place significant pressure on Medicaid, the state/federal program that funds health and long term coverage for 51 million low-income Americans. Medicaid is generally the states' second largest budgeted item. At the same time that the state revenues have fallen, spending on the Medicaid program has been increasing significantly, reflecting increasing health care costs and the growing number of people living in poverty as a result of the weak economy.

States have been implementing many new measures to control their budgets in the face of the declining revenues. The Kaiser Foundations' report outlines their conclusions all of which, I believe, reflect a need to reform Medicaid at the Federal level. I am here today to share with you my thoughts for your consideration as you review the Medicaid program, the increasing numbers of uninsured and underinsured, and our declining revenues.

The Medicaid program serves an important role in the provision of health care for some of the sickest and most vulnerable citizens in this country. It has been very successful improving care to individuals who would otherwise be without health care. For instance, in Maryland all children below the federal poverty level have access to care, including for the first time ever access to Treatment for Substance Abuse and Mental Health. This has resulted in a proliferation of providers for those services. Also in Maryland in our enthusiasm to provide coverage for as many kids as possible we enrolled more than we anticipated and funded. When we, on the budget committee attempted to freeze the enrollment of the program until the funding levels equaled the service demands, we were accused of limiting services. It is important to me that a program work efficiently before expansion occurs. Probably some advocates may characterize any effort to reform and improve Medicaid as an attempt to dismantle the program. This is simply not the case. In fact, as a health care provider/RN, I am committed to ensuring that Medicaid beneficiaries continue to receive access to high quality care and I believe that we can improve the kind of care they receive and how it is provided.

REFORM MEASURES

There are many challenges currently facing the Medicaid program. One of the primary problems is that the current rules limit the states' ability to provide the best care to the most needy citizens. The current Medicaid structure attempts to impose one set of rules and provide one standard set of benefits to a varied and diverse Medicaid population state by state. Moms and kids, the elderly, and the disabled all have different needs and would benefit from very different coverage packages. States need flexibility to determine eligibility and tailor different benefit packages to best meet the needs of these populations, rather than having to adhere to the fixed prescriptive formulas for eligibility and benefits.

Until recently states have not been allowed to design individualized packages without losing the federal monies. We in the states have appreciated the increased flexibility given in the SCHIP program, which gives states a greater degree of autonomy and control in how they design their benefit structure and provide coverage for children. States can tailor their programs consistent with beneficiaries' needs and existing government structures. States are under tremendous fiscal constraints, but cannot afford to drastically limit benefits because of the increasing pressure on our hospitals for treatment when other measures fail. If health care is not offered early through community based services and as we face the increasing numbers of citizens needing long-term care, our costs will continue to soar. The emphasis will continue to be on the more expensive inpatient care. The pressure will also continue to remain on the use of Medicare dollars. Many of our most vulnerable citizens need comprehensive coordinated services that can be provided in the community. Careful and thoughtful attention is important, as states design effective programs using the available Medicaid funds.

Flexibility also needs to be considered as we find solutions for the dually eligible Medicare-Medicaid beneficiaries. In Maryland within the Medicaid program 80 percent of the health care dollars are spent by 20 percent of the beneficiaries. Long-term care costs are increasing with the increasing numbers of seniors. Can we think about allowing states to use monies from both programs to institute managed care for this population. The coordination of care would improve and many states would welcome the opportunity to develop pilot projects. What have we got to loose. Most states want to provide quality care to families and flexibility is the key.

Another challenge facing Medicaid is how to deal with the culture of dependence that entitlement programs can sometimes breed. My state of Maryland has had tremendous success in interrupting the cycle of dependence in our Welfare to Work program. We have been able to work with individuals as they enter the workforce and assume productive roles in society. We also are taking advantage of the federal programs to allow those disabled individuals who are working to increase their earnings and not loose their healthcare benefits.

The culture of dependence in Medicaid can lead to over utilization of services. It can inhibit more and more individuals from taking personal responsibility for obtaining their own health insurance, when it is available. When we increase the

availability of free health care to higher income groups, we fail the poorest citizens and provide disincentives for employer sponsored coverage.

Another problem is that of individuals inappropriately attempting to gain Medicaid coverage for expensive services such as nursing home care and prescription drugs. A veritable cottage industry has developed to coach individuals in ways to shift and/or hide their assets in ways that will allow them to qualify for Medicaid. This type of abuse undermines the public trust in these programs and most importantly takes dollars away from the care of those persons who need it most and for whom Medicaid was intended to protect. Strong measures need to be taken to prevent this practice.

Prescription coverage is essential as we face the long-term care and increasing senior population. Without a Medicare Prescription coverage option, Medicaid foots the costs of those citizens who make difficult choices when the options include whether or not to buy food, fuel or medication. If the medication prescribed is difficult to obtain due to cost, citizens do not follow their plan of care and again the result is the utilization of hospital care. It is absolutely critical that we create a new drug benefit within the Medicare program to provide this assistance to our most vulnerable low-income citizens. Prescription drugs are the fastest growing expense within our states Medicaid budget, and individuals who are dually eligible are some of our biggest consumers of these drugs within the existing Medicaid benefit. Creating a new Medicare drug benefit will also allow for better coordination of care for Medicare services, which can lead to better clinical outcomes for these people.

In summary I have attempted to share with you my thoughts regarding Medicaid reform. I have reviewed the current Medicaid programs and some of the current information that the Kaiser Commission has presented about the States' response to their increasing fiscal crisis and increasing numbers of uninsured. As the county slowly comes out of our economic decline, now is the time to do something and reform Medicaid to prepare for the future. States have been doing the best with what they have patching their public health care system with whatever they can find to provide for the most vulnerable citizens. It is the right thing to do.

There are simply several ideas to keep in mind. Give states more flexibility—there are too many restrictions for managed care in the types of organizations and in regard to quality and access. Give states increasing flexibility with eligibility and benefits. Provide a way to limit the practice of hiding assets so that individuals have to utilize Medicaid. Encourage the use and tax relief for long-term care insurance. Develop pilot programs using Medicare and Medicaid funding to allow states to offer a managed care program for these individuals. Or better yet let the states develop plans and fund them on their creativity and ability to make the best use of the dollars for their populations. Provide incentives for states that promote health and personal responsibility and significant positive health outcomes. Remember that government closest to the people is the most effective and most responsive. Let the states decide whether they want to cover fewer people with more coverage or whether to cover more with fewer benefits.

I appreciate the opportunity to come before you today and on such short notice. It is important to me that we spend taxpayer's money wisely but together figure out a way to provide affordable quality health care to our constituents. I look forward to working with you.

Mrs. WILSON. Thank you very much.

Dr. Rowland.

STATEMENT OF DIANE ROWLAND

Ms. ROWLAND. Thank you. It is a pleasure to be with you today and to talk about the Medicaid program and the role that it plays.

Medicaid is, in fact, the linchpin program that addresses the health and long-term care needs of this Nation's low-income disabled and elderly populations, and children and families. It is, in fact, the glue that fills the many cracks in our fragmented health care system, and as we have heard so often today, it shares many of the ills that face our overall health care system.

Its most widely acknowledged role is as the source of health insurance coverage for 38 million low-income children and parents, and it has kept millions of poor children and their parents from adding to our growing uninsured population. As the census num-

bers that came out last week reveal, in the absence of Medicaid, we would have had an increase of 4 million instead of just 2.4 million to our uninsured population.

However, for Medicaid it is the coverage of the health and long-term care services of the 8 million people with disabilities and 5 million low-income elderly that dominate the spending. And Medicaid is also the program that enables the Medicare program, in fact, to work for 7 million of Medicare's sickest and most poor beneficiaries, one-quarter of whom are in nursing homes. These dual-eligibles account for 14 percent of Medicaid beneficiaries and 42 percent of all Medicaid spending. Spending for them on prescription drug coverage alone represents 6 percent of total Medicaid spending and nearly half of all Medicaid spending on prescription drugs.

The structure of our Medicare program provides States with the ability and the flexibility to broaden coverage beyond Federal requirements and to expand as need arises. About 65 percent of all programs—spending in the program is, in fact, at State option, and of that optional spending, 83 percent goes to care for the aged and disabled population, with the bulk being for long-term care and prescription drug coverage.

However, I would note that despite the rhetoric, Medicaid is actually a low-cost program given the population it covers. When we do adjustments for the health status of the population to compare Medicaid to private insurance, we see that spending per capita is actually lower in the Medicaid program than for the privately insured. Medicaid spends more overall because it covers a sicker population, not because it offers a broader benefit package. And despite the creative financing discussions that we have had earlier, the overwhelming share of Medicaid's dollars still actually go to pay for the care of our poorest citizens. And there is a growing cost of care for the elderly and disabled because of their greater health care needs.

When we look at spending increases, we have heard a lot today about enrollment expansions, but, in fact, of the increase in Medicaid spending from 2000 to 2002 of $50 billion, 60 percent of that was for the care of elderly and disabled individuals. So it is not our expansions to children that are the major culprit.

But nonetheless, Medicaid spending has risen in recent years with the downturn in the economy and rising health care costs. However, the good news, or the bad news if Mr. Scully's numbers were right, is that in fiscal 2003, the rate of growth in Medicaid spending fell by nearly a quarter to 9.3 percent, a marked contrast to the 13.9 percent increase we saw in private insurance premiums in that year.

As the States grapple, in fact, with their severe revenue shortcomings, there is a growing pressure to restrain Medicaid spending. Although it is the decline in State revenues and not the increase in Medicaid spending that is the major contributor to State budget shortfalls, nonetheless as a major budget item Medicaid is also being looked at for savings. Over the past 3 years, in fact, 34 States have had to reduce eligibility or even more restrict their health care benefits for those being covered. The fiscal relief offered by the Congress has made a difference and moderated many of

these cuts, but as you know, this relief will expire at the end of 2004.

The strategy States have undertaken appear to have been successful in reducing the rate of Medicaid spending growth, but they also raise real questions about how the program will be able to meet the health care needs of low-income people whose numbers are growing. There are no easy answers to reducing the cost of providing care to over 50 million Americans who now depends on Medicaid. They are low-income children, but they are also persons with chronic mental illness and retardation, those with HIV/AIDS, poor Medicare beneficiaries, and those with severe physical and mental disabilities. The cost of caring for this population is high, reflective of their serious health problems, not excessive or unwarranted spending by the program.

Program costs grow in response to downturns in the economy, the needs of an aging population and emerging public health crises and emergencies, and Medicaid's financing structure allows the program to respond. As we look to reform this program, we should be looking at finding ways to support and maintain essential coverage, to make sure that the coverage provided is meeting the health care needs of the population served, and to make sure that we are getting the kinds of health outcomes from those dollars that are warranted. Assuring that financing is adequate to meet the needs of America's most vulnerable and addressing our growing uninsured population ought to be among our Nation's highest priorities and a real commitment of our resources.

Thank you, and I welcome your questions.

[The prepared statement of Diane Rowland follows:]

PREPARED STATEMENT OF DIANE ROWLAND, EXECUTIVE VICE PRESIDENT, THE HENRY J. KAISER FAMILY FOUNDATION, EXECUTIVE DIRECTOR, KAISER COMMISSION ON MEDICAID AND THE UNINSURED

Mr. Chairman and members of the Committee, thank you for inviting me to appear before the Committee today to discuss the issues and challenges facing Medicaid in providing health and long-term care coverage for the low-income population. I am Diane Rowland, Executive Vice-President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured.

The Kaiser Commission on Medicaid and the Uninsured is a 16 member, bi-partisan national panel established by the Kaiser Family Foundation in 1991 to serve as a source of information and analysis on the Medicaid program and health and long-term care coverage of the low-income population. I am pleased to be here today to share the work of the Commission.

Medicaid Today

Since its enactment in 1965 as companion legislation to Medicare, Medicaid has operated as a federal and state partnership to meet the health needs of the nation's most vulnerable populations. It has evolved from a program providing federal financing to states for health coverage of their welfare population to a program that now provides health and long-term coverage to 51 million low-income Americans at an annual cost to the federal and state governments of $205 billion in 2002. It is now the nation's largest health care program.

In our fragmented health care system, Medicaid is the linchpin program that addresses the health and long-term care needs of this nation's low-income disabled and elderly populations and families and children. Medicaid has a broad reach—it is the source of health insurance coverage for 1 in 5 American children and over a third of all Hispanic and African-American children, but it also provides health and long-term care coverage for 60 percent of nursing home residents, 44 percent of people living with HIV/AIDS, 20 percent of people with severe disabilities and 15 percent of Medicare beneficiaries (Figure 1).

In meeting these needs, Medicaid accounts for nearly one of every five dollars of health care spending, nearly one of every two dollars spent on long-term care and over half of public mental health spending. Medicaid assists, on average, over one in ten state residents and is the largest source of federal support to states and a major engine for state economies, supporting millions of jobs across the country (Figure 2).

Medicaid's most widely acknowledged role is as the source of health insurance coverage for 38 million low-income children and parents. By providing fundamental health insurance protection, Medicaid keeps millions of poor children and their parents from adding to our growing uninsured population. With the enactment of the State Children's Health Insurance Program (SCHIP) in 1997 and the Medicaid expansions over the last decade, Medicaid and SCHIP now have the potential to reach all low-income children. Although more needs to be done to broaden outreach and facilitate enrollment to achieve full participation by all eligible uninsured children, the latest census numbers show that public coverage through Medicaid and SCHIP helped to offset the decline in employer coverage. While the number of uninsured grew by 2.4 million in 2002, Medicaid coverage kept another 1.6 million from being added to the uninsured and maintained coverage for children.

It is not, however, Medicaid's role as a health insurer of low-income families that provides Medicaid's most unique or costly undertaking. Medicaid's role in assisting 8 million low-income people with disabilities and 5 million low-income elderly people with both medical care and long-term care services dominates Medicaid spending. Although children account for half of all Medicaid beneficiaries, they account for only a small share of spending. Together children and their parents represent three-quarters of all beneficiaries and 30 percent of all spending, while the elderly and disabled account for a quarter of beneficiaries and 70 percent of spending (Figure 3). In 2002, per capita expenditures per child were $1,500 compared to $11,800 per disabled beneficiary and $13,100 per elderly Medicaid beneficiary. Higher utilization of acute care services coupled with long-term care spending for the elderly and disabled account for the difference (Figure 4).

For low-income Medicare beneficiaries Medicaid coverage is particularly important. Although Medicare provides basic medical coverage, the required cost-sharing and gaps in benefits, most notably lack of prescription drug or long-term care coverage, leave many holes to be filled by Medicaid. The 7 million individuals with both Medicaid and Medicare—the "dual eligibles"—are among Medicare's poorest and sickest beneficiaries. In addition to having low-incomes, these dual eligibles are also more likely than other Medicare beneficiaries to be in poor health, suffer from chronic diseases, and have limitations on their activities of daily living leading to long-term care needs (Figure 5). As a result, the dual eligible population accounts for 14 percent of Medicaid beneficiaries, but for 42 percent of all Medicaid spending (Figure 6). Spending on prescription drug coverage alone for the dual eligible population represents 6 percent of total Medicaid spending—$13.4 billion in 2002—and represents approximately half of all Medicaid spending on prescription drugs.

The structure of Medicaid provides states with federal matching funds for coverage of mandatory populations and services, but also enables states to obtain federal matching funds for a wide range of optional services and broader population coverage. Most notably, states are required to cover all children under the poverty level and most aged and disabled recipients of cash assistance under the Supplementary Security Income (SSI) program and have the option to cover children at higher income levels, their parents, and other low-income elderly and people with disabilities in the community and in nursing homes. However, coverage of non-disabled childless adults is not an optional category for coverage. With regard to benefits, states must cover basic physician, laboratory, and hospital services, but many benefits, including prescription drug coverage and community-based long-term care are covered at state option.

Although the configuration varies from state to state, about 65 percent of all program spending is at state option. However, in meeting the health and long-term care needs of the low-income population, the legislative language of "State Option" hardly applies to the population's need for the services covered—83 percent of optional spending is for the aged and disabled population and the bulk is for long-term care and prescription drug coverage (Figure 7). Without these "optional" services and the broadened coverage at state option of the aged and people with disabilities, millions of America's poorest and sickest people would be without essential health and long-term care services.

Moreover, despite its comprehensive coverage of services and limited cost-sharing, Medicaid is in reality a low-cost program when compared with other health care spending. Among children, per capita expenditures for those in Medicaid are significantly lower than for their privately insured counterparts (Figure 8). While per cap-

ita expenditures for adults in Medicaid are higher than the corresponding amounts for low-income adults who have private coverage, this is due to the much poorer health status of the adult population enrolled in Medicaid. When adults with disabilities are excluded from the analysis of both Medicaid and private insurance, per capita expenditures are significantly lower for Medicaid adults than for the privately insured. Medicaid spends more because it covers a sicker population.

Although Medicaid is a substantial investment of federal and state dollars, it also provides an effective return on that investment in terms of improving access to care for our low-income population. Medicaid does a particularly good job in helping low-income populations close the gap in access to care and in connecting people to the health system. Uninsured children and adults are less likely to obtain medical care and more likely to postpone needed care and lack a regular source of care than those with Medicaid coverage (Figure 9). Among the elderly and disabled with Medicare coverage, Medicaid supplements Medicare coverage and provides access comparable to those with private supplemental insurance and notably better than that experienced by the population covered with Medicare only (Figure 10).

Medicaid Spending

These roles make Medicaid both a complex and costly program. Medicaid is complex because it is not a single program, but an array of services and programs under a single name, structured and operated somewhat differently in each of the 50 states and the District of Columbia. It is a costly program because health care, and especially long-term care, in America is expensive and Medicaid covers those with among the most substantial health care needs—including those with severe disabilities and chronic health problems requiring on-going care.

Medicaid spending is determined by the number of people covered, the cost of their medical and long-term services and the amount of services used. During the early 90s, Medicaid spending growth was particularly high, largely due to the use of provider taxes and donations and other financing mechanisms used by states to gain additional federal matching funds (Figure 11). Once these practices were curbed, Medicaid spending growth returned to levels more consistent with private spending and reflective of expanding coverage. A notable drop occurred in the period surrounding welfare reform, largely due to individuals losing Medicaid coverage during the welfare reform transition. This was also a time when cost increases for the private health insurance were at an all-time low (Figure 12). In recent years, Medicaid spending has increased as enrollment has grown and the cost of medical care has risen for both the public and private sectors.

Over the 2000-2002 period, Medicaid expenditures for services grew by 12.9 percent overall—a rate comparable to the increases seen for private health insurance premiums. Although Medicaid is historically a low-paying purchaser of health care services, there is continual pressure on the program to keep pace with payment rates in the private sector in order to maintain access to care for Medicaid beneficiaries. As a result, the spiraling costs for health care also impact Medicaid. Just as for private insurance, prescription drugs costs had the highest rate of growth among Medicaid services, increasing 18.8 percent from 2000 to 2002 (Figure 13). However, after several years of rapidly accelerating Medicaid spending growth, in FY 2003 the rate of growth in Medicaid spending fell by nearly a quarter, to 9.3 percent. This rate of growth, which is still substantial, stands in marked contrast to growth trends for employer-sponsored health insurance, which continue to increase and reached 13.9 percent that year.

The rapid Medicaid spending growth has been driven, in part, by enrollment increases resulting from the loss of income and private insurance coverage during the current economic downturn, together with continued increases in hospital and prescription drug costs that have affected the entire health care sector. Yet, Medicaid spending increases on a per capita basis remained substantially lower than increases in per capita spending in the private sector—from 2000 to 2002, Medicaid per capita spending increased on average 8.6 percent compared to over 12 percent increases in private insurance premiums per person. Moreover, Medicaid enrollment growth also helped to soften the recession's effects, stemming further increases in the number of uninsured. However, the increased enrollment of low-income children and parents is not the major driver of Medicaid spending increases—it is the cost of care for the elderly and disabled who depend on Medicaid to fill Medicare's gaps and provide assistance with both acute and long-term care needs. The elderly and individuals with disabilities accounted for almost 60 percent of the $50 billion growth in Medicaid spending from 2000 to 2002 due to their extensive need for health service and their use of costly long-term care coverage (Figure 14).

The State Fiscal Challenge

At the same time as these pressure push Medicaid spending up, states are facing extremely challenging fiscal conditions, and have been for several years. State tax revenues declined significantly in 2002 and remained at that low level throughout 2003 (Figure 15). The recent falloff in state tax revenue is large even by the standards of recent history---the decline in state tax revenue is twice as big as it was in either of the two most recent recessions. Moreover, it is this revenue falloff, not the recent increase in Medicaid spending, that has been by far the major contributor to state budget shortfalls, which reached more than $70 billion this year.

As states have grappled with the challenge of balancing their budgets in the face of declining revenues, most have devoted significant attention to implementing new measures to control their Medicaid spending growth. For fiscal year 2003, every state and the District of Columbia has put in place some Medicaid cost containment mechanism. Over the past three years, 34 states have reduced eligibility and even more have restricted health care benefits (Figure 16). These strategies appear to have been successful in reducing the rate of Medicaid spending growth, but they also raise real questions about how the program will be able to meet the health care needs of low-income people, whose numbers are growing.

The outlook for state budgets in FY 2004 and 2005 remains challenging. The state revenue picture remains depressed. Spending pressures continue to build. States have exhausted a lot of one-time measures they have used to balance their budgets. Medicaid expenditure assumptions in FY 2004 appear optimistic, and Medicaid budget shortfalls are likely in a majority of states. Finally, the federal fiscal relief Congress provided in June, which helped states avoid making additional and deeper changes to their Medicaid programs this year, expires at the end of fiscal year 2004. This, along with present expectations of low revenue growth, will leave states with significant gaps in their budgets for FY 2005. As states enter another year of Medicaid cost containment, they will continue to struggle to balance the health needs of their low-income citizens with the need to close what are for many states gaping holes in their overall state budgets.

Looking Ahead

Medicaid's role in providing health and long-term services to our nation's most vulnerable people and its widening safety net responsibilities have brought notable improvements in coverage of low-income families and assistance to the elderly and individuals with disabilities. As the primary source of financing and coverage for the low-income population, Medicaid has been a critical force in moderating the growth in America's uninsured population over the last three decades. Without Medicaid, millions of our nation's poorest children would be without health insurance. And, Medicaid continues to provide coverage beyond that of private insurance or Medicare to the most vulnerable and frail in our society—acute and long-term care services for persons with chronic mental illness and retardation; medical and long-term care services and drug therapy for those with AIDS; assistance with Medicare's premiums and cost-sharing and prescription drug coverage for poor Medicare beneficiaries; and home-based and institutional care for those with severe physical and mental disabilities that require long-term care. In the absence of Medicaid, it is hard to envision how these enormous societal needs would be met.

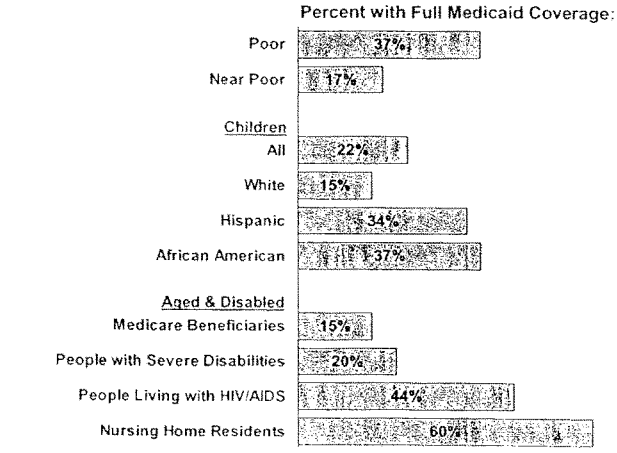
Yet, one of the most daunting challenges facing Medicaid's future is how to meet the growing need for health and long-term care coverage within the constraints of federal and state financing. The fiscal situation in the states, coupled with the growing federal deficit, makes assuring adequate financing and meaningful coverage for low-income families, the elderly, and people with disabilities a growing challenge. Yet, it is a challenge we must meet with responsible proposals that assure that the most frail and vulnerable among us are protected and able to obtain the health and long-term care services they need.

There are no easy answers to reducing the cost of providing care to the over 50 million Americans who now depend on Medicaid for health and long-term care assistance—the poorest, oldest, frailest, and most disabled of our population. The cost of caring for this population is high, reflective of their serious health problems, not excessive spending by the program. Program costs grow in response to downturns in the economy, the needs of an aging population and emerging public health crises and emergencies. Efforts at reform should be directed at finding ways to support and maintain the coverage the program offers while balancing the responsibilities for coverage and financing between the federal and state governments. Assuring that financing is adequate to meet the needs of America's most vulnerable and addressing our growing uninsured population ought to be among our nation's highest priorities.

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

Figure 1

Medicaid's Role for Selected Populations



Note: "Poor" is defined as living below the federal poverty level, which was $14,128 for a family of three in 2001.
SOURCE: KCMU and Urban Institute estimates, 2002.

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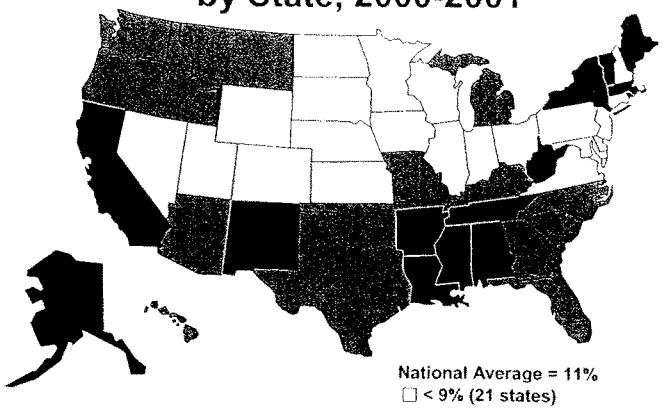
Medicaid and the Uninsured

Figure 2

Percent of Residents Covered by Medicaid, by State, 2000-2001



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of 2 year-pooled data from March 2001 and 2002 Current Population Survey, 2002.

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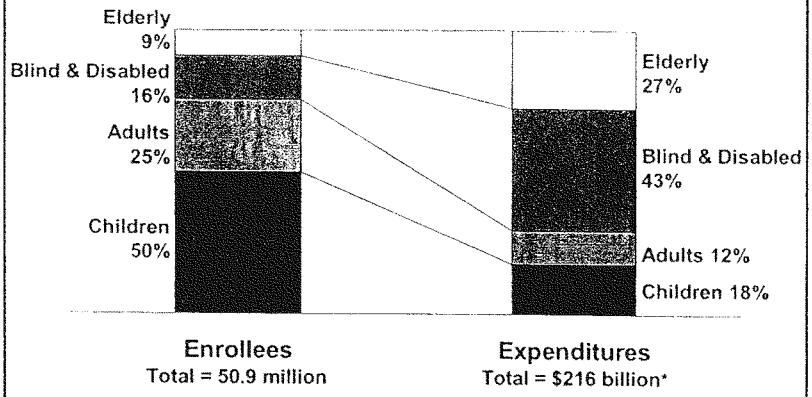
Figure 3

Medicaid Enrollees and Expenditures by Enrollment Group, 2002



Expenditure distribution based on CBO data that includes only spending on services and excludes DSH, supplemental provider payments, vaccines for children, and administration.
SOURCE: Kaiser Commission estimates based on CBO and OMB data, 2003.

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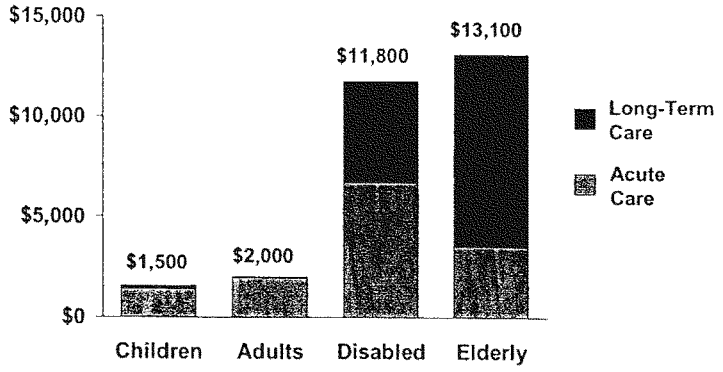
Figure 4

Medicaid Expenditures Per Enrollee by Acute and Long-Term Care, 2002



SOURCE: KCMU based on CBO and Urban Institute estimates, 2003.

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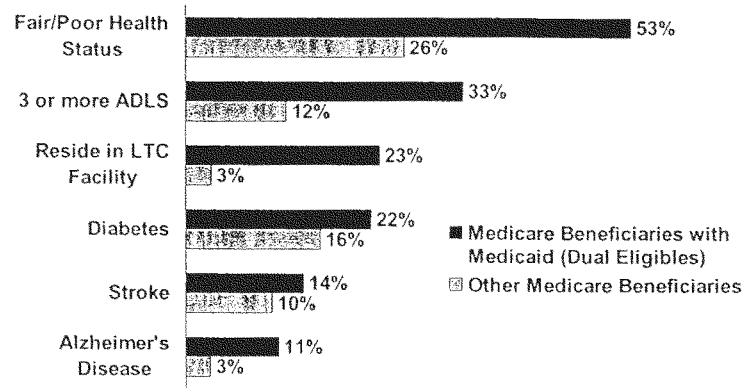
Figure 5

Characteristics of Dual Eligibles Compared to Other Medicare Beneficiaries, 1999



Note: ADLS = Number of limitations in Activities of Daily Living
SOURCE: 1999 Medicare Current Beneficiary Survey.

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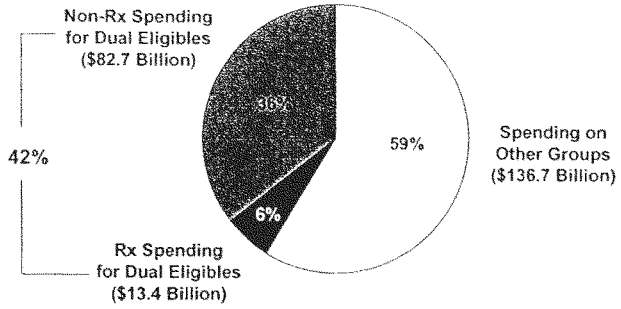
Figure 6

Spending on Dual Eligibles as a Share of Medicaid Spending on Benefits, FFY2002



Total Spending on Benefits = $232.8 Billion

NOTE: Due to rounding, percentages do not total 100%.
SOURCE: Urban Institute estimates prepared for KCMU based on an analysis of 2000 MSIS data applied to CMS-64 FY2002 data.

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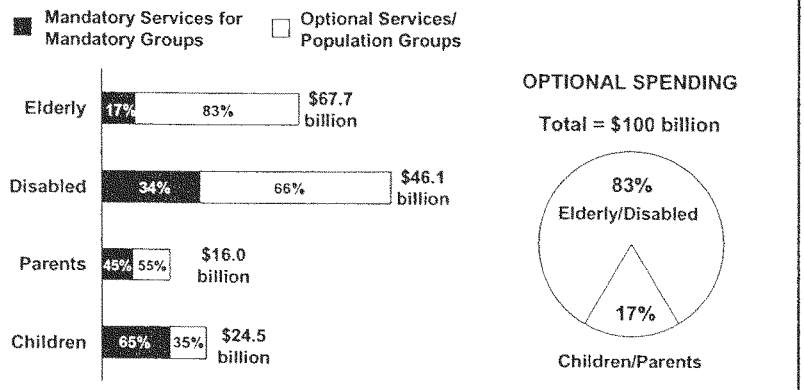
Figure 7

Distribution of Medicaid Spending by Eligibility Group and Type of Service, 1998



Note: Expenditures on services.
SOURCE: Urban Institute estimates, 2001.

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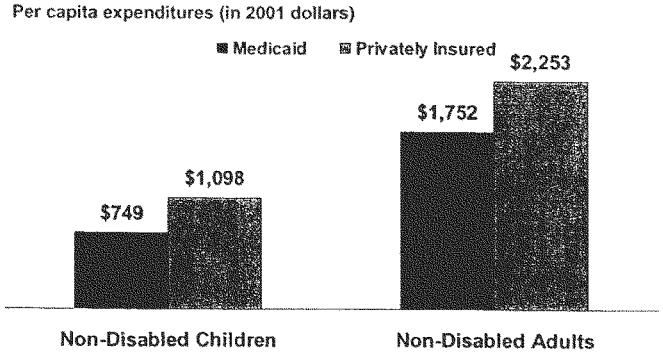
Figure 8

Per Capita Expenditures for Non-Disabled Low-Income Children and Adults



Note: "Low income" defined as those with incomes less than 200% of the Federal Poverty Level. "Non-disabled" defined as those not reporting any limitations.
SOURCE: Holahan and Hadley analysis of MEPS data from 1996, 1997, 1998, and 1999, prepared for the Kaiser Commission on Medicaid and the Uninsured.

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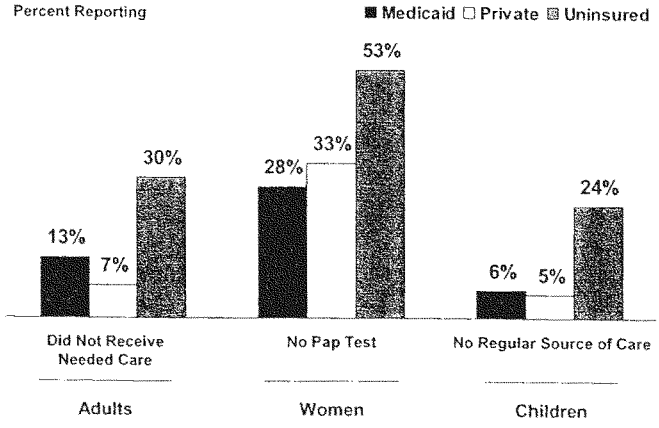
Figure 9

Medicaid's Impact on Access to Health Care for Families



SOURCES: The 1997 Kaiser/Commonwealth National Survey of Health Insurance; Women's Health, The Commonwealth Fund Survey, 1996; Dubay and Kenney, *Health Affairs*, 2001.

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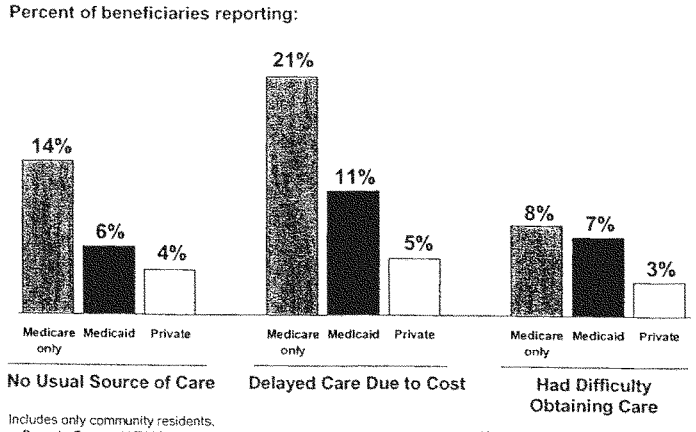
Figure 10

Medicaid's Impact on Access to Health Care for Medicare Beneficiaries, 1999



Note: Includes only community residents.
Source: Barents Group of KPMG Consulting's analysis of the 1999 Medicare Current Beneficiary Survey.

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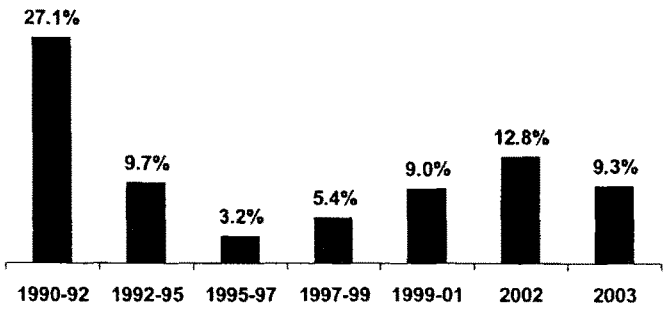
Figure 11

Average Annual Growth Rates of Total Medicaid Spending



SOURCE: For 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid an the Uninsured, 2000. For 2001-2003: Health Management Associates, for the Kaiser Commission on Medicaid and the Uninsured.

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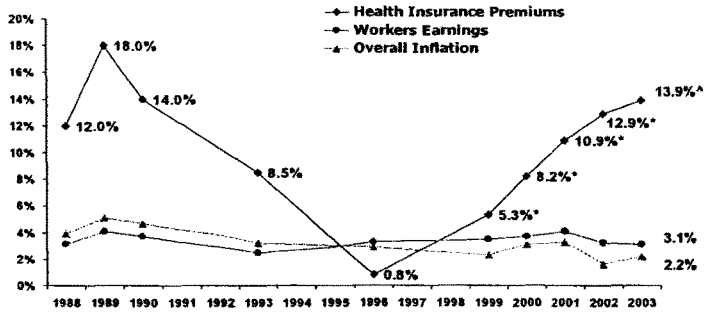
Figure 12

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003



Notes: Data on premium increases reflect the cost of health insurance premiums for a family of four.
*Estimate is statistically different from the previous year shown at p<0.05: 1996-1999, 1999-2000, 2000-2001, 2001-2002.
^ Estimate is statistically different from the previous year shown at p<0.1: 2002-2003.
SOURCE: KFF/HRET Survey of Employer-Sponsored Health Benefits; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1989, 1990, 1993, 1996.

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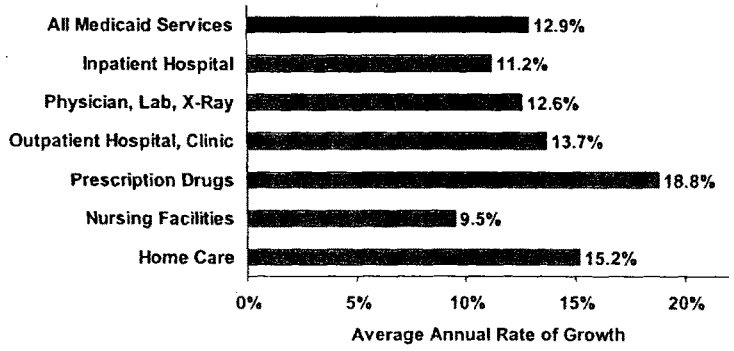
Figure 13

Average Annual Rate of Expenditure Growth for Medicaid Services, 2000-2002



Note: All growth rates shown represent changes in total fee-for-service expenditures for the types of services listed.
SOURCE: Kaiser Commission on Medicaid and the Uninsured / Urban Institute analysis of HCFA-64 data.

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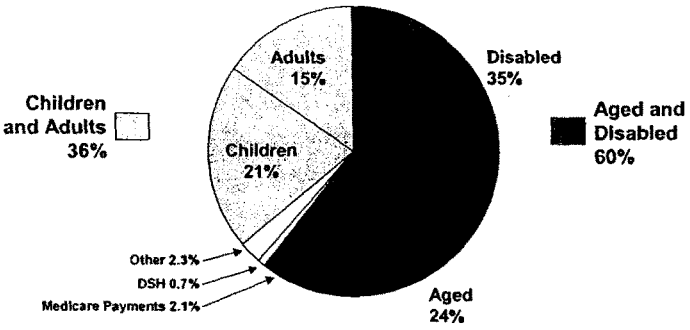
Figure 14

Contributors to Medicaid Expenditure Growth by Enrollment Group, 2000-2002



SOURCE: Estimates for KCMU prepared by the Urban Institute, 2003.

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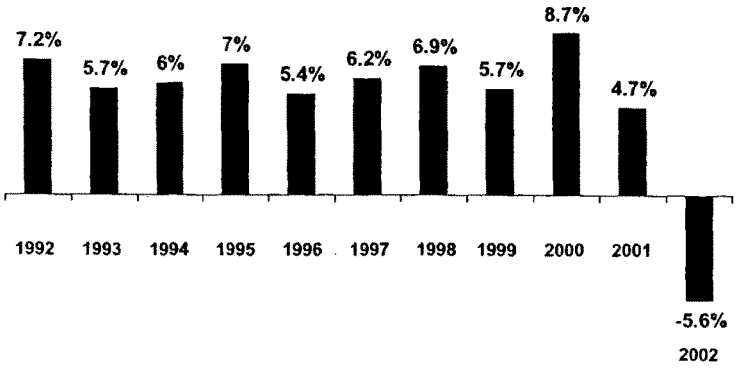
Figure 15

Change in State Tax Revenue Collections, 1992-2002



SOURCE: Rockefeller Institute of Government, Fiscal Year 2002 Tax Revenue Summary, May 2003. Changes are shown in nominal terms and are not adjusted for tax-related legislative changes.

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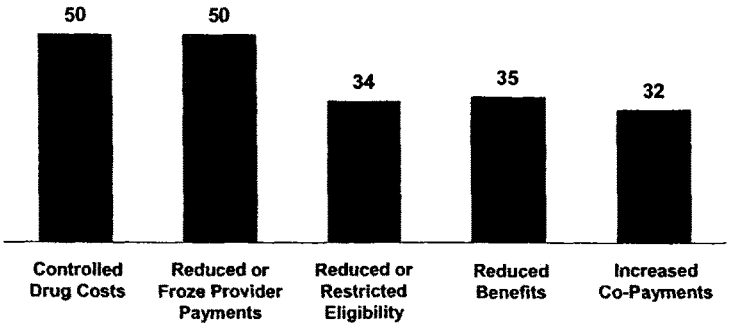
Figure 16

Number of States Implementing Medicaid Cost Containment Strategies Over the Past Three Years

(FY 2002 – FY 2004)



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and September 2003.

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Mrs. WILSON. Thank you both very much. I think I will start out here with a few questions.

Addy, how would your mom's care have been different—if we gave you a magic wand and you could change the Medicaid system, how would you change it so that your mom's experience would be different?

Ms. ECKARDT. I am very biased.

Mrs. WILSON. Bias is okay.

Ms. ECKARDT. I am biased in that. I would have liked to have somebody who had managed her care, somebody who truly—who had managed her care, not managed, as again I said, the cost. The insurance companies—and again, she was partly on the insurance company, and that was a problem. It is a problem across State lines because States differ. We could not have had her—she was from—living in Delaware. We thought she was in a facility where there was managed care in that facility, and that wasn't true. We thought it was assisted living, and that really wasn't true because I didn't realize that what it constitutes, assisted living, in one State is not assisted living in another State.

So, I mean, there are some the things that we have tried to deal with in Maryland with the community services waiver, long-term care and community services waiver. She went to Pennsylvania, and, of course, then their reimbursement differs for hospital care. So they wanted her out of there as soon as possible, and she couldn't go back to where she was. We wound up bringing her back to Maryland thinking, well, when her resources run out, we know Medicaid will pick it up. Well, that is when I learned how people deal with spending down because I was—everybody tells you, they have been there, and they now how to divert the money so that you can wind up qualifying for the medical assistance component.

I would have liked somebody to have worked with her to really facilitate the prescription end of it for the—because for the first time she had to take like 12 different medications, and it was costing us like—would have cost about $800 a month or more. So that eats up resources right then and there.

And the physicians didn't talk to each other. And I thought from my nursing experience, nurses are good ones to be able to get people to talk together who usually don't talk to each other, and that may have facilitated her care.

If she had had a little bit more time for rehab, that would have made a difference because I think she came out prematurely, and I—of course, what happens then, people get—if they are not managed well, they wind up getting heart attacks, and then they go the hospital, and then they get more expensive hospital care. And I thought a lot of that was unnecessary. And that is the same story I hear from lots of constituents.

Mrs. WILSON. Okay. Dr. Rowland, in your testimony you talked about Medicaid, and in particular that Medicaid spends less for children than the comparable private insurance plans. And I think the words that you use, in the written testimony anyway, it is an effective return on investment in terms of improving access to care for our low-income population. Do you have data or does the Kaiser Family Foundation have data on not just improving access to care,

but does it improve health outcomes compared to those with private insurance?

Ms. ROWLAND. There is very limited data, obviously, on the improvement in health outcomes because we don't tend to track Medicaid populations over time. That requires really a longitudinal study. There are some limited studies that have shown, obviously, that those who are uninsured have poorer health outcomes than those with insurance, and Medicaid is included in the insured population. But the length of time for health insurance purposes that people are on the Medicaid program has generally been too short to pick up some of the health outcomes that you are talking about.

In addition, there is really virtually no data collected at the State level on the Medicaid program or on the outcomes for the population.

Mrs. WILSON. In your experience with Kaiser, and I know you work with a lot of States in looking at the different health care programs, are there States who do have good—who are models for looking at improving health status as opposed to just paying for the bills as they come in and managing the claims?

Ms. ROWLAND. We think that many of the States have really tried through their use of managed care to provide for a better medical home for many of the Medicaid children that are enrolled in the program, but when we look at the patterns of care in Medicaid, the real programs that seem to have some of the most effective outcomes are more of our pace programs where we are really looking at coordinated care for very frail elderly people, and we see there some advantages. But overall, I would say that most States have been trying through their children's programs to provide better access to immunizations and better access to broader coverage, but have not necessarily yet seen the benefits of that in terms of long-range outcomes.

Mrs. WILSON. Thank you.

Mr. Stupak is recognized for 5 minutes.

Mr. STUPAK. Thank you.

Dr. Rowland, I have a two-part question, if I may. And I know you sat through it, and I used some of your statistics there about what has been happening over the past 3 years in the Medicaid population with 50 States having taken action to control the drug costs, 50 States have reduced or frozen provider payments, 34 have reduced or restricted eligibility, and 32 States have increased copayments. These numbers indicate that the State actions are having a far-reaching impact on health coverage for low-income families at a time when enrollment is increasing, as you said in your testimony, due in part to our sluggish economy.

If we continue on this current economic decline, is it likely that we will see improvement in people's ability to access certain health care services, or is it more realistic to believe that low-income family pieces will continue to face barriers and restrictions while trying to obtain certain health care services?

Ms. ROWLAND. No. I think that we are clearly seeing—we are clearly seeing that as the States have tried to grapple with their revenue decline, which is their major contributor to their economic financing problems, that they have will to turn first to rainy day funds, into other sources of funds to try and maintain their Med-

icaid coverage. But we are now getting to the point where with the fiscal relief last year, some cuts have been moderated, but all States are saying that by 2005 fiscal year they will be facing severe constraints in their Medicaid program.

I think we will see a continued erosion in some of the coverage for especially parents, so that the parents of low-income children are going to see real rollbacks in their kind of coverage. And we are also seeing, obviously, in the Medicaid programs coverage of prescription drugs, that that population heavily dependent on them are the elderly and the disabled, and there, even there, the benefits are beginning to be tighter.

I think the good news is that States have really valued the kind of coverage they have been providing through the Medicaid program, tried to keep from rolling it back wherever they could, and have taken all the easy cuts to date, and so now what we are going to have to see is, without some additional financing assistance, of some real rollback in the kind of coverage that has been available.

Mr. STUPAK. Well, most of the States, as I am sure you are aware, and I know they mentioned California earlier in the earlier testimony today, most of them have to balance their budget, unlike the Federal Government. So you have to look for ways to balance the budget and those expenses, which Medicaid is a big expense for the States, that is where they start cutting. In Michigan they have cut about 7 percent of the hospital reimbursements last year, and they are looking to take $110 million out of Medicaid reimbursements to the hospitals in Michigan, and I don't know how they are going to do it.

Ms. ROWLAND. The other piece is that a Medicaid cut for a State is a double-edged sword, because to save a dollar of State money, they have to cut $2 or more out of the program. So it really then begins to deplete the economic value because Medicaid is also a source of much jobs and much income generation in the economy of these States.

Mr. STUPAK. We all had some discussions on this side of the aisle, at least with Mr. Scully, about this block granting that they would like to do, which really would relinquish more responsibility and accountability to the individual States, and in this current economic crisis, I am sure the impact or the ability for low-income families to obtain health care that they need will really be greater.

If we block grant, are we not giving more responsibility and accountability to the individual States at a time when they are under economic difficulties to even try to provide basic services under Medicaid?

Ms. ROWLAND. Well, certainly, any way in which you cap the financing on the program limits the ability of States to continue to raise the program's profile in times of economic emergencies or other hazards, so that when you put a limit on the program, you may be giving greater flexibility in terms of who can be covered and what the benefits are, but you are really limiting the flexibility to respond to emergencies, changes in the States' coverage, changes in the economy.

And what we have currently seen with the Medicaid program is that the downturn in our economy has moved many people from middle-income groups into the lower-income groups where they

now qualify for the Medicaid program, and it is, in fact, the matching formula of Medicaid that at least has allowed States to have the Federal funds to go along with that. And I think when you put a limit on the program, you can't be sure what the conditions will be in the future that will change that, so it could, in fact, be restrictive.

I know in conversations with the State of Ohio, they have told us that they would have done worse under the administration's proposal than under their current Medicaid spending even though they are under strict fiscal constraints.

Mr. STUPAK. Do you have some thoughts on how we should revamp the system so as to provide the most care to the most people and insure that this vital care is not eliminated by State budget deficits or other competing priorities? Do you have some thoughts on it?

Ms. ROWLAND. Well, certainly, I think that looking at the coverage of the dual-eligible population and the costs incurred by that population and what the appropriate level of Federal financing for the dual-eligibles versus State financing is, picking up the cost of their Medicare premiums and removing that from the State budgets, perhaps even going as far as to help relieve the $7 billion annually that States now spend on the Medicare dual-eligibles for their drug benefits would be a start at really realigning some of the fiscal responsibilities.

As we look at the program, we have heard talk of swaps in the past. The swaps disadvantaged many of the States. What I think we really need to look at is where the Federal share should be greater, and where the States can maintain the coverage, and how to do that balance. But putting a cap on the funding doesn't seem to me to address the fundamental need to really secure financing for the most vulnerable in our society.

Mrs. WILSON. Thank you.

Mr. STUPAK. Thank you.

Mrs. WILSON. Mr. Brown for 5 minutes.

Mr. BROWN. I thank the Chair. I apologize for having to leave to cast a vote in another committee. I apologize. I didn't get to hear Mr. Stupak's questions, all the questions and answers.

Implicit in much of the earlier testimony, Dr. Rowland, is that Medicaid spending is out of control. We have got to rein in Medicaid spending. And surely it is difficult for State budget writers, obviously. But a couple of questions.

What is the estimated—what—how—what level are administrative costs with Medicaid?

Ms. ROWLAND. It is somewhere under 4 percent; usually about 3.5 to 4 percent.

Mr. BROWN. And what would you estimate the overhead costs for a private insurance?

Ms. ROWLAND. Private insurance usually runs between a 10 and 20 percent, more likely around 15 percent, overhead cost.

Mr. BROWN. Is that differential recent, or has that been for some time?

Ms. ROWLAND. It has been historically there. Private insurance obviously has more marketing costs, a lot of other attributes that they build in.

Mr. BROWN. I think one of the myths that we deal with around here that we try to bat down from time to time is that these public health programs, public programs for health care, Medicare and Medicaid, are actually more efficient than the private sector and by many measurements, when the assumption too many people here make, it is the exactly opposite.

Ms. ROWLAND. Well, actually, as my statement also shows and some of the research we have done, because private insurers tend to pay higher rates to providers than the Medicaid program, if you were to take a Medicaid beneficiary and put them in private insurance, it would probably cost you more per beneficiary than what Medicaid is currently paying. The real differential in Medicaid payment rates or per capita spending is that most people on the Medicaid program who are adults are either disabled or pregnant individuals who by their very nature have higher health expenditures.

Mr. BROWN. Okay. On the first panel, Mr. Scully made some points about mandated benefits driving up costs and how Medicaid should have more flexibility to tailor benefits to need. Are there—a couple of questions. Do all Medicaid beneficiaries use all Medicaid benefits? I mean, I—and are there any studies indicating mandated benefits aren't medically necessary?

Ms. ROWLAND. Well, just as in your private insurance plan, you have a range of benefits that are covered. I am sure in any given year you don't use all of those benefits, and within the Medicaid program we would hope and we see that the individuals who need long-term care services use them, but a 5-year old child does not need long-term care, does not use long-term care benefits under Medicaid, so that in reality what we are talking about here is that States need to do a very good job of utilization control, and the managed care plans need to make sure that the services they are providing are the medically necessary ones. But individuals should not be using benefits even though they are covered that are not medically necessary for them.

Mr. BROWN. So as in all insurance there is a range of benefits that Medicaid offers. People use some of those benefits at different times in their lives. And the ones that are offered are not medically necessary for certain parts of the population at certain times. And when you enroll in Medicaid, you obviously don't know which of those benefits you are going to need at some point in the next year or 2 years or 5 years, correct?

Ms. ROWLAND. Correct. And Medicaid covers a very diverse population, and especially for the individuals with disabilities on the program, a broad range of benefits there exceeds that of any private insurance plan. But that is why most of those people have to turn to Medicaid for their coverage.

Mr. BROWN. So this whole term that Mr. Scully used as a flexibility to tailor benefits to need just doesn't really wash.

Ms. ROWLAND. I believe the States currently have the ability to tailor benefits to need because that is how you provide medical care services.

Mr. BROWN. Delegate Eckardt, one question for you. You have consistently in your career, my understanding is, championed payments for nurse midwives, nurse practitioners, other skilled nursing professions. You yourself were a psychiatric nurse. If reductions

in Medicaid funds from the Federal Government, reductions in State tax receipts occasioned by the recession force cuts in Medicaid, how much of the cut should come from provider payments; and in answering that, if you would, how much room is left to cut reimbursements before providers simply refuse to treat Medicaid patients?

Ms. ECKARDT. That is a very good question. I hadn't thought long about the reimbursement end of it, because I think there is reimbursement—in Maryland there is reimbursement for an array of providers. And I think that providing that gives the kind of choice within the Medicaid program—like in our children's health care, we have an array of choices, and, for instance, in our wellness centers in a lot of our schools, we have a variety of providers, and those providers are reimbursed. And I dare say that you need to look at that in conjunction with outcomes, clinical outcomes, and if we can, in fact, demonstrate through our school-based health centers and our wellness programs and our schools that kids are staying in school, that they are healthy, that they are graduating from high school, then I think those provider reimbursements are adequate.

And I think that we are going to be looking in Maryland, we are looking at program by program as opposed to just reducing reimbursement to providers.

Mrs. WILSON. Thank you.

Mr. Strickland is recognized for 5 minutes.

Mr. STRICKLAND. Thank you.

Dr. Rowland, I don't want to beat a dead horse, but when Mr. Scully was here, we talked at some length about what a block grant is or isn't, and Mr. Scully, it seemed to me, was contending that what he was proposing was not a block grant. But when I look at the OMB table that I think you probably have access to, it shows that, as I pointed out to Mr. Scully, in 2013 there will be an $8.285 billion cutoff of the baseline.

Mr. Scully did indicate that the baseline includes the projected growth in the program for the numbers of people that will be added. So if you have an $8.285 billion cut, doesn't that necessarily mean that people will be cutoff and lose benefits? If we stay in this recession especially there may be even more people cutoff. Isn't that what a block grant does? You have increased need and a limited amount of money, a set amount of money, that people are necessarily going to lose benefits?

Ms. ROWLAND. In the administration's original proposal, they talked about an allotment, an allotment that would be a little more generous in the early years and then would decrease in the later years and did not want to call that a block grant. But in general when we think even about the SCHIP program, we talk about a program in which there is a fixed Federal allotment of dollars. Once you have spent that amount of dollars, there is no more Federal dollars to be given, even if the population needs continue to grow and you end up having to cap enrollment or reduce benefits or do other things to live within the budget. That we have called and would continue to call a block grant. That seemed very similar to what was being proposed by the administration, although some of Mr. Scully's language here today was quite different in terms of

talking about a per capita cap instead of an overall block grant. So I am not sure that the administration hasn't changed their position.

In a typical block grant, you fix the amount of Federal financing that goes up over time. You may use some factors to increase it, such as a growth factor or a cost of living adjustment or whatever, but it tends to be a fixed amount, it is a predictable amount. If for some reason the needs—the economy falls and more people fall into low-income categories and more people go on to the program, there are no more Federal dollars to expand to match that as there are under the current Medicaid program, so you would expect the States then to have to reduce their spending.

Moreover, of course, one of the attractivenesses to the States in terms of flexibility in a block grant is that they would have less accountability for how they spend their dollars. So it would be harder to tell whether any of the groups, especially those optional groups, would continue to receive coverage under a block grant.

Mr. STRICKLAND. Thank you. I just wanted to make it clear that, regardless of what we call it, the effect it seems to me would be the same effect that you would expect from a block grant as we have historically defined a block grant program to be.

I just wanted to ask you quickly about the dual-eligibles and the proposal that at least was in the Senate Medicare prescription drug reform bill. What are the implications or what would be the implications to the Medicaid program and to the individual States if the provision in the Senate regarding dual-eligibles were to be enacted into law, in your judgment?

Ms. ROWLAND. I think leaving the dual-eligible population that is covered by Medicaid out of a Medicare drug benefit is, first of all, the first time there would be differential treatment; and leaving the poor out of the coverage under Medicare would be a real exception to the overall policy of Medicare. But I think it would also mean that there would be a lot of difficult coordination issues at the State level between those who would qualify under Medicare for the low-income subsidies but they are not on Medicaid so they don't get the Medicaid coverage but Medicaid beneficiaries would be on the side in the Medicaid program.

We also know that the drug benefit under the Medicaid program is an optional benefit, and it does vary across the States, so I think that the dual-eligible population would not have an equal benefit to the extent that the Medicare benefit would be provided to the rest of Medicare beneficiaries. Clearly, the cost implications for the States of having to maintain coverage of the dual-eligibles under the current fiscal crisis that they are facing means that many States may have to look at cutting back on this population at the very time as other beneficiaries in Medicare are just gaining drug coverage. So I would say that the best strategy for making coverages equitable is to put the entire population in the Medicare program that is entitled to Medicare and then have Medicaid be really the wraparound for those with serious illnesses and drug costs that go beyond the limits of the Medicare program.

Mr. STRICKLAND. Dr. Eckardt, would you have a comment regarding the dual-eligible provisions that are in the Senate bill and its potential impact upon the States?

Ms. ECKARDT. I have to admit honestly I am not real familiar with that, but I can tell you that I have been an advocate of using Medicare dollars for prescription relief for our most vulnerable population, and I think certainly the dual-eligible are our most vulnerable citizens.

Mrs. WILSON. Mr. Strickland, I think you are plumb out of time.

Mr. STRICKLAND. I am sorry. I want to thank the witnesses for their helpful information. Thank you, Madam Chair.

Mrs. WILSON. Mr. Waxman is recognized for 5 minutes.

Mr. WAXMAN. Thank you very much, Madam chairman.

Ms. Rowland, in your testimony you painted a very compelling picture of the contributions the Medicaid program has made in providing health care coverage to populations that would otherwise be likely to be uninsured or have their specific health needs unmet. I would like your opinion on two related issues. Is the fact that Medicaid is a matching program where the Federal Government has an open-ended commitment to bear its share of the cost of providing services to this population a positive thing in terms of helping the program meet the needs of these vulnerable people?

Ms. ROWLAND. I think if you look back at the history of the program over its many years you see that the matching rate system and the fact that there were Federal dollars to stimulate State investments has proven to be a very successful strategy. We see that there are both mandated populations covered by Medicaid but that many States use the availability of the matching funds to expand coverage beyond the mandates, and without the Federal matching funds I don't think States would have been able to respond to some of the economic downturns that we have had. They may not have been able to respond as fully as they would like because the matching doesn't come in a countercyclical way early enough. But they have been able to keep the program and maintain it over its history, and they have grown it in ways as we have societal needs that we have asked the States to pick up through Medicaid.

One perfect example is the coverage of people with HIV/AIDS. When that epidemic came out, there was no health insurance coverage provided through the private insurer. Medicaid was really able to step in. It is today the provider of—44 percent of all of the people with HIV/AIDS receive their care through Medicaid. If the program was a block grant or a capped program, I don't see any way that a new epidemic like that could have had the resources committed to it because they would have had to compete within the block for the existing funds.

Mr. WAXMAN. In other words, asking my question another way, if we put the cap on the amount of Federal dollars available to help the States finance these services, you would think that that wouldn't help the States do a better job and it would put them in a more difficult position during economic downturns or adding to the rolls while reducing the States' economic base which would occur when you have these unanticipated health emergencies?

Ms. ROWLAND. In my view, the crisis that we face now is how to pay for and finance and how to divide the financing between the Federal Government and the States for long-term care or care of our most vulnerable citizens. There are lots of ways that I think we can improve the way in which that care is delivered both for

those on Medicaid but, frankly, for all of us in our health care system because we know our health care system has lots of inequities and lots of cracks in the way care is delivered. But I don't think putting a cap on financing is going to create a whole incentive to create a better world for all of us to receive our health care, and I think it is just going to squeeze down on the available resources for the poorest and the most vulnerable.

Mr. WAXMAN. The Kaiser Commission recently released a study that I believe was done for you by the Rockefeller Institute that indicated that the decline in revenues available to the States was a much more significant factor in putting pressure on State Medicaid budgets than increases in program expenditures. As I understand it, many States have pegged their tax system to the Federal system so that when we vote to reduce taxes we have the automatic effect of reducing State revenues. State revenues also decline when we are in a recession. That is exactly the time when more people are in need of Medicaid. Could you elaborate a little on that study for the benefit of members of the subcommittee?

Ms. ROWLAND. The Rockefeller Institute has done a study looking at the finances of the States and at the tax pressures that support State efforts. What they have found is that the $70 billion of deficit that the States have recently incurred is largely due to the fact that they have had a significant drop-off, the first time in over two decades, in their State revenue collections, largely due to the downturn in the economy and partially due to the effect of tax cuts eroding some of the other revenues they would obtain and that Medicaid contributed about $7 billion of that in terms of their cost increases. So, by and large, the overall problem we are facing at the States is a revenue-based problem, but that does affect the Medicaid program because it is still a substantial share of State spending.

Mr. WAXMAN. Madam Chair, I would like to ask unanimous consent to put the report on this issue in the record.

Mrs. WILSON. Without objection.

Mr. WAXMAN. Last, the Medicaid Commission has done work documenting the changes States have made in their Medicaid program in response to their declining fiscal situation. Could you tell us maybe for the record which of the people served by the Medicaid program have been most adversely affected by the cutbacks and can you generalize about that, giving us some examples?

Ms. ROWLAND. Certainly, and I would be glad to make the recent report that has the survey findings available for the record, too, if you would like.

Mr. WAXMAN. I will ask unanimous consent to put that in.

Mrs. WILSON. Without objection, we will include that in the record.

[The information referred to follows:]

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The Current State Fiscal Crisis and its Aftermath

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September 2003

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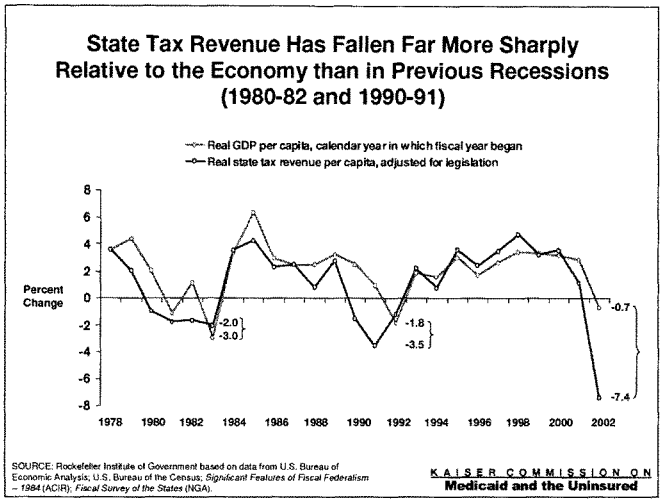
Tables and Figures

Executive Summary

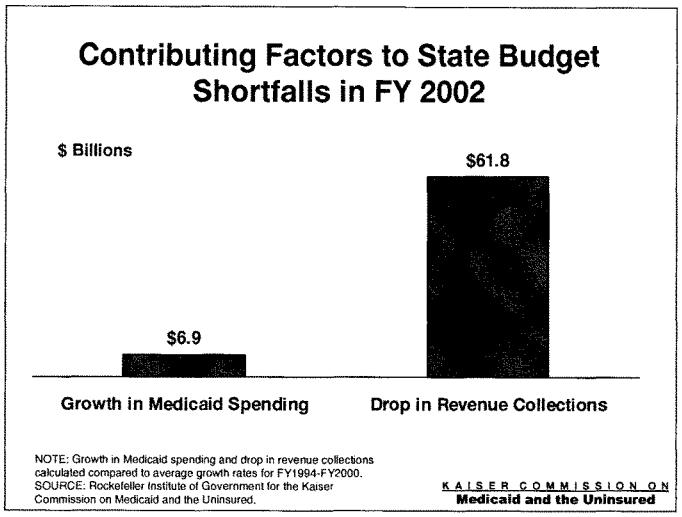
The states are in the middle of a severe budget crisis. Facing aggregate budget shortfalls of over $70 billion this fiscal year, states have drawn down reserve funds, cut spending, and, in some cases, increased taxes as well. But just a few years ago, states faced extraordinarily strong fiscal conditions. The strong economy, experiencing the longest expansion in U.S. history, and exuberant stock markets helped states cut taxes, increase spending, and shore up reserve funds. Suddenly, as the national economy weakened in 2000 and entered a recession in 2001, the stock markets fell dramatically, tax revenue plummeted, and spending pressures increased. How did states arrive at this point, and what are the prospects for state finances over the next several years?

This paper describes the root causes of the state fiscal crisis, examines trends in state revenues and spending, and offers a prognosis that states are likely to face continued fiscal stress for the next several years. This analysis finds:

The fiscal crisis facing states is far worse than the condition of the nation's economy. The national recession was relatively mild, but state tax revenue has been hit hard. Even by the standard of the two previous recessions, in the early 1990s and 1980s, state revenues have declined dramatically. Fiscal year 2002's astonishing 7.4 percent decline in real per-capita tax revenue was more than twice as steep as state tax revenue declines that accompanied the 1990–91 and 1980–82 recessions. The main reason tax revenue fell so sharply relative to the economy is that revenue had been propped up in the late 1990s by unsustainable forces, especially the run-up in the stock market, which have unraveled rapidly in recent years. The result has been that nearly every state faced budget gaps beginning in fiscal year 2002, and these gaps grew in fiscal years 2003 and 2004.



The primary cause of the state fiscal crisis has been the sudden falloff in state tax revenues. Starting in 2002, state tax revenue collections fell further and faster than anyone predicted. This paper estimates that the falloff in state tax revenues contributed far more to this crisis than the acceleration in Medicaid spending. Tax revenue in 2002 fell short of prior trends by about $62 billion. Growing Medicaid spending has contributed to state fiscal stress, but plays a far smaller role: growth in Medicaid costs in 2002 raised state spending by about $7 billion relative to prior trends. In other words, the decline in tax revenue contributed almost nine times as much to state budget gaps in 2002 as did faster-growing Medicaid spending. Other categories of spending have not played a major role in state budget shortfalls, either. This crisis was caused primarily by a sudden and sharp decline in tax revenue.



In the 1990s, state revenues and spending grew significantly, and states also cut taxes substantially. Between 1990 and 2000, revenue states raise on their own increased 81 percent in nominal terms and 26 percent in real per-capita terms. Despite relatively large tax cuts in the second half of the 1990s, states saw a large increase in tax receipts. For example, the income tax as a share of personal income rose by 17 percent between 1995 and 2000 even though states in aggregate were cutting the tax each year. Much of this growth can be traced to the many different ways in which the stock market surge affected state tax revenue. In addition, states benefited from strong personal consumption and from the tobacco settlement. The increase in state revenue in the 1990s relative to the economy was larger than it had been in the 1980s, but smaller than in each of the three preceding decades.

State spending from state funds increased by 26 percent between 1990 and 2000, after adjusting for inflation and population growth. This was slower than the growth of the 1960s and 1980s, but exceeded that of the 1950s and 1970s. These increases continued a longer-term trend of increasing reliance on state and local governments, which have played an increasingly important role in financing and delivering services in the United States for more than 50 years. Much of the growth has been financed by a growing economy, but state and local government also has been increasing relative to the economy. Virtually all areas of state spending increased substantially in the 1990s, with Medicaid dominating state spending growth in the first half of the 1990s, and elementary and secondary education playing a much greater role in the second half.

The state fiscal picture changed dramatically, beginning in 2001. Tax revenue growth slowed in fiscal year 2001 and then plummeted in 2002, reflecting the weakened economy and a 50 percent drop in capital gains. States cut spending growth in fiscal year

2002 and drew down reserves dramatically. In fiscal years 2003 and 2004, with fewer reserves to draw on and little appetite for tax increases other than on cigarettes, most states cut spending growth even further. When comprehensive data are available, total spending from own funds in both years is likely to have been flat, and to have declined modestly in real per-capita terms. Fiscal year 2003, which just ended, showed no bounce-back from the 2002 trough. Preliminary data show that fiscal year 2003 tax revenue, after adjusting for inflation and legislated changes, was down 0.2 percent from the already-low 2002 level.

States are likely to face continued fiscal difficulties for at least the next several years. Although national economic conditions seem to be stabilizing, it is unlikely that any recent improvement in the economy will close states' budget holes for quite some time. There are, broadly, three reasons for this dismal outlook:

- *The prognosis for state revenue growth is dim.* Although the recession is over, employment remains very weak. These conditions are unlikely to bring about a significant change in the state revenue picture. Income tax revenue is likely to begin to grow again, but this growth will be from a far smaller base than before. But capital gains income would have to more than double to return to levels of just two years ago. Since stock markets are lower than they were when many people purchased stocks, capital gain-related tax revenues are unlikely to return to those levels for many years. Revenue from state sales taxes will face erosion due to continuing shifts in consumption from taxed goods to untaxed services and to difficulties collecting taxes on the growing activity conducted via the Internet.
- *At the same time, states face substantial spending pressures.* Many states have adopted elementary and secondary education policies such as high-stakes testing and higher graduation standards that will increase costs by requiring more teachers, more highly paid teachers, or more time in school. Meanwhile, Medicaid spending has been growing rapidly, largely as a result of higher health care costs and increased enrollment fueled largely by the weak economy.

- *States will face additional fiscal stress as a result one-time budget balancing measures.* Many states will face additional pressure because the manner in which they have closed budget gaps for fiscal years 2003 and 2004 has pushed part of the problem into 2005 and beyond. This may be a perfectly rational response given the system in which elected officials operate, but it does exacerbate future problems. And although states received a welcome boost this year from the federal government in the form of temporary fiscal relief, the prospects for sustained fiscal assistance from the federal government are dim, in part because the federal government faces fiscal problems of its own.

The result of these forces and decisions is that state revenue has fallen away from spending, and the falloff, while it may not be permanent, seems likely to persist for years. States will need to make difficult decisions to bring spending and revenue into closer alignment, either by reducing spending or raising revenue. They have begun to do this in their fiscal year 2003 and 2004 budgets. Barring a miraculous return to the fiscal environment of the late 1990s, it will take at least a few more years of difficult spending and revenue decisions before states see their budget problems easing.

Introduction

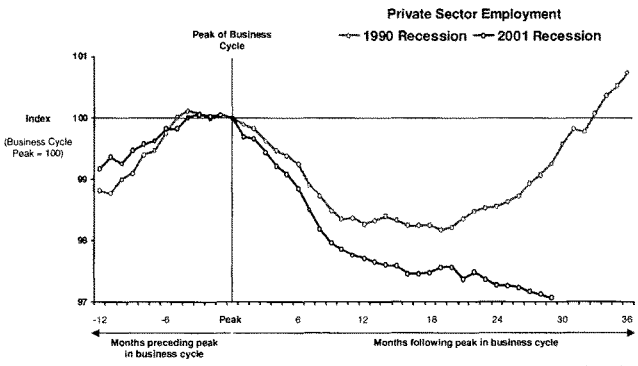
State government tax revenue boomed in the 1990s due to a strong economy and exuberant stock markets, allowing states to increase spending, cut taxes, and boost reserve funds. The national economy weakened in 2000 and entered a recession in 2001, stock markets fell dramatically, tax revenue plummeted, and spending pressures increased. Uncertainties related to the war in Iraq and subsequent rebuilding made the economic environment worse. Almost every state has faced severe budget gaps, has drawn down reserves, and has enacted or is contemplating spending cuts *and*, in many cases, tax increases of some sort. How did states arrive at this point, and what will happen to state finances in the aftermath of the current fiscal crisis?

This fiscal crisis is far worse than the economy would suggest

The United States economy entered its tenth postwar recession after March 2001, and growth resumed after November 2001. The recession was brief and mild by historical standards, using the traditional measure of gross domestic product. Although gross domestic product has resumed growing, private sector employment, which is an important factor affecting state tax revenue, has been far weaker in this cycle than in the last one and has continued to decline substantially even after the recession's end, with no slackening yet. Figure 1, which shows monthly private sector employment for the prior recession and recovery, as well as the current one (through August 2003), demonstrates that employment is much weaker this time around and shows no signs of recovery yet.

Figure 1

Monthly Private Sector Employment in 1990 and 2001 Recessions
1 Year Before through 3 Years After Start of Recession
Indexed to Peak of Business Cycle



SOURCE: Rockefeller Institute of Government based on data from Bureau of Labor Statistics, Current Employment Statistics, as of 9/5/2003

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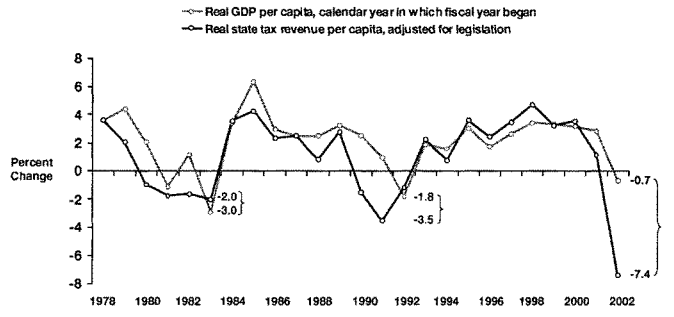
Despite the mild economic downturn as measured by gross domestic product, state tax revenue has been hit far harder than in the "double-dip" recessions of 1980–82 or the 1990–91 recession. Figure 2, which compares the growth in state tax revenue to growth in the economy, clearly shows this decline. Fiscal year 2002's astonishing 7.4 percent decline in real per-capita tax revenue (the solid line) was more than twice as steep as declines in the fiscal crises that accompanied the 1990–91 and 1980–82 recessions, even though real per-capita gross domestic product (the dashed line) fell far less this time than in either of the last two crises.

Figure 2

State Tax Revenue Has Fallen Far More Sharply Relative to the Economy than in Previous Recessions (1980-82 and 1990-91)



SOURCE: Rockefeller Institute of Government based on data from U.S. Bureau of Economic Analysis; U.S. Bureau of the Census; *Significant Features of Fiscal Federalism – 1984* (ACIR); *Fiscal Survey of the States* (NGA).

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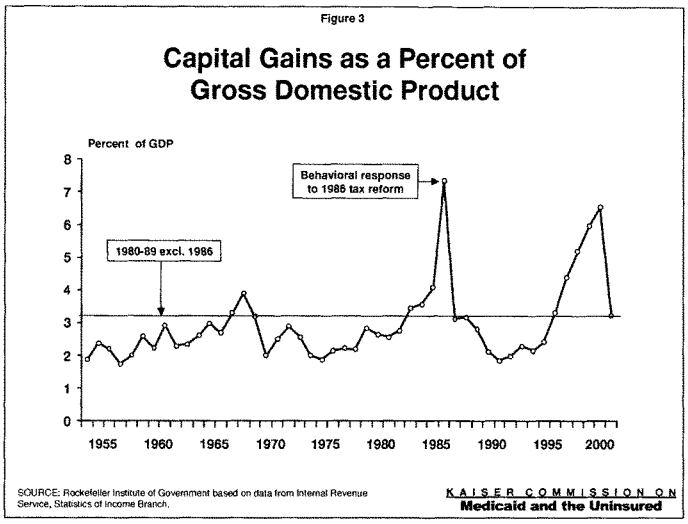
The main reason tax revenue fell so sharply relative to the economy is that revenue had been propped up in the late 1990s by unsustainable forces, particularly forces related to the run-up in the stock market, which more than tripled between the end of 1994 and its March 2000 peak. The strong stock market led to a surge in capital gains, which are included in most states' income taxes. The market also boosted wages of executives and others who exercised "nonqualified" stock options (the gain from which is taxed as compensation), and benefited state finances in other, difficult-to-measure ways.



These forces unraveled rapidly. Figure 3 shows the extraordinary rise in capital gains in the late 1990s in the context of nearly 50 years of history. After stock markets fell for two consecutive years, this surge was followed by a sharp drop of approximately 50 percent in 2001.[2] The late 1990s' increase was unlike any other sustained increase in the prior 50 years (the one-year spike in 1986 was atypical, reflecting taxpayer response to President Reagan's tax reform act). The huge drop in 2001 contributed to massive tax revenue shortfalls in the states, which were especially pronounced when 2001 tax returns were filed in April of 2002 – the final quarter of the fiscal year for most states.

Capital gains realizations are not included in traditional measures of the economy, helping to explain why the falloff in revenue was sharper than economic data might suggest.

Even as tax collections began to fall sharply, the cost of Medicaid – the second-largest area of state spending – accelerated rapidly. After increasing by only 5 percent in fiscal year 2000, growth in Medicaid spending from state funds accelerated to 10 percent in fiscal year 2001 and to 13 percent in fiscal year 2002.

The net result of these two major shifts in state finances was widespread and deep budget problems. In fiscal year 2002, 43 states reported budget gaps that opened up after budgets were enacted, and 12 reported problems exceeding 10 percent of their general fund budgets.[3] Virtually every state faced a projected budget gap at the start of fiscal year 2003; states attempted to close these gaps through a combination of policies including spending increases, use of reserve funds, and tax increases. Despite efforts to enact balanced 2003 budgets, at least 36 states reported that budget gaps reopened as the year progressed, due to revenue shortfalls and spending overruns. Nearly every state again

faced a large budget gap for fiscal year 2004, and according to the National Conference of State Legislatures, at least 33 states faced gaps exceeding 5 percent of the state budget, and at least 18 faced gaps exceeding 10 percent.[4]

Sudden tax revenue declines have played a much bigger role in the crisis than accelerating spending

What caused the fiscal crisis, sudden tax revenue declines or accelerating spending, especially for Medicaid? We begin to examine this question by comparing two "gaps":

- The gap between actual fiscal year 2002 tax revenue and what might have been collected at a previously "normal" revenue growth rate.

  and

- The gap between actual Medicaid spending in 2002 and what might have been spent at a previously "normal" Medicaid growth rate.

If the revenue gap is larger than the Medicaid gap, then revenue played a bigger role in causing the crisis, and vice versa.

Figure 4

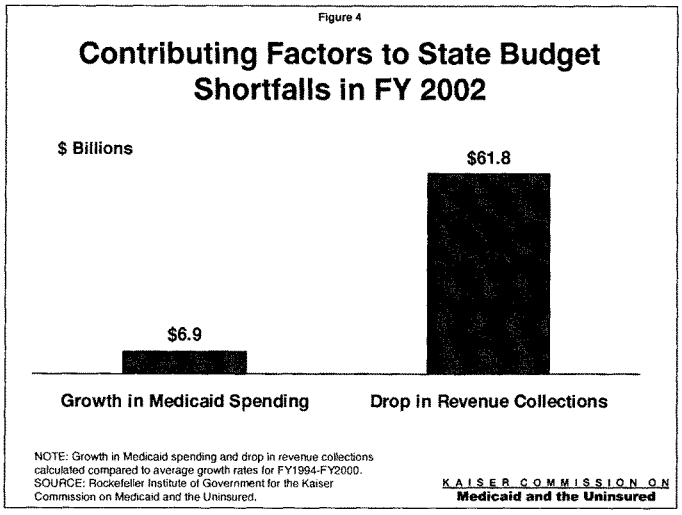


Table 1 and figure 4 illustrate this. The first column begins with actual Medicaid spending from state funds in fiscal year 2001. The next two rows in the column show (1) the actual 2002 growth rate, and (2) an estimate of the previously "normal" growth rate, pegged at 5 percent, which was the median Medicaid spending growth rate during the fiscal boom from fiscal year 1994 through 2000.

The remaining rows show actual Medicaid spending in 2002, estimated "normal" spending, and the gap between the two – Medicaid's contribution to the fiscal gap under these assumptions.

The next column shows similar information for state tax collections. The 6% "normal" growth rate for taxes reflects actual experience from 1994 through 2000, adjusted for the impact of legislation.

Under these admittedly simple assumptions, the Medicaid acceleration raised state costs in fiscal year 2002 by about $7 billion relative to prior trends, while the tax revenue falloff reduced tax revenue by about $62 billion relative to earlier trends – 9 times as much. Plausible alternative estimates of "normal" Medicaid and tax revenue growth all would yield the same fundamental conclusion – the tax revenue decline played a far bigger role in the sudden fiscal problems states faced in 2002 than did Medicaid cost acceleration.

Table 1

What Caused State Fiscal Problems -
- Tax Revenue Declines or Medicaid Spending Increases?

	State Spending From Own Sources on Medicaid	State Tax Revenue
Fiscal year 2001 actual (millions of dollars)	$ 85,141	$ 528,169
Actual growth rate	13.2%	(5.7%)
"Normal" growth rate (illustrative)	5.0%	6.0%
Actual fiscal year 2002 amount (estimated - millions of dollars)	$ 96,380	$ 498,064
Potential fiscal year 2002 amount at "normal" growth rate (millions of dollars)	89,398	559,860
Estimated contribution to state budget gaps (millions of dollars)	$ 6,982	$ 61,796
Ratio of tax gap to Medicaid gap	**9 : 1**	

Sources:
Medicaid expenditures: State Expenditure Report, National Association of State Budget Officers, Summer 2002
Fiscal Survey of the States, November 2002
Tax revenue, U.S. Bureau of the Census, adjusted by Rockefeller Institute of Government to remove impact of tax legislation

Another way of looking at the same issue is to compare actual tax revenue and Medicaid spending to projections used at the time budgets were adopted rather than to "normal" growth. While there are no readily available data on state Medicaid forecasts and forecasting errors, this is relatively easy to do with tax revenue forecasts, as Table 2 shows.

Table 2

Tax Revenue Shortfalls in Fiscal Year 2002
(Amounts in $ millions)

	Shortfall	% Shortfall
Personal income tax	$ 27,508	12.8%
Sales tax	4,810	3.2%
Corporate income tax	5,921	21.5%
Sum of 3 main taxes	$ 38,239	9.7%

Source:
National Association of State Budget Officers, Fiscal Survey of the States November 2002, Table A-9

In fiscal year 2002, collections of major state government taxes fell short of original projections by an astounding $38 billion, or 9.7 percent.[5] The income tax accounted for $27.5 billion, or more than 70 percent, of the shortfall in these taxes. While comparable numbers are not available for Medicaid, it is clear that the tax revenue shortfall must have dwarfed the Medicaid "overage" – looking back to the previous table, even if Medicaid had grown as much as 20% faster than states expected, the additional spending would have been only about $17 billion, which is less than half of the $38 billion tax shortfall.

Some analysts have argued that the current fiscal crisis results from rapid growth in state spending during the 1990s. In a technical sense, this argument certainly is not correct. That is, the sudden appearance of large state budget gaps did not result from a sudden increase in spending – as the analysis above makes clear, the gaps result primarily from a sharp falloff in state tax revenue that is far worse than declines in either of the last two recessions. While accelerating Medicaid spending has exacerbated the crisis, non-Medicaid spending has grown more slowly and has been more stable. In fact, state-financed non-Medicaid spending increased by less than 2.3 percent in fiscal year 2002, down substantially from the 7.7 percent increase in 2001.[6] Thus, non-Medicaid spending plays a smaller role than Medicaid – or no role at all - in the sudden change in state finances.

In a broader sense, however, the argument that the crisis resulted from state spending increases has no simple answer. As will be discussed in the next section, states *did* increase spending substantially in the 1990s. If real per capita spending from state funds had grown at only the rate of population and inflation during the 1990s, current spending would be more than $120 billion less now than it is – more than the entire budget gap states face. If spending had grown at only the same rate as personal income, current spending would be more than $40 billion lower than it is now – still enough to avert a sizable portion of the gap.[7] This is the real point of those who argue state spending is the

problem: "To avoid budget crunches during slowdowns, states should limit spending growth during booms, sort of like setting a lower highway speed limit."[8]

But is it realistic to say if states had not spent so much, they would not have budget gaps now? No – states generally operate under balanced budget requirements, and if their spending had been lower, then presumably they would have cut taxes to avoid accumulating huge surpluses. Then, when tax revenue fell in fiscal year 2002, states still would have had significant budget gaps. Those who argue that spending is the problem may not really be arguing that spending increases caused state budget gaps – they didn't – instead, they may be arguing that states have spent more than enough, they should have limited spending increases, and they should now close budget gaps by cutting spending, rolling it back to earlier levels.

The 1990s in the longer-term context

1. State revenue

This section examines revenue trends in three phases: longer-term trends, more-detailed analysis of trends from 1990 through 2000, and recent trends. I focus primarily on revenue as a percentage of personal income - a rough measure of the level of revenue relative to the economy and ability to pay.

State and local government revenues have been rising for 50 years

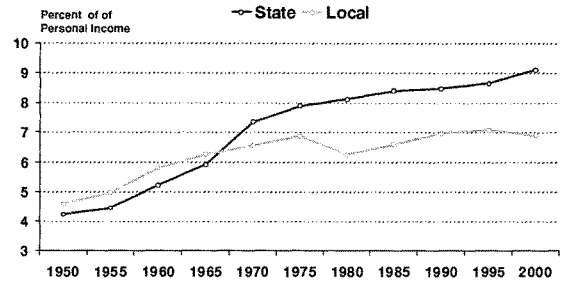
State and local governments financed the increase in spending of the last 50 years in part through economic growth and in part through increases in revenue relative to the size of the economy.

Real per-capita income – one indicator of states' capacity to raise revenue – increased substantially in each decade, with increases ranging from 12.5 percent in the 1970s to 33 percent in the 1960s. Overall real per-capita income increased by about 13 percent in the 1990s.

Not only did economic growth increase states' capacity to raise revenue, but as Figure 6 shows, state own-source revenue has risen throughout the last five decades. In 1950 state own-source revenue was 4.2 percent of personal income (a broad measure of the economy), and it increased in each decade, reaching 9.1 percent in 2000. State revenue increased especially sharply between 1955 and 1970, and rose more moderately in other periods. Local own-source revenue rose less sharply and was about the same share of personal income in 2000 as it was in 1970.

Figure 5

State Government and Local Government Own-Source Revenue as a Percentage of Personal Income



SOURCE: Rockefeller Institute of Government

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State revenue growth in the 1990s

Between 1990 and 2000, nominal state revenue grew 90 percent. This reflected 81 percent growth in "own source" revenue (driven primarily by taxes) and 119 percent growth (more than doubling) in revenue from the federal government.

Much of this revenue growth was related to inflation and growth in the overall size of the economy. In real per-capita terms – one measure of the ability of revenue to finance services – general revenue grew by 32 percent. Real per-capita intergovernmental revenue grew 51 percent and own-source revenue grew 26 percent. Although the revenue available to finance spending grew considerably, the increase relative to the size of states' economies was much smaller: own-source revenue increased only by 7 percent per $100 of personal income.[9]

The sources of revenue growth varied significantly within the decade. Table 3 shows major categories of state government revenue in 1990, 1995, and 2000. The first set of columns shows revenue per $100 of personal income, and the second set of columns shows the percentage change in revenue per $100 of personal income for different parts of the decade.

Table 3

State government revenue per $100 personal income, 1990, 1995, and 2000

	Per $100 of Personal Income			Percentage Change		
	1990	1995	2000	1990 to 1995	1995 to 2000	1990 to 2000
General Revenue	11.29	12.57	12.66	11.3%	0.7%	12.1%
Intergovernmental revenue	2.76	3.67	3.53	33.0%	-3.7%	28.1%
Own-source revenue	8.53	8.90	9.13	4.3%	2.5%	7.0%
Taxes	6.56	6.79	6.94	3.5%	2.2%	5.8%
Individual income tax	2.10	2.14	2.50	1.9%	16.9%	19.1%
General sales tax	2.18	2.25	2.25	3.4%	-0.2%	3.2%
Excises and selective sales taxes	1.03	1.10	1.00	6.3%	-9.0%	-3.3%
Corporate income tax	0.47	0.49	0.42	4.2%	-15.4%	-11.8%
Other taxes	0.78	0.81	0.78	4.3%	-4.0%	0.1%
Non-tax own-source revenue	1.98	2.11	2.19	7.0%	3.6%	10.9%

SOURCES: U.S. Bureau of the Census, U.S. Bureau of Economic Analysis

In the first half of the decade intergovernmental revenue (essentially, aid from the federal government) per $100 of personal income increased by 33 percent, while tax revenue – the largest component of own-source revenue – increased by only 3.5 percent. The increase in intergovernmental revenue in this period is really quite significant – in 1990, this revenue was only 24 percent of total state revenue, and yet it grew so rapidly that it accounted for 54 percent of all revenue growth between 1990 and 1995, while taxes, which were 58 percent of revenue, accounted for only one-third of the growth.

This reversed in the second half of the decade – intergovernmental revenue provided only 16 percent of state revenue growth while taxes provided 62 percent of the growth, despite the fact that states were cutting taxes throughout the period.

Perhaps the most surprising number in the table above is the 16.9 percent growth in income taxes per $100 of personal income between fiscal years 1995 and 2000 – this was much faster than the 1.9 percent increase in the first half of the decade, and occurred despite substantial income tax cuts in every year of the late 1990s, for reasons discussed in the next section. The result was a boom in state tax revenue that allowed states to increase spending even while cutting taxes.

As the table shows, the role of intergovernmental revenue – which is almost exclusively federal aid, and is dominated by Medicaid – varied significantly during the 1990s. States received a substantial boost from the federal government between fiscal years 1990 and 1995, but aid then declined as a share of personal income in the remainder of the decade. Table 4 shows the changing patterns of major categories of federal aid: aid related to public welfare (mostly Medicaid) and for health and hospitals increased dramatically between fiscal years 1990 and 1995, as did aid for education to a lesser extent. By contrast, between 1995 and 2000, relative to personal income, growth in federal aid slowed or turned negative in all major categories.

Table 4

State Revenue From Federal Government

	Per $100 of Personal Income			Percent change		
	1990	1995	2000	1990 to 1995	1995 to 2000	1990 to 2000
Public welfare	1.30	1.96	1.90	50.9%	-3.0%	46.4%
Education	0.46	0.54	0.54	17.1%	-0.3%	16.8%
Highways	0.30	0.33	0.30	8.7%	-8.9%	-1.0%
Health & hospitals	0.12	0.18	0.18	47.3%	4.1%	53.3%
All other	0.40	0.44	0.41	10.2%	-6.7%	2.7%
Total	2.58	3.44	3.33	33.4%	-3.2%	29.1%

SOURCES: U.S. Bureau of the Census, U.S. Bureau of Economic Analysis
NOTE: States receive a small amount of intergovernmental revenue from governments other than the federal government, and hence the total here is slightly less than the intergovernmental total presented in Table 3.

What factors drove state revenue increases?

State tax revenue benefited from a confluence of positive trends in the 1990s, several of which were unsustainable.

The national economy consistently grew faster in the 1990s than most economic forecasters expected, in large part because worker productivity, which had grown at an annual average rate of 1.6 percent between 1991 and 1995, accelerated to 2.6 percent between 1995 and 2000.[10]

As noted above, the nature of economic growth in the 1990s was especially good for state finances. Taxable income consistently grew faster than broader measures of the economy such as gross domestic product or personal income. That growth resulted in large part from the more-than-quadrupling of realized capital gains between 1994 and 2000.[11] This was driven by strong economic growth, rising stock markets, widespread participation in the stock market, and lower tax rates on capital gains. Other income sources also grew faster than the economy, especially taxable retirement income such as distributions from 401(k) plans and IRAs.[12]

State income taxes benefited from the financial market boom in other ways as well. States reported to the Rockefeller Institute of Government in the late 1990s that withholding tax collections were growing far faster than expected because many firms, especially high-tech firms, were compensating high-level employees with nonqualified stock options.[13]

Not only did taxable income grow far more rapidly than the economy, but income growth was disproportionately concentrated among persons in the highest tax brackets. Governments with income taxes, including most states and the federal government, became even more reliant on the income and tax liability of a relatively small percentage of tax filers. Between 1995 and 2000, the number of federal tax returns showing incomes

of $200,000 or more grew by 117 percent, while the total number of federal tax returns grew by only 10 percent. Taxable income on these high-income returns increased by 161 percent, compared to 60 percent for taxable income on all returns.[14] Because states generally conform to federal income definitions, state income taxes also became far more reliant on a relatively small proportion of taxpayers, thus increasing their volatility.[15]

State sales taxes also benefited from a decline in the savings rate – the flip side of which is a rise in consumer spending as a share of income. The savings rate fell from almost 9 percent early in the decade to a record low of 1 percent in 2000. The drop in the savings rate was enough to boost consumption by the end of the decade to a level 8 percent higher than it otherwise would have been, and this benefited state sales taxes.

Should states have known that the extraordinary rates of revenue growth in the late 1990s were unsustainable? Probably – and in fact, many did know this. Several states remarked on this risk in their budget documents, and noted that tax revenue could decline very sharply particularly if the stock market declined. Unfortunately, it was not possible to predict when the decline would come, nor was it easy to predict how sharp it would be – and state budget and political processes do not reward the prudence that would have been needed to prepare for the decline.

How did tax changes in the 1990s affect state revenue?

Between 1990 and 1995, when states were responding to the weakened economy and the 1990-91 recession, they increased taxes substantially. Adding together increases enacted for each year of this period, states increased taxes by more than $33 billion, with most of the increases taking initial effect in the 1991 and 1992 fiscal years.[16] This understates the total increase significantly because most tax increases were recurring. Some of the increases would become larger in subsequent years and some would become smaller.[17] Assuming all tax increases were recurring and that their initial amounts were reasonable estimates of their recurring value, this would have amounted to about an 11–12 percent increase in taxes, and contributed considerably to revenue growth in the first half of the 1990s.[18]

These increases are particularly apparent in excise taxes and sales taxes. As Table 3 above showed, between fiscal years 1990 and 1995, selective sales and excise taxes per $100 of personal income increased by 6.3 percent, even though these taxes normally decline as a share of personal income if their rates are constant.[19] Similarly, the large boost in general sales taxes as a percentage of personal income is partly an artifact of the higher rates states adopted in the early 1990s, although some of the increase also reflects the consumer spending rebound as the economy recovered from recession.

Beginning with legislative actions for the 1996 fiscal year, states cut taxes annually for each fiscal year through 2002, for an aggregate reduction of somewhat more than $33 billion in aggregate. This is roughly the same in nominal terms as the increases in the first half of the decade, but not as a percentage of revenue since revenue rose during the period. Using the same method for accumulating tax reductions as was used for tax increases above, this amounts to an aggregate reduction of about 7 percent in taxes.[20]

Thus, the net result over the course of the two periods appears to have been a small net tax increase.

The tax changes also may have caused a significant shift in the distribution of taxes, although that is difficult to analyze without sophisticated tools. The increases in sales and excise taxes in the early 1990s were similar in size to the increases in income taxes. The tax reductions of the late 1990s, however, were far more skewed toward income taxes. Because lower income people tend to consume a larger share of their income than upper income people, sales and excise taxes tend to constitute a larger share of income for low-income people; by contrast, income taxes usually rise as income rises, and tend to constitute a larger share of income for upper-income people than lower income people.

As a result, considered in isolation, policy shifts in the last decade may have led to lower-income people paying a greater share of state taxes now than in 1990.[21] Potentially offsetting this, however, is the fact that taxable income of upper-income individuals rose sharply in the late 1990s for reasons discussed earlier, and the net effect of the two changes is not possible to determine without sophisticated empirical methods.[22]

Even though state policy actions favored income tax reductions, through most of the 1990s, these actions did not make states less reliant on the income tax – in fact, the extraordinary growth of the income tax, discussed above, means states actually became more reliant on the income tax despite cutting it. The relatively large reliance on the income tax means greater volatility in state revenue structures.

Most of the tax increases enacted so far in the current fiscal crisis have been excise tax increases. If this pattern continues, states may become more reliant on relatively regressive excise taxes. However, it is too early to tell whether that will be the final result – as discussed below, states still face large fiscal problems. If they want tax increases to play a significant role in closing budget gaps, they will need to consider more income tax increases than they have so far.

State revenue has declined dramatically recently

Growth in state tax collections dropped sharply from 6 percent in state fiscal year 2000 to less than 3 percent in 2001, after adjusting for inflation and legislated changes.[23] Income tax growth was fairly strong, but the sales tax slowed and corporate tax collections declined. States that relied heavily on manufacturing industries were hardest hit, particularly the Great Lakes, southern, and Plains states, reflecting declines in manufacturing that began even before the national recession started.

Tax collections worsened significantly in fiscal year 2002, declining each quarter as the year progressed. In the October-December quarter, income tax payments related to capital gains and other nonwage income fell by 27 percent, withholding and sales tax growth was near zero, and corporate tax payments declined by 32 percent.[24] The situation deteriorated markedly in the remainder of the fiscal year: the income tax declined by double-digit percentages in the January-March and April-June quarters, the corporate

income tax fell for its sixth and seventh consecutive quarters, and sales tax growth hovered on either side of zero.

Tax collection data suggest that capital gains and similar income declined far more in 2001 than state revenue forecasters expected. Many states budgeted on the assumption that capital gains would decline by 10 to 15 percent, but the decline clearly was much worse. Unfortunately, data from the U.S. Treasury now show that capital gains declined by approximately 50 percent in 2001.

Deterioration continued in fiscal year 2003: adjusted for inflation and legislated changes, tax revenue declined by 0.9 percent in the first quarter of the fiscal year, and by 1.9 percent in the second quarter. Each of these declines is in addition to a decline in the year-earlier quarter, so that real adjusted tax collections in the first two quarters of fiscal year 2003 were below their levels of *two* years ago, while spending pressures are higher than they were two years ago. Payments of estimated income taxes for the 2002 tax year to date were down by 11.8 percent in the median state, suggesting that collections related to 2002 income tax returns filed in April 2003 would be weak, adding to an already difficult fiscal year for states.[25] Preliminary figures for fiscal year 2003 as a whole show that tax revenue adjusted for inflation and legislated changes was down by approximately 0.2 percent.[26]

2. State spending

This section examines trends in state spending in three phases, first setting the scene by describing longer-term trends, then examining in detail trends from 1990 through 2000 using the latest comprehensive and comparable data from the Census Bureau available when this paper was being prepared, and finally discussing what we know about spending trends since 2000 from available but somewhat less comparable data sources.

The previous section focused on revenue as a percentage of personal income, a rough proxy for the level of taxes relative to the size of the economy. In most of this section we examine spending per person, adjusted for inflation.[27] This is one of two commonly used approaches for examining spending across states and time – the other common method compares spending to a measure of the economy, such as personal income or gross state product.[28] Per-capita spending can be thought of as a rough measure of the level of services provided, while spending as a percentage of personal income can be thought of as a rough indicator of spending relative to ability to pay.

State and local government spending have been rising for 50+ years

State and local governments have increased spending substantially for more than 50 years. Between 1950 and 2000, state spending from own funds (excluding revenue from the federal government) nearly quadrupled, after adjusting for inflation and population growth, and local spending nearly tripled. Figure 6 shows real per-capita spending by state governments and local governments from own funds, at 5-year intervals for the last 50 years.

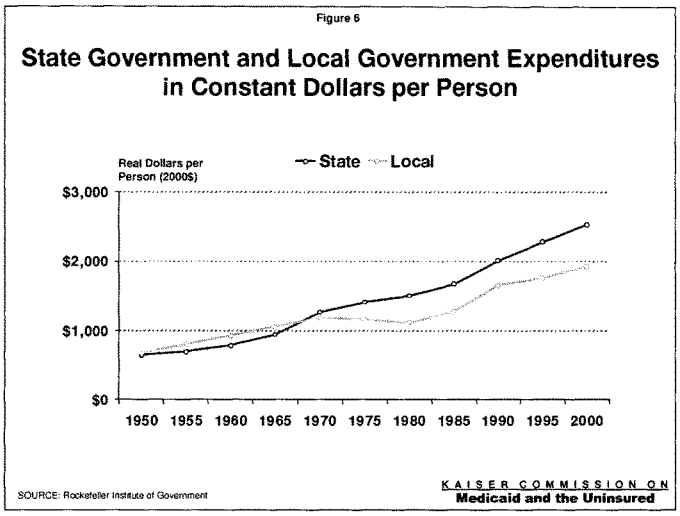

Table 5 shows the percentage change in real per-capita spending from own-source funds by decade and level of government. State governments and local governments both increased spending substantially in most decades, with minor exceptions. The main forces affecting state and local government spending have varied over time, but include:

- "Catch-up" spending after the subdued years of World War II and the Korean War;
- Large increases at the state and local level between the early 1950s and mid-1970s to educate the large cohort of baby boomers, and even larger state increases to shift a greater share of education spending to states from local governments;
- State government spending surged to finance rapid growth of Medicaid shortly after 1965, also in the early 1990s, and in certain other periods. As discussed later, the driving factors for this have varied over time, but have included program expansions, growth in eligible populations, rapid health-care inflation, and efforts by states to maximize Medicaid revenue from the federal government;
- The property tax revolt era, which played a role in local government spending declines of the 1970s; and
- State and local spending increases in the 1990s to finance education for the "baby boom echo" (children of baby boomers).[29]

Table 5

Percentage change in expenditures from own funds, by decade
In real per-capita terms

	State and Local Government Combined	State Government	Local Government
1950's	30.0	22.5	37.6
1960's	40.8	61.8	28.2
1970's	7.8	17.9	(5.7)
1980's	40.0	33.7	47.3
1990's	21.2	25.9	16.2

NOTES:
- 1950's defined as period from 1950 to 1960, and so on.
- Expenditures adjusted for inflation using the state and local government chain weighted price index

Sources:
- Fiscal data collected by Bureau of the Census, obtained from Significant Features of Fiscal Federalism 1994 Vol. 2, www.census.gov, and Census Bureau staff
- Price index from Bureau of Economic Analysis
- Population data from the Census Bureau

The next table focuses on *state* government spending, showing growth in total spending financed by (1) federal and state sources combined, (2) the federal government, and (3) states' own funds (which corresponds with own-source spending in the earlier table). The table also shows average annual growth of spending from own funds. Among other things, the table shows that growth in revenue from the federal government accelerated sharply in the 1990s, helping total spending to grow more rapidly than in the 1980s.

Table 6

Percentage change in state government expenditures, by decade
In real per-capita terms

	State Government Spending From All Funds	State Government Revenue From Other Governments	State Government Spending From Own Funds	
			Total	Annual Average
1950's	30.6	63.6	22.5	4.1
1960's	64.6	73.3	61.8	10.1
1970's	21.3	31.1	17.9	3.3
1980's	27.8	12.7	33.7	6.0
1990's	32.2	51.3	25.9	4.7

NOTES:
- 1950's defined as period from 1950 to 1960, and so on.
- Expenditures adjusted for inflation using the state and local government chain weighted price index

Sources:
- Fiscal data collected by Bureau of the Census, obtained from Significant Features of Fiscal Federalism 1994 Vol. 2, www.census.gov, and Census Bureau staff
- Price index from Bureau of Economic Analysis
- Population data from the Census Bureau

While state government spending increases of the 1990s were substantial, and it is fair to ask whether they could be supported by the longer run tax revenue outlook, viewed in the context of the last five decades they do not look unusual. We now turn to a more detailed look at the 1990s.

States significantly increased spending in the 1990s

Between 1990 and 2000, state government spending from own sources increased 81 percent in nominal terms, from $382 billion in 1990 to $690 billion in 2000. Total state government spending from all sources (including revenue from the federal government) grew by 90 percent, from $508 billion in fiscal year 1990 to $965 billion in 2000.[30] (Recently released data from the Census Bureau show that total state spending has since passed the trillion-dollar mark.[31])

Much of the nominal spending increase reflected higher prices and a larger population to serve: prices of the goods and services governments purchase increased 30 percent and the population increased 11 percent.[32] After adjusting for inflation and population growth, state governments increased real per-capita spending from own funds by 26 percent in the 1990s, and increased spending from all sources by 32 percent. These spending increases were part of a much longer trend of substantial growth in state and

local government in the United States. As noted above, the own-funds increase was slower than the growth in the 1980s, while the increase in spending from all funds was slightly faster, reflecting an acceleration in aid from the federal government (mostly related to Medicaid).

Table 7 provides a crosswalk between the growth in nominal spending from own funds and growth in spending after adjusting for population growth and inflation.

Table 7

Growth in State Government Spending From Own Funds, Two Decades

	Percentage Change	
	1980 to 1990	1990 to 2000
General expenditures from own funds, nominal % growth	133.0	80.7
Factors used to compute real per-capita spending growth:		
Population growth	9.9	10.5
Inflation (state & local governments)	58.6	30.0
General expenditures from own funds, real per-capita % growth	33.7	25.9

Sources: Rockefeller Institute analysis of data from U.S. Census Bureau and U.S. Bureau of Economic Analysis

Spending increases were widespread: every state but Alaska increased real per-capita own-source spending in the 1990s, and 38 states increased real per-capita own-source spending by 20 percent or more. (Alaska is an outlier because of its highly unusual tax structure: it is one of only two states that have no broad-based income or sales tax - New Hampshire is the other. In addition,Alaska relies very heavily on oil-related revenue, which dropped by one-half in the last decade while most other states enjoyed a fiscal boom.)[33] The states that spent the least in 1990 tended to increase spending the fastest, as shown in Table 8.

Table 8

States Ranked By Spending Increases in 1990s

	Real Per-Capita State Government General Expenditures From Own Funds In FY 1990	Percent change from FY 1990 to FY 2000
Mississippi	1,467	64.9
Arkansas	1,546	58.7
New Hampshire	1,535	56.7
Pennsylvania	1,751	49.7
Utah	1,911	49.4
Vermont	2,502	47.5
Texas	1,327	42.5
Minnesota	2,440	42.4
Oregon	1,831	40.5
Michigan	2,163	39.8
Wisconsin	2,180	38.2
South Carolina	1,900	37.3
Nebraska	1,763	36.0
Idaho	1,751	35.5
Montana	1,796	34.9
Colorado	1,695	33.9
Indiana	1,823	32.9
Kentucky	1,878	32.8
Missouri	1,507	29.1
Virginia	2,072	28.4
Illinois	1,776	28.3
Alabama	1,728	27.9
North Carolina	1,964	27.7
Kansas	1,774	27.7
South Dakota	1,551	27.2
Florida	1,705	26.4
Iowa	2,182	26.0
United States	2,056	25.9
California	2,412	25.8
New Mexico	2,693	24.9
Delaware	3,337	24.3
Tennessee	1,448	24.1
Georgia	1,729	23.9
Connecticut	2,825	23.7
Ohio	1,890	23.7
Louisiana	1,874	22.7
West Virginia	1,865	22.4
Maine	2,189	20.4
Maryland	2,131	20.3
Hawaii	3,491	17.2
Washington	2,507	16.8
Massachusetts	2,971	16.6
Rhode Island	2,589	12.9
New York	2,663	12.3
North Dakota	2,303	9.3
Wyoming	2,784	5.6
Nevada	2,288	5.6
Oklahoma	1,763	4.5
Arizona	2,243	4.4
New Jersey	2,492	2.7
Alaska	8,711	(11.5)

Sources: U.S. Bureau of the Census, U.S Bureau of Economic Analysis of Economic Analysis

Spending increases by functional area

The two largest spending areas in the typical state budget are elementary and secondary education and Medicaid, with most of the former usually paid as aid to local school districts, and most of the latter paid to private medical vendors such as doctors, hospitals, and nursing homes, and to managed care organizations. In state fiscal year 2000, elementary and secondary education accounted for 23 percent of total state spending from all funding sources and Medicaid accounted for 20 percent. Higher education was a distant third, accounting for 11 percent, followed by transportation (9 percent) and corrections (4 percent).[34] Cash assistance, while a significant element in state public policy debates, accounted for only two percent of state government spending in 2000.

Medicaid and K-12 education took turns dominating state spending growth in the 1990s, with Medicaid growing extremely rapidly in the first half of the decade, then subsiding and elementary and secondary education growing more rapidly in the second half. Corrections spending also grew rapidly in the first half of the 1990s, but its relatively smaller size means it did not have as large an impact on state budgets or on budget debates.

When we examine individual functional areas, Census Bureau data do not allow us to distinguish state spending state spending financed by federal funds from state spending financed from states' own funds. As a result, Table 9 below shows growth in real per-capita spending from all funds, in each half of the 1990s and for the decade as a whole. (These data do not isolate spending on Medicaid – but the Census Bureau concept of "Medical Vendor Payments" is a fairly good proxy for Medicaid.)

Table 9

Growth in State Government Spending in the 1990s
- Includes State Spending From Own-Source and Federal Funds -
(% Change in Real Per Capita Expenditures)

	Total Percentage Change			Average Annual Percentage Change		
	1990 to 1995	1995 to 2000	1990 to 2000	1990 to 1995	1995 to 2000	1990 to 2000
Total General Expenditure	20.5	9.6	32.2	3.8	1.8	2.8
Elementary & Secondary Education	13.2	18.5	34.2	2.5	3.5	3.0
Medical Vendor Payments	77.6	5.9	88.1	12.2	1.2	6.5
Higher Education	11.0	10.8	22.9	2.1	2.1	2.1
Transportation	9.6	9.3	19.8	1.8	1.8	1.8
Corrections	26.1	12.3	41.7	4.8	2.3	3.5
Cash Assistance	9.3	(39.8)	(34.2)	1.8	(9.7)	(4.1)
All Other	14.2	8.8	24.3	2.7	1.7	2.2

Source: Rockefeller Institute analysis of data from U.S. Census Bureau and U.S. Bureau of Economic Analysis

Other information sources suggest that state spending of their own funds was largely consistent with the total spending show in Table 9, at least for the larger functional areas. For example, (1) Data from the National Center on Education Statistics show that state financing of elementary and secondary education grew less rapidly than federal financing during the 1990s, but that even so, the federal share remained relatively small at the end of the decade – still only 7.3 percent of total education spending, up from 6.1 percent in 1990[35]; and (2) Data from the National Association of State Budget Officers show that reported state spending from own funds on Medicaid grew at rates virtually identical to growth rates for federal spending in both periods above.[36] The most significant exception appears to be transportation, where NASBO data show that state spending from federal funds grew slightly faster than spending from state funds during the first half of the 1990s, but in the second half of the 1990s, transportation spending from states' own funds grew at about twice the rate of spending from federal funds.

What factors drove state spending increases?

Elementary and secondary education

K-12 education spending was driven primarily by increased spending per pupil rather than by increases in numbers of students. Higher spending per pupil partly reflected more staff per student, rising non-staff costs, and other factors. A substantial share of the increase may have been related to the costs of special education, although these costs are difficult to measure comparably across states and time.[37] Average teacher salaries did not increase in real terms in the typical state, although a few states did increase teacher salaries considerably.[38] Table 10 decomposes changes in real per-capita changes into changes in the numbers of pupils and changes in spending per pupil.

Table 10

Factors Related to Spending on Elementary and Secondary Education
1990 to 2000

	Real spending per capita (2000 $)	Pupils per 100 population	Real spending per pupil (2000 $)
Level in 1990	554.6	16.4	3,376
Percent change:			
1990 to 1995	13.2%	3.2%	9.8%
1995 to 2000	18.5%	1.4%	16.9%
1990 to 2000	34.2%	4.6%	28.3%
Level in 2000	744.3	17.2	4,332

Source: Rockefeller Institute analysis of data from U.S. Census Bureau, U.S. Bureau of Economic Analysis, and National Center on Education Statistics

Medicaid

Between 1990 and 1995, real per capita medical vendor payments grew by 78 percent – an average annual rate of 12.2 percent – and consumed 42 percent of state real per-capita spending growth, despite accounting for only 11 percent of 1990 spending.

Some of this growth is attributable to disproportionate share hospital (DSH) payments, which are included in medical vendor payments in the Census Bureau's definitions. DSH payments are payments states make to hospitals that serve a disproportionate share of poor patients. They are important because states often were able to recover most or all of these payments in the form of taxes or other required payments from the hospitals, at the same time they used their payments to the hospitals as matching expenditures under the Medicaid program, allowing them to draw down additional federal aid. Many observers considered the use of DSH in this manner a gimmick intended solely to drive up federal aid to the states. Information from the Centers for Medicare and Medicaid Services indicates that nominal DSH payments increased more than tenfold between federal fiscal year (FFY) 1990 and 1995. [1]

Even if we remove the impact of DSH payments, however, real per capita spending on Medicaid benefits increased by about 60 percent.[39] According to Bruen and Holahan (1999), major factors behind this growth were:

- Medicaid enrollment grew from 28.9 million to 41.7 million reflecting expanded eligibility, the recession of 1990-1991, and other factors. This was a 44 percent increase during a period that saw only 6 percent growth in the overall population. Enrollment of blind and disabled persons, who are far more expensive to care for than other Medicaid recipients, increased by 58 percent. .This was a major factor in spending increases..[40]
- Medical care price inflation was 37 percent over the five-year period, compared with 13 percent general inflation for state and local governments.[41] Thus, economywide increases in health care costs were a major factor behind increasing Medicaid costs.
- States became increasingly adept at shifting services from other programs into Medicaid.

As a result of the above factors, nominal spending on Medicaid benefits more than doubled between FFY 1990 and 1995.[42]

Real per capita spending on medical vendor payments slowed dramatically in the second half of the 1990s, growing by only 6 percent between SFY 1995 and 2000. Essentially all of that growth occurred in SFY 2000, with less than 1 percent growth between SFY 1995 and 1999.

[1] Under federal law, Medicaid DSH payments were capped in the early 1990s, and have been declining in recent years.

Analyses of federal data on Medicaid spending yield insights into the slowdown. Average annual growth in Medicaid expenditures between federal fiscal years 1995 and 1997 was the slowest in the history of the program, according to the Kaiser Commission on Medicaid and the Uninsured, using data from the Centers for Medicare and Medicaid Services. The slowdown continued in FFY 1998. Medicaid enrollment declined during this time, primarily because the improving economy and federal and state welfare reform caused the number of enrolled children and parents to drop, and total Medicaid enrollment fell for the first time in the program's history. Overall Medicaid expenditures grew at an average annual rate of almost 4 percent between FFY 1995 and 1998, reflecting annual average growth in medical services of 5 percent and declines in DSH payments of 8 percent. Spending for managed care, home care, and prescription drugs grew at double-digit rates, while most other spending categories grew at rates of 5 percent or less.

Medicaid spending began to accelerate after FFY 1998, growing by 7 percent in FFY 1999 and almost 9 percent in FFY 2000. The increase reflected a rebound in enrollment, especially forof children and families, a surge in expenditures on prescription drugs, and accelerated spending on long-term care, driven by continued double-digit growth in home care expenditures. At the same time, utilization of services increased, especially by the elderly and disabled.

DSH payments declined by just over 1 percent annually from FFY 1998 to 2000. In this period, and perhaps earlier, states began to rely more heavily on "Upper Payment Limit" arrangements to maximize federal reimbursement. (Under these arrangements, states make inflated payments, often to county-owned hospitals or nursing homes, that drive up federal matching payments. The states then recover these payments from the hospitals and nursing homes through intergovernmental transfers from these entities to the state.) However, because UPL payments tend to be included in hospital and nursing home spending and are not separately identifiable, as DSH payments are, it is not easy to be precise about the magnitude or timing of the growing use of UPL arrangements, although the Congressional Budget Office recently estimated that UPL-related payments cost the federal government $7.4 billion in fiscal year 2002.[2]

Higher education

As with K-12 education, higher education enrollment did not grow as quickly in the 1990s as the overall population, but state spending per student (including spending from tuition funds) increased very substantially. Table 11 shows trends in major factors affecting higher education spending.

[2] Congressional Budget Office, Fact Sheet for CBO's March 2003 Baseline, www.cbo.gov.

Table 11

Factors Related to Spending on Higher Education 1990 to 2000

	Real state government spending per capita (2000 $)	Enrolled higher education students per 100 population	Real state government spending per student (2000 $)
Level in 1990	383.4	4.3	8,947
Percent change:			
1990 to 1995	11.0%	-0.2%	11.2%
1995 to 2000	10.8%	-3.5%	14.7%
1990 to 2000	22.9%	-3.7%	27.6%
Level in 2000	471.4	4.1	11,416

Source: Rockefeller Institute analysis of data from U.S. Census Bureau, U.S. Bureau of Economic Analysis, and National Center on Education Statistics

Transportation

Real per-capita spending increased 20 percent. This was driven by a 65 percent increase in real per-capita spending from state bond funds and a 23 percent increase in other state funds (financed largely by motor fuel taxes and other dedicated sources). The federal contribution increased modestly – 10 percent in real per-capita terms.

Corrections

Between 1990 and 2000, real per-capita spending on corrections increased by 42 percent. This increase resulted not from increases in spending per prisoner – in fact, spending per prisoner declined by 18 percent during this period. Instead, spending increased as a result of dramatic increases in incarceration rates. On December 31, 1989, 276 people were incarcerated per 100,000 population, but by December 31, 1999, that had increased to 478 prisoners per 100,000 population – a 73 percent increase in the incarceration rate in 10 years.[43] Much of the increase in incarceration rates appears related to new determinate sentencing policies and to drug-related arrests. This led to a prison-building boom in the late 1980s and early 1990s.

Table 12 below shows trends in corrections spending and incarceration rates:

Table 12

Growth in State Corrections Spending, 1990 to 2000

	Real corrections spending per capita (2000 $)	Incarceration rate (prisoners per 100k population)	Real corrections spending per prisoner (2000 $)
Level in 1990	$91.0	275.9	$33,004
Percent change:			
1990 to 1995	26.1%	41.6%	-10.9%
1995 to 2000	12.3%	22.5%	-8.3%
1990 to 2000	41.7%	73.3%	-18.3%
Level in 2000	$129.0	478.2	$26,969

Sources: Rockefeller Institute analysis of data from U.S. Census Bureau, U.S. Bureau of Economic Analysis, and U.S. Bureau of Justice Statistics

States have begun to curtail spending

Fiscal year 2000 is the latest year for which comprehensive and comparable expenditures data were available from the U.S. Bureau of the Census. However other information sources show that states began to curtail spending growth sharply after 2001, and are now beginning to cut spending in response to the severe fiscal crisis.

Table 13 shows spending growth rates by major function and funding source for fiscal year 2001, and for fiscal year 2002 as estimated in early 2002. While Medicaid spending was expected to grow at about the same rate in 2002 as it did in 2001, states cut sharply their planned spending growth in elementary and secondary education andhigher education. In 2002 many states also began implementing measures to control spending growth in their Medicaid programs, and states' efforts at Medicaid cost containment have grown significantly over time. [3]

[3] Vern Smith, Kathy Gifford, Eileen Ellis, and Victoria Wachino, States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment, Kaiser Commission on Medicaid and the Uninsured, September 2002, www.kff.org

Table 13

Percentage Change in State Government Spending By Function and Funding Source
Fiscal Year 2000 to Fiscal Year 2002

	FY 2000 to FY 2001 Actual Growth			FY 2001 to FY 2002 Estimated as of early 2002		
	State Funds	Federal Funds	Total	State Funds	Federal Funds	Total
Elementary and secondary education	8.0	7.0	7.9	3.3	4.4	3.4
Medicaid	9.8	11.7	10.9	11.0	10.0	10.4
Higher education	7.6	11.5	8.1	4.3	3.1	4.2
All other	7.5	7.4	7.5	1.2	14.2	4.2
Total	7.9	9.4	8.3	3.3	10.8	5.2

Source: State Expenditure Report 2001, National Association of State Budget Officers, Summer 2002
Note: States cut FY 2002 spending after the date of estimates presented here, but details by function are not available.

Although details are not yet available, actual spending growth in categories other than Medicaid is likely to have been much lower in fiscal year 2002 than shown here. According to the National Governors Association and National Association of State Budget Officers, 37 states cut their budgets in fiscal year 2002, and total general fund spending (roughly analogous to the "state funds" spending shown above) was only 1.3 percent – meaning that spending declined after adjusting for inflation and population growth.[44] Furthermore, Medicaid spending growth was revised upward to 13.2 percent from the figures shown here,, reflecting increases in health care costs and enrollment due to the weak economy.[45] The state share of Medicaid spending appears to have slowed in fiscal year 2003 to about 8 percent and the federal share of Medicaid spending appears to have slowed to about 9.8 percent.[46]

Before fiscal year 2003 was completed, NGA and NASBO estimated that state general fund spending growth would be approximately 1.3 percent again, with 17 states projecting outright declines in nominal spending. States subsequently cut budgets further for 2003.

Although states expect tax revenue to improve somewhat for fiscal year 2004, spending is likely to be restrained, with states planning to increase general fund spending by about 1 percent above 2003.[47]

3. Reserve funds: States boosted reserve funds but these funds are now nearly depleted

States built their fund balances up moderately in the late 1980s, to a cyclical peak of $12.5 billion at the end of fiscal year 1989, or 4.8 percent of expenditures. Economic weakness and recession then hit, and states drew down balances by 75 percent in two years, to $3.1 billion or 1.1 percent of expenditures at the end of fiscal year 1991.

The economy then began to recover, tax increases kicked in, the fiscal boom of the late 1990s began, and by the end of fiscal year 2000, states built their balances up to a 20-year

high of $48.8 billion, or 10.4 percent of expenditures.[48] This made them much better prepared for the 2001 recession, in terms of balances, than they were for the 1991 recessions.

The fund-balance cycle has since begun to repeat – states used their balances before adopting significant spending cuts or tax increases, and by the end of fiscal year 2002 had drawn these balances down by 66 percent, to $14.8 billion or 3.1 percent of expenditures. They drew balances down further by the end of fiscal year 2003, to an estimated 1.3 percent of expenditures.[49]

The outlook for state spending and revenue

1. Forces that will affect state revenue

Personal income tax

Personal income taxes are likely to grow far more slowly than in the late 1990s, when income tax revenue grew faster than the economy despite tax cuts. Nonetheless, over the longer term the income tax will resume its role in most states as the fastest growing major state tax. The reason for this is that income taxes generally are progressive, with higher effective tax rates for higher incomes. As incomes rise due to inflation and productivity growth, the effective tax rate rises, so that tax revenue generally grows faster than income.

Many of the states that benefited most from the financial market run-up of the late 1990s will face the most difficulty now. It is hard to overstate the role that financial markets played in driving up state income tax revenue in many states. States that relied heavily on revenue related to the stock markets now are suffering withdrawal and are likely to take some time to adjust to the new, lowered, revenue environment. While it is difficult to measure precisely which states rely most heavily on this revenue, in part it depends on how much each state's income tax depends on income from capital gains, and how much the state relies on the income tax as a source of revenue. Table 14 ranks states according to an index that takes both factors into account. While there are important factors not reflected in this measure, nonetheless it gives a rough idea of which states are facing and will face difficulty as a result of declines in financial markets.[50]

Table 14

States Ranked By Importance of Capital Gains in 2000

	State indexed to the nation (US=100)		
	Capital Gains as % of Adjusted Gross Income	Income Tax as % of State General Revenue	Combined Effect
California	148	138	205
Colorado	143	121	173
Connecticut	126	132	167
Massachusetts	167	97	163
New York	139	116	160
Oregon	145	99	144
Idaho	116	101	117
Virginia	144	80	115
Maryland	130	86	112
Minnesota	134	84	112
Georgia	138	80	111
New Jersey	113	94	107
Maine	104	103	106
Illinois	100	103	103
Nebraska	105	97	102
Rhode Island	104	98	101
United States	100	100	100
North Carolina	132	70	92
Utah	109	79	86
Vermont	74	108	81
Missouri	109	73	80
Kansas	111	67	75
Montana	75	100	75
Hawaii	94	78	73
Arizona	79	91	72
Ohio	116	61	70
Pennsylvania	82	82	67
Delaware	86	76	65
Oklahoma	100	61	61
Michigan	92	65	60
Iowa	97	62	60
Kentucky	93	61	57
Indiana	101	56	56
Wisconsin	142	37	53
Alabama	74	62	46
South Carolina	94	42	39
Louisiana	55	62	34
West Virginia	70	45	31
New Mexico	57	50	28
Mississippi	53	54	28
North Dakota	36	66	24
Arkansas	82	19	15
New Hampshire	9	128	11
Tennessee	6	72	4
Alaska	-	61	-
Florida	-	132	-
Nevada	-	147	-
South Dakota	-	95	-
Texas	-	91	-
Washington	-	116	-
Wyoming	-	190	-

Sources:
Income tax as percent of general revenue obtained from U.S. Bureau of the Census
Capital gains as percent of adjusted gross income obtained from Internal Revenue Service, Statistics of Income branch
Note: Combined effect is first column multiplied by second column, divided by 100

Sales taxes

States are likely to find their sales taxes depressed for three reasons in the coming decade. First, as noted above, consumption had been rising faster than income throughout the 1990s (savings rate was falling), giving a boost to sales taxes. If this simply stops, as has occurred at least temporarily and as many economists expect to continue, the boost to sales tax revenue will be no more. *Consumption may no longer grow faster than income, and may even grow more slowly.*

Second, consumers will continue to shift their spending from goods to services. Most states currently do not tax many services, and services often are difficult to tax for administrative, legal, and political reasons. *Taxable consumption will not grow as quickly as total consumption.*

Finally, not all taxable consumption is taxed. The advent of Internet commerce makes it easier for people to purchase goods without paying tax owed, due to difficulties of collecting taxes on goods sold over Internet or via mail order. Absent concerted state effort, or federal action, sales taxes will continue to erode for this reason. *Taxed consumption will not grow as quickly as taxable consumption.*

Bruce and Fox (2001) project sales tax bases will erode by three percent of total state and local tax revenue between 2001 and 2006, with the continuing shift to services consumption accounting for one percentage point and Internet sales accounting for two percentage points. The five states with the greatest revenue loss as a percentage of total tax revenue are Nevada, Texas, Florida, Tennessee, and South Dakota – non-income-tax states that rely heavily on the sales tax. Each faces erosion in its total tax base of 5 percentage points or more in a five year period – enough to place substantial strain on state and local budgets. [51]

Simulations by the Rockefeller Institute of Government that use an economic forecast from Economy.com and take the Bruce and Fox projections into account suggest that in an economic environment in which personal income grows by 5.1% annually the sales tax might only grow by 3.7 percent annually, on average.

Excise taxes

Selective sales and excise taxes will continue to be a weak third leg of state revenue structures. States are likely to raise rates in the current fiscal crisis – in fact, they have already done so – approximately 20 states raised cigarette taxes in the 2002 legislative session – but after this short-term boost, these taxes probably will continue their long-term decline because they generally are imposed on bases that do not keep up with economic growth.

Federal grants

Current projections by the Congressional Budget Office assume that non-entitlement federal grants and other discretionary spending will grow at a 2.4 percent annual rate through 2013. [52] As required under the federal Deficit Control Act, this allows federal spending to keep pace with the overall rate of inflation, but is a decline in real per-capita

terms since population will be growing. This is considerably slower than the 5 to 7 percent annual growth states experienced in the 1990s for most non-health and non-Medicaid grants.

Medicaid-related revenue is likely to grow at approximately the same rate as Medicaid spending, absent major federal policy changes, or about 8 to 9 percent annually – far faster than the 2.4 percent assumed for other federal grants.

Longer term issues in state tax systems

States face two very significant revenue issues over the longer term, both of which affect sales taxes: the difficulty in collecting taxes from residents who buy goods and services via the Internet or mail order, known as "remote sales," as discussed above in the section on sales taxes, and the longer-term shift in the economy from consumption of goods, which states generally include in their sales taxes, toward consumption of services, which states tax relatively lightly. Neither issue has easy solutions.

In the case of remote sales, the fundamental problem is that under current law states cannot require out-of-state sellers that do not have a physical presence in their states to collect sales and use taxes on sales to in-state residents, even though a "use tax" on these transactions typically is due. This gives out-of-state sellers an advantage over in-state sellers, who are required to collect the tax. Although Congress has the authority to require out of state sellers to collect these taxes, it has not been willing to do so, on the grounds that under the current patchwork of varying state and local sales tax laws, this would be extraordinarily complex and would put too much burden on remote sellers.

Many states hope to reduce this burden by passing conforming laws under the Streamlined Sales Tax Project (SSTP). Many large, multi-state businesses also supoort the SSTP because it could reduce their costs of complying with state sales taxes and could also level the playing field with businesses not currently collecting sales taxes on transactions conducted via the Internet or mail order.

States participating in this project hope that if they demonstrate widespread acceptance and use of the streamlined sales tax, Congress will require remote sellers to collect sales and use taxes.

The second major sales tax issue is that many kinds of services are difficult to include in sales tax bases, administratively, legally, and politically. It is relatively easy to decide how and where services to people and property should be taxed: If a barber cuts a person's hair in the barber's shop in New York, then New York can tax the service. If a gardener tends property in New Jersey, then New Jersey can collect tax on the landscaping service. It is much more difficult to determine where and how business services might be taxed. For example, should the sale of advertising be taxed in the state in which the business purchasing the advertising is located? In the state in which the advertising agency is located? In the state in which the advertising market is located? Or on some other basis? Similar issues arise in taxing the services of lawyers and many other professionals who operate in a multistate environment.

Revenue risks states face

States face many risks to the revenue side of their budgets in the near term and over the longer term. Most states face two very large risks in the near term. The first is the possibility that economic growth this year and next will be lower than expected. States tend to be relatively conservative forecasters and most base their budgets on economic forecasts that are at or below the consensus of mainstream economic forecasters.

However, that consensus has moved downward significantly since most states prepared their current forecasts, in December or January. The economic outlook has worsened in large part due to uncertainty over the war in Iraq, which led businesses and consumers to put many spending plans on hold, weakening the economy. Nationally, employment declined by approximately 1 million jobs, heightening concerns that the labor market remains extremely weak and that the economy could even endure a double-dip recession.[53] Employment declines clearly have been worse than most private and government forecasters expected, and could foreshadow a new round of revenue shortfalls for states.

Another major near-term risk states face is related to the stock market. Even at the new lower levels of the stock markets and capital gains, financial markets can have large and uncertain effects on state budgets. As a result of the large decline in the stock market, many taxpayers have large capital losses that they can use to offset future capital gains, and this could drive state tax revenue down further in the near term, and keep it depressed for years to come. It is very difficult to forecast the size of this effect, and forecasters have widely varying forecasts of capital gains in coming years.

The Congressional Budget Office predicts that after falling by 50 percent in 2001, capital gains fell an additional 17 percent in 2002, and that this decline will be followed by growth of 10 percent in each of the next two years. New York's budget office forecasts that capital gains fell by 37 percent in 2002 and projects that they will decline by an additional 13 percent in 2003. By contrast, Arizona, California, and Colorado all think the 2002 decline will be 10-15 percent and, similar to CBO, they think that gains will increase slightly in 2003. Clearly these estimates are highly uncertain, and have the potential to wreak havoc yet again on state budgets. Prelminary results for the April-June quarter of 2003, which includes the April 15 filing date for 2002 tax returns, suggest that tax returns were weak, but generally not weaker than states had expected.

In addition to these two very specific risks, state revenue forecasts are subject to a host of risks related to the general economic outlook, all of which have the potential to make their actual results significantly different from their projections, in one direction or the other.

2. Forces that will affect state spending

The "Big 3" areas of state government spending are elementary and secondary education, Medicaid, and higher education. Each will face its own set of pressures in coming years.

Elementary and secondary education

Enrollment pressures affecting elementary and secondary education will ease over the next decade. According to the "middle" projections of the National Center for Education Statistics, *national* K-12 public school enrollment will not grow in the 10 years from 2002 to 2012. This is welcome relief from the 11.2 percent growth in the previous 10 years, when the "baby boom echo" – the large cohort of children of baby boomers – was working its way through high school.

Although enrollment pressures may diminish, states will face many other pressures to finance education. The federal government and many states have adopted policies that appear likely to raise the costs of elementary and secondary education substantially. These policies include high-stakes testing, higher graduation standards, prohibitions against "social promotion," smaller class sizes, expanded student support services, enhanced professional development for teachers, and other activities intended to help students and teachers achieve these goals.[54] Many of these policies will increase costs by requiring more teachers, or more-skilled and more highly paid teachers, or more time in school for students (and teachers), or more extensive curricula material, or additional building space. While no estimates of the costs of these policies are available, it appears very likely that state-financed costs of K12 education will continue to rise substantially in coming years, as they have for every decade for at least the past 50 years, as the table below shows:

Table 15

Elementary and Secondary Education Spending In the Second Half of the 20th Century

School Year	Total Expenditure Per Enrolled Pupil In 2000-01 $		State Government Share of Total School District Revenue
	Amount	Average Annual % Change	
1949–50	$ 1,708		39.8%
1959–60	2,622	4.4%	39.1%
1969–70	4,075	4.5%	39.9%
1979–80	5,164	2.4%	46.8%
1989–90	7,135	3.3%	47.1%
1998–99	8,016	1.3%	48.7%

Source: *Digest of Education Statistics 2001*, National Center on Education Statistics, February 2002, Tables 36, 65, and 167

Medicaid

The Congressional Budget Office projects that national Medicaid spending will grow about 8.5 percent annually for the remainder of this decade. CBO projects that this rate of growth, which is lower than that the program experienced in fiscal year 2002 and 2003, will be driven by higher prices, increased use of services, and somewhat lower enrollment..[55] States generally will be affected by the same trends. The projected 8.5 percent growth is considerably higher than growth in the mid-1990's and faster than tax revenue in the typical state is likely to grow.

Table 16 shows state-financed Medicaid expenditures as a share of total state spending in each state. In states where Medicaid is a large share of the budget, rapidly growing Medicaid expenditures may cause significant fiscal stress.[4]

[4] These figures may reflect states' use of financing strategies, such as upper payment limit strategies, that draw down additional federal funds.

Table 16

State-Financed Medicaid as Share of All State-Financed Spending
Fiscal Year 2002

Connecticut	20.5%	Massachusetts	9.8%
Ohio	19.5%	Virginia	9.7%
Pennsylvania	19.3%	Nebraska	9.6%
Washington	19.1%	California	9.6%
New Hampshire	18.3%	South Dakota	9.4%
Tennessee	17.6%	South Carolina	9.4%
Rhode Island	16.8%	Oregon	9.0%
Missouri	15.7%	Arizona	8.8%
New Jersey	14.8%	North Dakota	8.8%
Illinois	14.0%	Idaho	8.3%
Georgia	13.5%	Kansas	8.0%
Florida	12.8%	Kentucky	7.6%
Texas	12.7%	Wisconsin	7.6%
Vermont	12.6%	Oklahoma	7.4%
New York	12.6%	West Virginia	7.3%
Michigan	12.0%	Alabama	7.3%
		Wyoming	7.0%
United States	12.0%	Mississippi	6.9%
		Montana	6.8%
Indiana	11.8%	Iowa	6.7%
North Carolina	11.7%	Arkansas	6.7%
Louisiana	11.6%	Delaware	6.3%
Minnesota	11.5%	New Mexico	5.8%
Maine	11.5%	Hawaii	5.0%
Colorado	10.6%	Utah	4.9%
Maryland	10.3%	Alaska	4.4%
Nevada	10.1%		

Source: 2001 State Expenditure Report, National Association of State Budget Officers, Summer 2001
Note: Alaska data not available in 2001 State Expenditure Report, and instead are from 2000 State Expenditure Report, for FY 2001

Over the longer term, a major looming risk to Medicaid is that the cost of long term care, hospital care, prescription drugs and other expenditures that are particularly important for the elderly will rise as the population ages. Medicaid expenditures per elderly beneficiary are more than three times as large as expenditures for the non-elderly, and as a result even though the elderly account for only about 11 percent of Medicaid beneficiaries, they account for approximately 31 percent of Medicaid spending.[56] This will become even more significant in years ahead: about three-quarters of projected growth in Medicaid expenditures is attributable to rising costs of care for the aged and disabled.[57]

While the aging of the population will not be a major issue in the near term for most states, it will hit some sooner than others, particularly a number of southern and western states. According to Economy.com, the nine states shown below are likely to have growth of more than 33 percent between 2002 and 2012 in their population aged 65-and-older:

Table 17

States Where Age 65+ Population Is Projected To Grow By More Than One-Third Between 2002 and 2012

	Projected Growth
Nevada	63%
Arizona	50%
Colorado	44%
Utah	44%
Oregon	41%
Idaho	39%
Georgia	38%
Alaska	37%
Washington	36%

Source: Rockefeller Institute analysis of June 2002 forecast provided by Economy.com

Higher Education

After coming to a virtual standstill in the late 1990s due to changing demographics, higher education enrollment is likely to grow considerably in the coming 5–10 years for two reasons. First, the leading edge of the large cohort of children of baby boomers (the "baby boom echo") is exiting high school and entering college. Second, labor market demands are increasing pressures for high school graduates to attend college. According to the U.S. Department of Labor, 43 percent of net new jobs in the 10-year period ending in 2008 will be in occupations that commonly require at least some higher education, even though these jobs constituted only 29 percent of the existing employment base.[58] According to the "middle" projections of the National Center for Education Statistics, *national* higher education full-time-equivalent enrollment is expected to grow by about 1.3 percent annually in the 10 years from 2002 to 2012, somewhat faster than the overall population growth rate.

In addition, higher education, like other service industries, often do not share in productivity gains and their prices tend to increase faster than overall inflation.

Uncertainties and risks

All budget projections contain uncertainty, although projections of expenditures tend to be somewhat less uncertain than revenue projections. Expenditure uncertainties that states face include:

- Medicaid expenditures are large and difficult to control, and the underlying forces driving growth in Medicaid, and health care expenditures more generally, have been difficult to predict. If health care price inflation accelerates again, it could have a large negative impact on state budgets.

- Implementing higher standards for elementary and secondary education, as all states are doing, could be very expensive. Similarly, hiring and training teachers to teach to the standards could be very expensive. In addition, some states face the risk that they will have to increase education expenditures significantly, depending on the outcome of pending state-specific litigation.
- State and local governments bear much of the responsibility for homeland security, and these costs could be affected by the outcome of the war in Iraq and its aftermath.

Conclusion: States will face budget difficulties for years

At this point, even if budget gaps for fiscal year 2004 remain closed, the outlook for state budgets in fiscal year 2005 is bad, for several reasons. First, the near term economic outlook has deteriorated from what private and government forecasters expected at the time they prepared their forecasts for fiscal year 2004, and employment has continued to decline despite the end of the recession.

Even if the economic outlook had not worsened, states had been predisposed to look for "easy" solutions to 2003 budget gaps – states tend to take the easiest actions first when closing budget gaps, and many of these actions tend to push fiscal problems off to future years. This tendency was exacerbated by the extraordinarily sharp dive in state revenue in the final quarter of fiscal year 2002, as states were debating their 2003 budgets, which overtaxed the political process in many states – policymakers found it extraordinarily difficult to come to grips with the full size of the problems they faced for fiscal year 2003. The result was that most states closed fiscal 2003 budget gaps incompletely, and with solutions that tended to exacerbate problems for fiscal year 2004 and beyond.[59]

Many states appear to have used solutions for fiscal year 2004 budget gaps that follow the same philosophy, pushing problems out to fiscal year 2005 and beyond. Several states, including California, Illinois, Massachusetts, New York, Wisconsin, and others used bonding, tobacco revenue, and other large nonrecurring resources to help close fiscal year 2004 gaps. With reserve funds nearly depleted and large amounts of nonrecurring revenue, many states are almost certain to face large budget gaps again in fiscal year 2005.

After much debate, and to the surprise of many observers, the federal government did enact a package of $20 billion in temporary fiscal relief for the states, spread across two fiscal years. The package includes $10 billion in flexible assistance, and another $10 billion in increased aid for Medicaid available to states that do not change Medicaid eligibility.[60] While the relief is welcome, it is temporary and relatively small, amounting to about one percent of state own-funds spending.

Over the longer term, the prospects for substantial and sustained increases in federal aid to states appear dim. The federal budget benefited from many of the same forces as state budgets, and it is being buffeted now by the recession and continued economic weakness, the decline in financial markets, accelerating health care spending, tax cuts, anti-terrorism spending, and the military and reconstruction costs of the war in Iraq. In projections released in August 2003 that reflect only some of these factors, the Congressional Budget

Office forecast deficits amounting to $1.4 trillion in total for the period from 2004 through 2008. Furthermore, these projections likely understate the severity of federal fiscal problems.[61] Thus, a sustained increase in federal aid to the states seems unlikely.

Over the longer term, beyond fiscal year 2005, states are likely to face continued budget difficulties. As discussed above, the income tax is likely to grow more slowly than in late 1990s, depressed in part by the impact of carryover capital losses. The sales tax is likely to grow slowly for the three reasons given earlier: the difficulty of taxing remote sales, the continued shift by consumers toward purchases of relatively hard-to-tax services, and the absence of the boost to consumption seen in the 1990s, when the savings rate plummeted.

Finally, while states face some spending pressures, particularly in Medicaid, which is large, , an entitlement program, and likely to grow by 8 to 9 percent annually – faster than the typical state tax structure is likely to grow.

What would change this dour outlook? Although it is always possible for the economy and stock markets to provide forecasters with positive surprises, in the short term the best that most states probably can hope for is an improvement that will reduce the size of their problems – not make them go away. The decline in revenue and use of nonrecurring resources simply have been too large for state fiscal problems to go away quickly.

Over the longer term – say four or more years - it certainly is possible for states to experience unanticipated good news large enough to lead, yet again, to surpluses. That is what happened in the 1990s. But for the moment, it is hard to see where this good news would come from.

Notes

[1] I acknowledge gratefully the help of Celia Ferradino, graduate assistant at the Rockefeller Institute of Government, in gathering some of the data and studies analyzed in this article.
[2] Computed from data in the file "01in01si.xls," dated May 2003, downloaded from the Internal Revenue Service Statistics of Income website (www.irs.gov/taxstats) on August 7, 2003.
[3] See "State Budget and Tax Actions 2002", *NCSL News*, National Conference of State Legislatures, August 28, 2002.
[4] *State Budget Update: February 2003*, National Conference of State Legislatures, Washington, DC: February, 2003.
[5] The actual revenue shortfall of $38 billion is much less than the $68 billion falloff from "normal" growth estimated above because states were well aware that tax revenue in 2002 would grow much slower than 6 percent – but actual collections still were far less than their dampened expectations.
[6] Author's analysis of data in *State Expenditure Report 2001*, National Association of State Budget Officers, Summer 2002.
[7] Author's analysis of data from the Bureau of the Census and the Bureau of Economic Analysis.
[8] See Chris Edwards, "New Data Show State/Local Spending Rose Almost 5 Percent in 2002," www.cato.org, March 13, 2003.
[9] NOTE: revenue per $100 of personal income is shown in the accompanying table. Real per-capita revenue is not shown in the table.
[10] Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2003-2012*, January 2002, Chapter Two.
[11] Based on data in "capgain1-2001.pdf" and "in00cm54.xls," both of which are available on the Statistics of Income area of the Internal Revenue Service website.
[12] Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2003-2012*, January 2002, pp. 50-51.
[13] State revenue analysts in several states, including California, New York, and Ohio, reported this to Rockefeller Institute of Government staff in periodic informal telephone interviews conducted by Institute staff in the course of preparing the Institute's quarterly *State Revenue Report*. These interviews were conducted by Elizabeth I. Davis, Nicholas W. Jenny, and Donald J. Boyd.
[14] See Balkovic, Brian, "High Income Tax Returns for 1999," *Statistics of Income Bulletin*, Spring 2002, for the latest in a series of annual articles on this topic by the Internal Revenue Service. The data in this paragraph were obtained from spreadsheets entitled 95IN01AR.xls, 95IN02AR.xls, and 00in54cm.xls, provided by the Internal Revenue Service's Statistics of Income branch.
[15] No comprehensive data are available on *state* income taxes paid by these high-income taxpayers, but those taxes would be very substantial.
[16] Two organizations track state tax changes - the National Conference of State Legislatures and the National Association of State Budget Officers – and their methods and numbers differ slightly. The sum of tax increases reported by NCSL for 1990 through 1995 fiscal years appears to be $33.4 billion, and the total reported by NASBO for 1990 through 1994 is $36.2 billion (NASBO shows a tax reduction in 1995).
[17] A tax increase could become larger in subsequent years if it was in effect for only part of its initial year, as is often the case. A tax increase might become smaller in subsequent years if the tax base is declining, as is the case with cigarette taxes, of if it was enacted in a fashion that "doubles up" in the initial year, as can occur with an income tax increase that is imposed for the entire tax year in which a state fiscal year begins, and for the portion of the tax year in which a state fiscal years ends. In addition, tax increases that are enacted with phase-out provisions also would decline in value in subsequent years.
[18] In other words, this assumes that the fiscal year 1990 increase recurred in 1991, 1992, 1993, and 1994 at its 1990 value; the fiscal year 1991 increase recurred in 1992, 1993, and 1994 at its 1991 value; and so on. This obviously is a very crude approach to estimating the recurring value of tax increases, and my over or understate their recurring value, but data that would allow a more sophisticated analysis would be extremely difficult to assemble. The 10-12 percent range accounts for the differences between NCSL and NASBO estimates of tax increases.

[19] Many of these taxes, such as cigarette, alcohol, and motor fuels taxes, are imposed on the quantity of goods sold, and these quantities generally either decline (in the case of cigarettes) or may not keep pace with growth in nominal incomes (as is often true with motor fuels).
[20] Analysis of NCSL and NASBO tax-cut estimates yields approximately equivalent results.
[21] Nicholas Johnson and Daniel Tenny of the Center on Budget and Policy Priorities argue this point in *The Rising Regressivity of State Taxes* (Jan. 15, 2002).
[22] In a recent study using a microsimulation model, the Institute on Taxation and Economic Policy concluded that the share of all state *and local* taxes paid by lower income people increased between 1989 and 2002, mainly as a result of higher sales, excise, and (largely local) property taxes. Taxes paid by upper-income individual families also rose, largely due to higher income taxes (perhaps due to rising capital gains, although it is possible to discern this from the methodological description provided by ITEP), but the increases for lower-income families were estimated to be larger than those for upper-income families. (NOTE: I have excluded ITEP's "Federal Offset" for purposes of this discussion.) See *Who Pays? A Distributional Analysis of the Tax Systems in All 50 States*, Institute on Taxation and Economic Policy, January 2003.
[23] Jenny, Nicholas W., Fiscal 2001 Tax Revenue Growth: Weakness Appears, *State Fiscal Brief* No. 64, Rockefeller Institute of Government, April 2002.
[24] Jenny, Nicholas W., *State Revenue Report* No. 47, Rockefeller Institute of Government, March 2002, and Donald J. Boyd and Nicholas W. Jenny, "States Will Raise Their Economic Forecasts But May Lower Their Revenue Forecasts," *State Fiscal News* Vol. 2, No. 3, Rockefeller Institute of Government.
[25] See Nicholas W. Jenny, "Sluggish State Revenue Continues", *State Revenue Report* No. 51, Rockefeller Institute of Government, April 2003.
[26] See Jenny, Nicholas, W., "Underlying State Revenue Picture Remains Bleak," *The Rockefeller Institute State Fiscal News* Volume 3 Number 6, August 2003.
[27] We measure inflation using the state and local government chain-weighted price index, which attempts to measure the prices of goods and services produced by state and local governments. As with all inflation measures, this measure has its flaws, but unless noted otherwise in the text, other measures such as the consumer price index yield conclusions similar to those in this paper.
[28] There also are a variety of more-sophisticated approaches to comparing spending levels and policies across states and times, but these go well beyond the purposes and needs of this paper.
[29] See Rudolph Penner, *A Brief History of State and Local Fiscal Policy*, Urban Institute , December 1998, Publication A-27, for a good discussion of these trends.
[30] Based on data from U.S. Bureau of the Census on state government "general expenditures."
[31] See state general expenditures for 2001, at www.census.gov/govs/state/01st00us.html.
[32] Inflation is based on the state and local government chain weighted price index from the U.S. Bureau of Economic Analysis. Population is based on data from the U.S. Bureau of the Census. By convention, price index data are for the calendar year in which a state fiscal year ends, and population data are for the calendar year in which a state fiscal year begins. Alternative conventions would have no material impact on 10-year growth rates.
[33] See Goldsmith, Scott, Linda Leask, and Mary Killorin, "Alaska's Budget: Where the Money Came From and Went, 1990-2002," *Fiscal Policy Papers* Number 13, Institute of Social and Economic Research, University of Alaska Anchorage, May 2003.
[34] These figures are based on data from the National Association of State Budget Officers, State Expenditure Report 2000. I use these here, rather than Census data, because NASBO identifies Medicaid as a separate category.
[35] *Digest of Education Statistics 2002*, National Center on Education Statistics, Table 156, June 2003.
[36] Nonetheless, states were aggressive in maximizing federal Medicaid revenue in this period; some spending counted as "state" spending had the effect of driving up the federal matching rate for Medicaid, even though this is not apparent from financial reports. For a discussion of these methods see Coughlin, Theresa A., and Stephen Zuckerman, "States' Strategies for Tapping Federal Revenues Implications and Consequences of Medicaid Maximization," in Holahan, John, Alan Weil, and Joshua Weiner (Eds.), *Federalism & Health Policy*, Urban Institute Press, 2003.
[37] For an analysis of spending changes in New York, see Don Boyd, Hamp Lankford, and Jim Wyckoff, *School District Expenditures and Fiscal Stress*, Condition Report Prepared for the New York State Education Finance Research Consortium, July 2002, http://www.albany.edu/edfin.

[38] See Digest of Education Statistics 2001, National Center on Education Statistics, Table 78.
[39] Based on data from Health Care Financing Administration Form 64. These data show that real per capita "total computable" spending on medical assistance payments (including DSH) increased by 80 percent between federal fiscal years 1990 and 1995, which is remarkably consistent with the 78 percent increase in real per capita medical vendor payments (which also include DSH) between state fiscal years 1990 and 1995. As with the Census data on medical vendor payments, the analysis of HCFA data is based on combined federal-state spending, with adjustments for DSH.
[40] Computed from Table 2 in Brian Bruen and John Holahan, *Slow Growth in Medicaid Spending Continues in 1997*, November 1999, The Kaiser Commission on Medicaid and the Uninsured, and from population data from the U.S. Bureau of the Census.
[41] Computed from annual average medical inflation rates given in the text of Bruen and Holahan (1999) and from data on the state and local government chain-weighted price index from the U.S. Bureau of Economic Analysis.
[42] Computed from Table 1 in and Holahan (1999).
[43] Based on data from the Criminal Justice Sourcebook, Table 6.27 as of 11/4/2002. These data are for prisoners under federal and state custody combined, but the vast majority of prisoners, by far, are under state custody.
[44] The Cato Institute has noted that state and local expenditures, as reported by the Bureau of Economic Analysis, grew by 4.9 percent in calendar year 2002. (See Chris Edwards, "New Data Show State/Local Spending Rose Almost 5 Percent in 2002," www.cato.org, March 13, 2003.) This growth rate appears to be consistent with the NASBO numbers reported here, which anticipate general fund spending in fiscal year 2002 of 1.3 percent, and total spending that presumably is somewhat less than the 5.2 percent shown in the table. The BEA data include spending from all sources and are more closely analogous to the NASBO total spending concept than general fund spending. If "transfers" – which include Medicaid spending – are excluded from the BEA numbers, then state-local spending on items other than transfers was up 3.3 percent in calendar year 2002.
[45] Fiscal Survey of the States, November 2002, Table 9.
[46] The 8 percent state-share spending increase is from *Fiscal Survey of the States*, June 2003, p.4. Note that this is the state share. The Congressional Budget Office estimates that the federal share of Medicaid spending rose by about 9.8 percent in federal fiscal year 2003 (*The Budget and Economic Outlook: An Update*, August 2003, p.5). The National Conference of State Legislatures recently reported that states project that the state share of Medicaid will grow by approximately 4 percent in stat fiscal year 2004 (*State Budget and Tax Actions 2003: Preliminary Report*, July 23, 2003, p.6), but this was for a sample of only 38 states and was based on projections prepared at the start of the fiscal year. States' early estimates have proven unreliable in the past and may not be a good indicator of Medicaid spending for 2004.
[47] *State Budget & Tax Actions 2003 Preliminary Report*, National Conference of State Legislatures, July 23, 2003.
[48] Fiscal Survey of the States, November 2002, Table 8.
[49] *Fiscal Survey of the States*, National Governors Association and National Association of State Budget Officers, June 2003, Table 9.
[50] Important factors not reflected in this index include: (1) the progressivity of a state's income tax, since the vast preponderance of capital gains are realized by top-bracket taxpayers, (2) the importance of stock options, and (3) the direct impact of the financial services industry on a state's economy.
[51] Bruce, Donald and William F. Fox, *State and Local Sales Tax Revenue Losses from E-Commerce: Updated Estimates*, Center for Business and Economic Research, University of Tennessee, September 2001.
[52] *The Budget and Economic Outlook: Fiscal Years 2004-2013*, Congressional Budget Office, January 2003, p. 80.
[53] *THE EMPLOYMENT SITUATION: MARCH 2003*, U.S. Bureau of Labor Statistics, April 4, 2003, http://www.bls.gov/news.release/empsit.nr0.htm.
[54] See Education Commission of the States, 2000-01 Selected State Policies, March 2002, for a listing of state policies that received serious consideration or were adopted in 2000 or 2001.
[55] See Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2004-2013*, January 2003, pp. 80-83 for discussion of the CBO Medicaid forecast.

[56] Based on data in *A Profile of Medicaid: Chartbook 2000*, Health Care Financing Agency, U.S. Department of Health and Human Services, September 2000, p.62.
[57] See Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2004-2013*, January 2003 p.83, and Leighton Ku, *Shift In Costs From Medicare To Medicaid Is A Principal Reason For Rising State Medicaid Expenditures*, Center on Budget and Policy Priorities, March 3, 2003.
[58] Braddock, Douglas, "Occupational employment projections to 2008, *Monthly Labor Review*, November 1999.
[59] See Kenneth Finegold, Stephanie Schardin, and Rebecca Steinbach, *How Are States Responding to Fiscal Stress?*, The Urban Institute, No. A-58, March 2003, for examples of these sorts of actions.
[60] *Jobs and Growth Tax Relief Reconciliation Act of 2003 (Public Law 108-27): Summary of State Fiscal Assistance Provisions*, National Conference of State Legislatures, June 10, 2003, http://www.ncsl.org/standcomm/scbudg/stateassistancesummary.htm.
[61] CBO projections make some unrealistic assumptions, among them that discretionary spending will grow more slowly than the economy and more slowly than recent experience, that tax cuts scheduled to expire will not be extended, that Congress will allow unintended increases in the Alternative Minimum Tax to go forward, and that Congress will not enact a prescription drug benefit for Medicare. Furthermore, these projections do not reflect most costs of the war in Iraq and its aftermath. For a discussion of these issues see Kogan, Richard and Robert Greenstein, *The New Congressional Budget Office Forecast and the Remarkable Deterioration of the Surplus*, Center on Budget and Policy Priorities, September 3, 2003.

THE KAISER COMMISSION ON
Medicaid and the Uninsured

States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004

Results from a 50-State Survey

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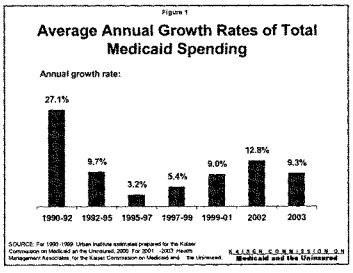
Executive Summary

States are beginning what is for some the fourth consecutive year of fiscal stress. State tax revenues declined significantly in 2002 and remained at that low level throughout 2003. As they completed their 2003 fiscal year and developed budgets for fiscal year 2004, states faced total budget shortfalls of at least $70 billion. To close these large budget gaps, states reduced planned spending and some began to raise taxes and fees. After the beginning of fiscal year 2003, states reduced budgeted spending levels for the year, and many states proposed to reduce fiscal 2004 spending.

These fiscal conditions place significant pressure on Medicaid, the state/federal program that funds health and long term care coverage for 51 million low-income Americans. Medicaid, which is funded jointly by the states and the federal government, is generally the second-largest program in states' budgets. At the same time that state revenues have fallen, spending on the Medicaid program has been increasing significantly, reflecting increasing health care costs and the growing number of people living in poverty as a result of the weak economy.

As states have grappled with the challenge of balancing their budgets in the face of declining revenues, many have put in place new measures to control their Medicaid spending growth. States have been implementing new Medicaid cost containment measures over the past four years, and in the past two years state emphasis on reducing Medicaid spending growth has increased significantly. To track the changes states are making, the Kaiser Commission on Medicaid and the Uninsured sponsors a survey of Medicaid directors in all 50 states and the District of Columbia, which is carried out by Health Management Associates. This report describes the findings of the most recent survey, which was completed in June 2003, as most states were preparing to begin their 2004 fiscal years. The survey found:

Medicaid spending continues to grow significantly, but the rate of growth declined substantially in FY 2003. Total average spending growth in fiscal year 2003 was 9.3 percent. While this represented significant growth and Medicaid remained one of the fastest growing parts of state budgets, it was significantly lower than the 12.8 percent growth rate states reported just one year before (Figure 1).

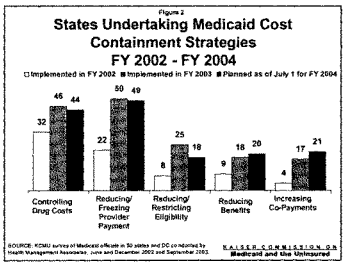


This decline, which is a one-quarter reduction in Medicaid spending growth, was the first time since 1996 that the rate of growth in Medicaid spending was less than the preceding year. The slowing growth rate of Medicaid spending is a significant departure from trends in private health insurance, where the rate of growth in employer-sponsored health benefits increased to 13.9 percent in 2003 from 12.9 percent in 2002. The primary factor behind the slowing rate of growth in Medicaid spending is likely to have been the cost containment strategies states have put in place. In addition, recent restrictions on state use of some federal financing

strategies probably also contributed to the lower growth. Nevertheless, the slower rate of growth in overall spending to 9.3 percent is remarkable in light of the fact that the number of people enrolled in Medicaid increased in FY 2003 by 7.8 percent, slowing somewhat from the 9.2 percent increase in the prior year.

All 50 states and the District of Columbia implemented Medicaid cost containment measures in FY 2003, and each of these states planned to put in additional spending constraints in FY 2004. The KCMU survey found that every state in the nation, including the District of Columbia, executed at least one new Medicaid cost containment strategy in fiscal year 2003. This represents slight growth from the 49 states and D.C. that reported undertaking fiscal year 2003 Medicaid cost containment activity in our last survey, which was completed in December. Moreover, every state planned to undertake additional cost containment action in their Medicaid programs in fiscal year 2004.

State cost containment activity continued to focus heavily on reducing provider payments and controlling prescription drug spending (Figure 2). Forty-nine states either froze or reduced provider payments, and 44 states put new mechanisms in place to reduce their spending growth on prescription drugs in FY 2004. At the same time, 18 states planned to restrict eligibility, 20 states planned to reduce the availability of benefits, and 21 states made plans to increase co-payments in FY 2004.



While most of the eligibility restrictions states have put in place have been narrow, a few of these restrictions have been large. A number of the larger restrictions have reduced coverage for parents and other adults. Significant numbers of children are also likely to be affected by some of the eligibility reductions. Most states have not targeted eligibility for seniors and people with disabilities. However, many of the benefit reductions states are making will affect seniors and people with disabilities. Moreover, as the biggest users of prescription drugs, these individuals are particularly likely to be affected by some of the many different prescription drug cost containment strategies, such as increased co-payments, that states are putting in place.

At the same time they implemented cost containment strategies in FY 2003 and FY 2004, some states also put in place some program expansions. These were generally modest, though three states undertook more significant expansions. Moreover, after reductions in FY 2003, in FY 2004 a number of states reported making improvements to their application and enrollment processes. States also continued to increase their efforts at disease and case management as well as combating fraud and abuse.

The recent federal fiscal relief to states helped forestall additional and larger reductions to the Medicaid program, but this relief is only temporary. In June, Congress provided $20 billion in fiscal relief to states, including $10 billion through a temporary increase in federal Medicaid matching rates. The survey found that these funds, which took effect recently and are scheduled to expire near the end of fiscal year 2004, were critical to helping to prevent additional, larger Medicaid cost containment action in states. The fiscal relief also helped some states avoid significant reductions in eligibility. At the same time, state officials expressed strong

concern about their budget situations in FY 2005, when the fiscal relief is no longer available. States do not expect that their fiscal conditions will have improved significantly by the time the federal fiscal relief expires next spring.

For many states, fiscal year 2004 marked the third consecutive year the state took new action to reduce spending growth in their Medicaid programs. When the results of this survey were compared to the results of our previous surveys, we found that between fiscal 2002 and 2004, 50 states had reduced or frozen provider payments at least once, and 50 states had restricted prescription drug spending at least once. In addition, between FY 2002 and 2004, 34 states took one or more action to reduce eligibility in the Medicaid program, 35states acted at least once to restrict benefits, and 32 states increased or added copayments at least once.

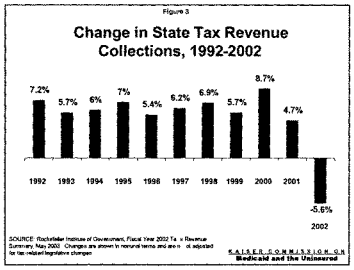
The outlook for state budgets in FY 2004 and 2005 remains challenging. The state revenue picture remains depressed. Spending pressures continue to build. States have exhausted a lot of one-time measures they have used to balance their budgets. Medicaid expenditure assumptions in FY 2004 appear optimistic, and Medicaid budget shortfalls are likely in a majority of states. Finally, the federal fiscal relief expires near the end of fiscal year 2004, which will leave states with significant gaps in their budgets. Present expectations of low revenue growth and continued substantial growth in Medicaid spending mean that states are likely to continue to look for additional ways to curb Medicaid spending growth.

States are increasingly emphasizing Medicaid cost containment as part of their overall budget balancing efforts. Most states have put in place a comprehensive array of Medicaid cost reduction strategies over the past three or four years. These strategies appear to have been successful in reducing the rate of Medicaid spending growth. But they also raise real questions about how the program will be able to meet the health care needs of low-income people, whose numbers are growing. In some cases, reducing provider payments, restricting benefits, and some prescription drug spending controls can limit beneficiaries' access to services they need. Recent changes to eligibility mean that the program, while growing, will not be serving some low-income, uninsured persons who previously would have been eligible. These changes raise the possibility of an increase in the number of uninsured. And increases in copayments may impact the availability of services for some low-income beneficiaries. As states enter another year – or more – of Medicaid cost containment, they continue to struggle to balance the health needs of their low-income citizens with the need to close what are for many states gaping holes in their overall state budgets.

Introduction

Medicaid is the nation's largest public health insurance program. Medicaid provides health and long-term care coverage to 51 million low-income people, including children, families, seniors, and people with disabilities, and fills in gaps in Medicare coverage for seniors, especially for prescription drugs and long-term care. On average, Medicaid covers about one in every nine Americans, with the exact percentage of residents covered by Medicaid varying by state. To meet the broad needs of the population it covers, Medicaid covers a range of comprehensive services, including physician and hospital care, nursing home care and prescription drug coverage. Medicaid also plays a major role in our country's health care delivery system, paying for nearly half of all nursing home care and 17 percent of prescription drugs.

Recently, Medicaid has become subject to strong budget pressure as a result of the states' fiscal crises. Beginning in 2001, as the national economy worsened and growth in state tax revenue slowed, states began focusing on controlling spending. By fiscal year 2002, state revenues had fallen sharply, and in fiscal year 2003 state revenue trends remained dismal (Figure 3).

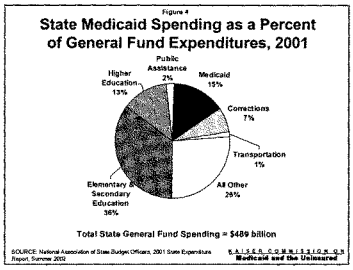


Today states continue to face extremely difficult fiscal situations. Nearly every state has spent the past three years putting in place actions to reduce spending growth in their Medicaid programs, including reducing benefits, eligibility, and provider payments. The present situation stands in stark contrast to the mid to late 1990's, when states, enjoying extremely strong revenue growth and historically low health care spending increases, used Medicaid to expand coverage and to lower the number of their residents living without insurance.

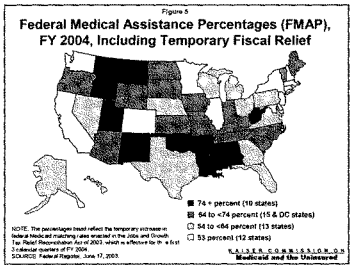
Since 2001, the Kaiser Commission on Medicaid and the Uninsured (KCMU) has worked with Health Management Associates (HMA) to survey the changes states are making to their Medicaid budgets as a result of their deteriorating fiscal conditions. The 50-state survey also tracks changes in Medicaid spending growth. This is the third comprehensive annual survey that KCMU and HMA have published. We have also published two mid-year survey updates, the most recent of which was released in January 2003. This report publishes the results of this third comprehensive survey, which was completed in June.

Background: The Medicaid Program and State Budgets

Medicaid provides health and long-term care coverage to 51 million low-income children, families, seniors, and people with disabilities. Medicaid is jointly funded and administered by the states and the federal government. It is expected to cost the federal government $169 billion in fiscal year 2004, according to the Congressional Budget Office, with the states spending an additional estimated $127 billion. On average, states spend about 15 percent of their own funds on Medicaid making it the second largest program in most states' general fund budgets (Figure 4).



The federal government matches state spending for the services Medicaid covers on an open-ended basis. The federal matching rate, known as the federal medical assistance percentage (FMAP) varies by state (Figure 5).

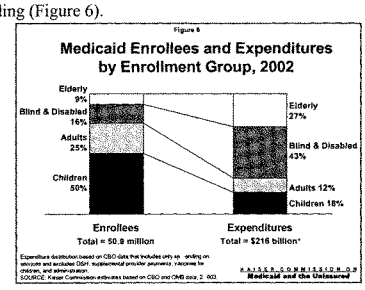


Because of the matching formula, state spending on Medicaid brings increased federal dollars to the state. For example, at a 50 percent matching rate, a state draws down $1.00 for every dollar it spends. Likewise, at a 70 percent matching rate, a state draws down $2.33 for every $1 it spends. Medicaid's matching formula provides an important incentive for states to draw down federal dollars and to increase funding for health and long-term care services.

States have the responsibility to design and administer their program within the federal rules that define the terms and conditions under which a state can earn federal matching funds. Within the federal structure, states enroll beneficiaries using their own eligibility criteria, decide which services are covered, and set payment rates

for providers. States also decide other key policies, such as which eligibility groups receive care within a managed care system, how the state will use Medicaid to finance a range of other medical services such as those provided through the mental health or public health systems, and special payments to hospitals that serve a disproportionate share of indigent patients. While the federal government requires states that participate in Medicaid to provide a core set of benefits, it also permits states the flexibility to provide "optional" services at the states' discretion. Optional services include prescription drugs, which all states have elected to provide, as well as services such as dental care, hospice care, and prosthetic devices.

Medicaid expenditures vary by the population being served. Low-income children and their parents represent about three-fourths of Medicaid beneficiaries, but their health coverage is less expensive as they account for just 30 percent of Medicaid spending (Figure 6).



At the same time, persons with disabilities and the elderly account for most of Medicaid's costs. In fact, the elderly and disabled represent just one-quarter of Medicaid enrollees, but they account for 70 percent of Medicaid spending, reflecting their intensive use of acute and long-term care services. Medicaid also plays a significant role in supplementing Medicare coverage for 7 million seniors and people with disabilities who are enrolled in both programs. For these people, Medicaid covers services Medicare does not, most notably prescription drugs and long-term care, and assists with Medicare cost-sharing.

After a period of historically low growth, Medicaid spending began increasing again in 1999. In 2002, total Medicaid spending increased 12.8 percent. This is consistent with the rate of growth in private health insurance premiums. This consistency is not surprising, because Medicaid purchases health care services in the same private market that employment-sponsored insurers do. Higher health care costs, especially for prescription drugs, are a major factor behind the increase in both Medicaid spending and private health insurance premiums. At the same time, Medicaid faces a significant burden that private insurers do not: during a weak economy, Medicaid frequently serves more people, while employer-sponsored health insurers generally serve fewer people. Despite this difference, as this report will discuss, athough the rate of growth in employer-sponsored health insurance continued to increase in 2003, the rate of growth in Medicaid spending fell.

When state revenues decline, as has occurred in many states over the past two years, states generally scale back state spending for all services, from education to health care. Medicaid program reductions can pose a particular challenge, because the need for Medicaid is usually greatest during an economic downturn, when more people live in poverty and qualify for the program. This dynamic is inherent in the design of the program, which serves as insurer of last resort of low-income people. But Medicaid's responsiveness to economic conditions also means that the program frequently grows the fastest when state revenues are down. In other words, the need for the Medicaid program is frequently greatest when states are least able to afford it.

The severity of state fiscal conditions has forced states to consider difficult options that have affected health coverage for millions of low-income people in every state. Over the past three years, nearly every state has tried to limit prescription drug costs and cut or freeze provider payment rates. As the length of the fiscal crisis has endured, states have turned to reducing Medicaid eligibility and limiting benefit coverage.

As states prepared their budgets for FY 2004, most continued to face significant budget shortfalls as state revenue collected was not sufficient to meet state spending obligations. State "rainy day" funds, which had been set aside for difficult budgetary times, were largely depleted because the current economic downturn was severe and hit states quickly. At the same time, spending on Medicaid increased significantly due to higher health care costs and program enrollment growth. As a result, states have continued to look for new ways to control the growth of spending in their Medicaid programs.

Largely as a result of these conditions, a policy debate is underway about the future of the Medicaid program. In June 2003, Congress temporarily increased federal Medicaid matching rates, providing states with $10 billion as part of a larger $20 billion state fiscal relief package. Earlier this year, the Bush Administration proposed to allow states to replace federal matching funds with a fixed allotment of federal funds for their optional services and populations. Most recently, as Congress considers legislation to create a Medicare prescription drug benefit, attention has focused on the federal role in financing prescription drug coverage for individuals who are enrolled in both Medicaid and Medicare. These individuals are referred to as the "dual eligibles," and spending on prescription drugs for these seven million people represents half of all Medicaid spending on prescription drugs.

In FY 2004, states are beginning what is for most the third or fourth consecutive year of fiscal stress. In each of those years, states have put in place new actions to reduce their Medicaid spending growth. As long as their revenues remain low, states will continue to focus on Medicaid cost containment, and these efforts are likely to have a significant impact on the scope of the program and how it serves low-income individuals. Because state revenue growth is projected to remain low and Medicaid costs will continue to grow substantially, states will face an ongoing challenge as they try to both balance their budgets and keep pace with Medicaid spending growth.

Methodology

To track trends in Medicaid spending and the changes states are making to their Medicaid programs as a result of their overall budget pressures, the Kaiser Commission on Medicaid and the Uninsured commissioned Health Management Associates (HMA) to survey Medicaid officials in all 50 states and the District of Columbia. This is the third annual KCMU/HMA survey, and was designed to capture the actions states plan to undertake as they begin fiscal year 2004 and the actions taken in FY 2003.[1] In addition, mid-year update surveys were conducted in 2001 and 2003 to track additional cost containment actions taken after the beginning of the fiscal year. A midyear survey update at the end of 2003 will update the information in this report for fiscal year 2004.

The survey for this report was conducted primarily in June 2003, so states could describe Medicaid cost containment actions implemented in FY 2003 and planned for FY 2004.[2] In most cases, states had completed their legislative sessions at the time of the survey. In the 12 states where the state legislature had not yet adopted the FY 2004 budget at the time of the initial survey, HMA received updated information from the state through August 2003 as their state budgets were adopted. The 2003 survey instrument was designed to provide results consistent with those of our previous surveys.[3]

The data for this report was provided directly by Medicaid directors and other Medicaid staff. The survey was sent to each Medicaid director in late May 2003. Then, a personal telephone interview was scheduled during June 2003. The purpose of the telephone interview was to review the written responses or, if the survey had not been completed in advance, to conduct the survey itself. These interviews were invaluable to clarify responses and to record the details of state actions. Generally, the interview included the Medicaid director along with policy or budget staff. In a limited number of cases the interview was delegated to a Medicaid budget or policy official. Responses were received from and interviews conducted for all 50 states and the District of Columbia.

With regard to their FY 2004 budgets, state officials were asked to report only changes that the state planned to begin implementing in FY 2004. In some cases FY 2004 actions were put in place on July 1. In other cases, the actions are to be implemented during the year when the necessary systems changes and notice requirements are completed. Because implementing these actions is complex, involving large-scale administrative and systems change, and are sometimes subject to legal or political challenge, at times policy changes prove too difficult or complex to be implemented within the original timelines. For this reason, although actions described in this report for FY 2004 represent state decisions to undertake specific policy changes, a few of these actions may not be implemented during FY 2004.[4] In other instances, policies still under consideration and therefore not

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[1] A few questions were added to the 2003 survey to obtain more detailed information, separately identify changes to application and enrollment processes, and to explore states' reaction to recent federal policy changes. For previous survey results, see Vernon Smith, Eileen Ellis, Kathy Gifford and Victoria Wachino, *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002. Publication 4064. Also: Vernon Smith and Eileen Ellis, *Medicaid Budgets Under Stress: Survey Findings for State Fiscal Years 2000, 2001 and 2002*, Kaiser Commission on Medicaid and the Uninsured, January 2002.

[2] State fiscal years begin on July 1 in 46 states. New York begins its fiscal year on May 1, Texas on September 1, Alabama, Michigan and the District of Columbia on October 1.

[3] The survey instrument is included as Appendix J to this report.

[4] For this reason, this survey identified some changes in the number of states carrying out changes in a given fiscal year. For example, in our January survey update, 27 states indicated plans implement eligibility reductions or restrictions in fiscal year 2003. In our June survey, when states were asked for their 2003 eligibility changes, 25 states reported having made such a change. Similarly, 25 states reported in January that they planned to reduce or restrict Medicaid benefits in FY 2003. In this survey, a total of 18 of these 25 states indicated that these reductions were actually implemented in FY 2003. Similarly, although 49 states and D.C. reported undertaking any kind of Medicaid cost containment strategy in January for FY 2003, 50 states and D.C. reported doing so for FY 2003 in this survey.

recorded in this survey may be implemented in FY 2004. Notwithstanding this element of uncertainty, the actions reported here for FY 2004 are those that Medicaid programs had been directed to implement and which they expected to implement as they began the fiscal year.

Because this is the third year of this survey of state Medicaid budgets, we have been able to examine state Medicaid cost containment activity over a three-year period from fiscal year 2002 to 2004. We have aggregated some of this three-year data, and in some places in the report, in addition to showing the number of states who are implementing some types of Medicaid cost containment in 2003 and 2004, we provide the total number of states who have implemented that type of strategy over the 2002 and 2004 period.

Survey Results: State Medicaid Policy Changes for Fiscal Years 2003 and 2004

The 2003 survey found that as the state fiscal crisis enters its fourth year, states increased their focus on Medicaid cost containment in both the 2003 and 2004 fiscal years, with all 50 states and the District of Columbia not only implementing Medicaid cost containment measures in 2003, but also putting additional measures in place in 2004. Probably as a result of these efforts, states have slowed the rate of growth of their Medicaid spending in 2003 to 9.3 percent, down from 12.8 percent in fiscal year 2003. While states report primarily focusing on reducing or freezing provider payments and trying to contain prescription drug spending, many states are also restricting eligibility, reducing benefits, and increasing beneficiary copayments.

The 2003 survey results for FY 2003 and FY 2004 are presented below in the following order:

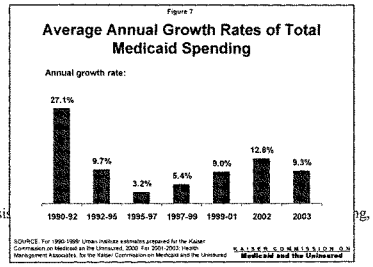
1. Medicaid Spending Growth Rates
2. Medicaid Enrollment Growth
3. Factors Contributing to Increasing Medicaid Spending
4. Medicaid Cost Containment Measures
5. Provider Taxes
6. Role of "Dual Eligibles"
7. Impact of 2003 Federal Fiscal Relief
8. The Outlook for FY 2004

1. Medicaid Spending Growth Rates

The survey asked states to report their total Medicaid spending and spending growth. Total Medicaid spending reflects actual Medicaid payments to medical providers for the services they provide to Medicaid beneficiaries. Total Medicaid payments also include special payments to providers such as Disproportionate Share Hospital (DSH) payments to qualifying institutions meeting specific criteria, or other payments that qualify for federal matching funds. Total Medicaid spending for this survey does not include any Medicaid administrative costs. Total Medicaid spending includes spending from all fund sources, including state, local and federal funds.[5]

In FY 2003, total Medicaid spending increased on average by 9.3 percent. Although this is a substantial growth rate, it is significantly lower than the 12.8 percent growth rate states reported just one year ago, for fiscal year 2002 (Figure 7). Looked at another way, states reduced the rate of growth in Medicaid spending by just over one quarter in the past year. The FY 2002 total Medicaid spending increase had been the highest rate of growth since FY 1992. FY 2003 marks the first time since 1996 that the rate of growth in Medicaid spending was less that the previous year.

Figure 7

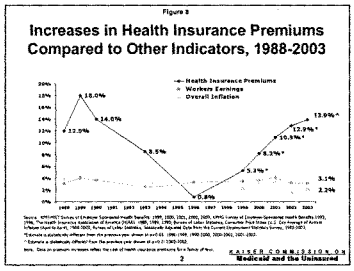


[5] Because it is difficult to apply consis ng, we report only growth rates, not total spending levels.

This significant decline in the Medicaid spending growth rate implies that states' cost containment efforts have been successful in reducing the rate of increase in their Medicaid spending. In FY 2003, a number of underlying factors, including increasing enrollments as a result of the weak economy and ongoing increases in health care costs, might have led to an even higher rate of growth, but state Medicaid programs implemented a wide range of cost control measures that slowed the rate of growth. These measures are described later in this report. Federal restrictions on Medicaid financing strategies and Disproportionate Share Hospital (DSH) payments were also likely contributors to the declining growth rate of Medicaid spending.

This rate of growth in Medicaid spending can be viewed through two lenses. First, it can be compared to the rate of growth in other state programs, which was negligible, and to total state revenues, which was negative. Overall state spending in 2003 for all programs increased by only 0.3 percent. Preliminary data for FY 2003 indicate that FY 2003 tax revenue declined 0.2 percent, when inflation and legislative changes are accounted for.[6] Compared to these measures, the rate of growth in Medicaid spending is substantial.

However, Medicaid spending growth can also be compared to that taking place in the private insurance market, which buys many of the same health care services and faces many of the same cost pressures as Medicaid does. Medicaid's growth rate is also significantly lower than the growth of private health insurance premiums. In 2003, the rate of growth in premiums for employer-sponsored health insurance increased to 13.9 percent from 2002, when it grew 12.9 percent (Figure 8).[7] In comparison with employer-sponsored health insurance, Medicaid spending growth rates were more than 4.5 percentage points lower. This disparity would become even greater if the growth rates were compared on per-enrollee basis, because Medicaid enrollment has been growing as a result of the weak economy, while enrollment in employer-based coverage generally declines when the economy is weak and businesses employ fewer workers.



In the past, the KCMU/HMA state budget surveys have reported on the growth rate of state spending on Medicaid as well as total Medicaid spending. Although federal matching payments mean that the federal government shoulders the bulk of the Medicaid costs, states make their spending and policy decisions for

[6] See National Governors Association and National Association of State Budget Officers, Fiscal Survey of States, June 2003, www.nga.org. and "The State Fiscal Crisis and its Aftermath" by Donald J. Boyd, Kaiser Commission and Medicaid and the Uninsured, September 22, 2003, ww.kff.org.

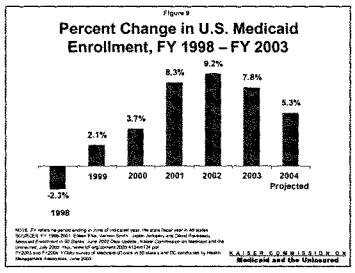
[7] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, "2003 Annual Employer Health Benefits Survey, September 2003, http://www.kff.org/content/2003/20030909a/

Medicaid on the basis of the cost to the state in terms of the state funds that are required to maintain the program. However, the survey was not able to obtain reliable data on the change in state-only spending on Medicaid.

As the survey was being conducted, federal policy changes temporarily increased the federal share and reduced the share of state Medicaid spending. The June 2003 tax cut law included a temporary increase of 2.95 percentage points in the federal Medicaid matching rate (FMAP) for all states for the period from April 2003 through June 2004 as part of a larger fiscal relief package. Because of the timing of this survey, this temporary increase in FMAP was not completely reflected in state Medicaid spending growth rates for FY 2003 and 2004. Some states responded to the survey before the fiscal relief was enacted, and therefore did not include estimates of the effect of the fiscal relief in their growth rates; other states responded to the survey after the fiscal relief was enacted, and did include the effect of the fiscal relief. As a result, the results of the responses to this survey question were not reliable and are not reported here.

2. Medicaid Enrollment Growth

Enrollment in the Medicaid program is still growing, but at a somewhat slower rate. States reported that Medicaid enrollment growth would average 7.8 percent in FY 2003, according to the results of the survey. Looking ahead to FY 2004, Medicaid officials reported that Medicaid enrollment is projected to continue to grow at a significant but slower pace, averaging 5.3 percent (Figure 9). These increases for FY 2003 and FY 2004 represent a slowing in growth from the two previous years. A separate survey designed to look specifically at Medicaid enrollment growth, which relies on data sources different from those used in this survey, documented that Medicaid enrollment increased by 8.3 percent in FY 2001 and by 9.2 percent in FY 2002.[8]



State officials attributed the current enrollment growth to the economic downturn and the associated increase in number of low-income uninsured persons newly eligible for Medicaid. The effect that a weak economy can have on enrollment in Medicaid has been well documented. The Urban Institute has estimated, for example, that a one percent increase in the unemployment adds 1.5 million people to the Medicaid program, at a cost of $1 billion in state Medicaid spending.[9] State officials also cited eligibility expansions of the late 1990s as contributing to increased enrollment.[10]

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[8] Eileen Ellis, Vernon Smith, Jason Jorkasky and David Rousseau, *Medicaid enrollment: June 2002 Data Update*, Kaiser Commission on Medicaid and the Uninsured, July 2003. Publication 4124.
http://www.kff.org/content/2003/4124/4124.pdf

[9] "Medicaid Coverage During Rising Unemployment, Kaiser Commission on Medicaid and the Uninsured," December 2001, http://www.kff.org/content/2001/4026/4026.pdf.

[10] For a fuller discussion of this dynamic, see John Holahan and Brian Bruen, "Medicaid Spending Growth 2000-2002," Kaiser Commission on Medicaid and the Uninsured, September 2003, www.kff.org.

Comments of State Medicaid Officials on Medicaid Enrollment:
"I am very concerned about the economy and the caseload. That is a big uncertainty for us right now."
"We are starting to see some leveling off [in enrollment]. Can't say it is a trend yet, but it is leveling."
"I am assuming our caseload growth is going to mellow out."
"We anticipate somewhat less dramatic growth in [children and family] caseloads in FY 2004. However, the increasing price and utilization of services used most by ABD [aged, blind and disabled] will continue to be a major factor in FY 04."

When asked to describe which eligibility groups they believed were contributing most to current expenditure growth, many Medicaid officials mentioned children and families first, since that was the group most directly affected by the economy and where most of the enrollment growth was occurring. However, because the elderly and disabled beneficiaries are so much more expensive on average than children and families, a majority of Medicaid officials indicated that their cost growth was primarily due to the adult disabled and the elderly categories, even though enrollment growth was less dramatic for these eligibility groups.[11]

3. Factors Contributing to Increasing Medicaid Expenditures

State Medicaid officials were asked to identify the factors they believed had been most significant in causing Medicaid spending to increase in their state over the past year, FY 2003, and also for FY 2004. This was an open-ended, non-structured question. HMA grouped states' responses into five categories.[12]

It was clear that in FY 2003 Medicaid spending growth was not attributable to a single dominant factor. In fact, nearly four out of five states listed three key factors that in combination were regarded as the top drivers of Medicaid spending growth: prescription drug cost growth (40 states), increasing costs of medical services (37 states), and Medicaid enrollment growth (36 states). In light of the recent and continuing significant increases in enrollment growth, it is perhaps not surprising that for the first time in the three KCMU/HMA state Medicaid budget surveys, enrollment growth was the factor most frequently listed first as the most significant contributor to Medicaid spending growth. A total of 23 states listed enrollment growth ahead of all other factors as the most important contributor to Medicaid spending increases. A total of 16 states listed increased costs of prescription drugs first, ten states listed rising costs of medical care as the most significant factor, and three states listed long-term care. (In last year's survey, the increasing cost of prescription drugs was listed first by 25 states, followed by increasing growth in Medicaid caseloads, which was listed first by 18 states.)

For FY 2004, Medicaid officials indicated that the same factors were expected to continue to drive Medicaid spending. In 45 states and the District of Columbia, officials indicated they expected exactly the same factors to influence spending growth. In five states, the order was changed, but the factors remained the same.

Comments of State Medicaid Officials on Factors Increasing Medicaid Expenditures:
"We have almost every dynamic that would cause spending to go up."
"Even though elderly and disabled caseloads are growing just 2 percent, and most of the caseload growth is in families, the costs are mostly for the elderly and disabled. The elderly and disabled are really driving cost."
"Hopefully we won't have another year like that. We are just holding our breath that the economy is going to pick up."

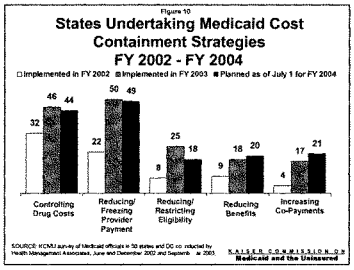
[11] Ibid. Also, the Kaiser Commission on Medicaid and the Uninsured analyzed growth in Medicaid expenditures as projected in the Federal CMS January 2003 Medicaid baseline. The analysis showed that the elderly and disabled accounted for 62 percent of the expenditure growth from fiscal year 2002 to 2003, while children accounted for 21 percent and adults 17 percent.

[12] For example, increasing enrollment included responses such as "higher caseloads," "more eligibles," or "higher numbers of recipients." Pharmacy cost growth included factors such as "increasing costs of drugs," "higher utilization of drugs," higher product costs for drugs." A group labeled "increasing medical costs" included "higher hospital costs and utilization," "overall medical inflation," "increases in mental health costs and utilization," "increases in managed care costs," and "higher costs for medical services." Similarly, other responses were grouped under increasing long-term care costs and other factors.

"The problem we have is the persistent growth in expenditures in health care."

4. Medicaid Cost Containment Measures

The survey found that every state in the nation, including the District of Columbia, executed at least one new Medicaid cost containment strategy in fiscal year 2003. This represents slight growth from the 49 states and D.C. that reported undertaking fiscal year 2003 Medicaid cost containment activity in our last survey update, which was completed in December. Moreover, every state planned to undertake additional cost containment action in their Medicaid programs at the outset of fiscal year 2004 (Figure 10). This comes on the heels of significant previous cost containment activity in Medicaid. In 2002, 45 states had implemented cost containment measures in their Medicaid programs.[13] FY 2004 will be the third, and for some states, the fourth consecutive year that states have implemented significant Medicaid cost containment initiatives. Most states are implementing not just one, but many different cost containment strategies simultaneously.[14]



This section outlines the different cost containment strategies states reported undertaking in fiscal years 2003 and 2004, and is divided into the following sections:

- Provider payment rate decreases or freezes
- Pharmacy utilization and cost control initiatives
- Benefit restrictions or reductions
- Eligibility restrictions or reductions
- New or higher copayment requirements
- Managed care expansions
- New disease or case management programs
- Enhanced fraud and abuse controls
- Long-term care initiatives

The cost containment actions described in this report are those newly adopted for implementation in each fiscal year. State actions adopted in previous years are not listed even though they may continue to be in effect. Specific cost-containment actions newly taken by states in FY 2003 are summarized in Appendix B. Actions for

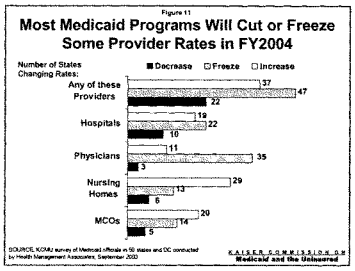
[13] Vernon Smith, Eileen Ellis, Kathy Gifford and Victoria Wachino, *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002. Publication 4064.

[14] For example, Kentucky implemented 14 cost containment actions in fiscal year 2002 and 43 actions in fiscal year 2003. See "Kentucky's Roadmap in Closing the Gap," presentation by Marcia Morgan, Secretary, Cabinet for Health Services, Commonwealth of Kentucky, for Foundation for Healthy Kentucky's Forum on Medicaid, http://www.healthyky.org/

FY 2004 are in Appendix C. Specific state-by-state actions on pharmacy, eligibility and benefits are listed in Appendices D through I.

Provider Rate Cuts or Freezes

In FY 2003, fifty states reported that they cut or froze Medicaid payment rates for at least one group of providers (i.e., hospitals, physicians, managed care organizations or nursing homes). Virtually every state (49 states) froze rates (i.e., neither increased or cut rates) for one or more provider groups (Figure 11).



In 21 states, payment rates were actually cut for one or more provider groups. At the same time, 39 states reported that they increased rates in FY 2003 for one or more other provider groups.[15]

Comments of State Medicaid Officials on Payment Rate Cuts and Freezes:
"We tried to hold off on any rate decreases due to the access issues."
"Whenever you don't raise rates, that is an effective form of cost containment."
"We haven't increased Medicaid rates for a long time."
"We've had good provider participation here. When you start freezing rates for two or three years at a time, you begin to get a little concerned."

The results for FY 2004 are consistent with those for FY 2003. In FY 2004, a total of 49 states indicated they would be freezing rates for at least one provider group, including 21 states that will also cut rates. A total of 37 states plan to increase rates for one or more provider groups for FY 2004 (Figure 11).

- *Physicians*: Physician rates were cut or frozen in 41 states in FY 2003 and in 38 states in FY 2004. In FY 2003, five states cut and 36 states froze physician rates. In FY 2004, three states cut and 35 states froze physician rates. Physician rates were increased in 11 states in FY 2003, and again in 11 states in FY 2004.

- *Inpatient Hospitals*: Inpatient hospital rates were cut or frozen in 31 states in FY 2003 and in 32 states in FY 2004. In FY 2003, nine states cut and 22 states froze hospital payment rates. In FY 2004, ten states cut and 22 states froze hospital payment rates. Hospital rates were increased in 22 states in FY 2003, and in 19 states in FY 2004. Payment increases for hospitals often reflect state statutory requirements to increase rates annually based on a specific index.

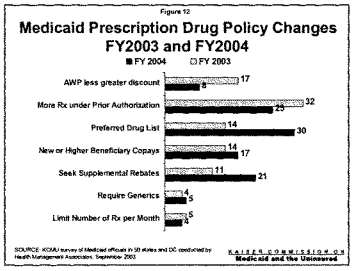
[15] The survey recorded inflation adjustments to provider rates as increases. In our previous surveys, states were not specifically asked to record inflation adjustments as increases, so comparisons with the results of our previous surveys on provider payment reductions should not be made.

- *Nursing Homes:* Nursing home rates were cut or frozen in 17 states in FY 2003 and in 19 states in FY 2004. In FY 2003, five states cut and 12 states froze nursing home rates. For FY 2004, six states cut and 13 states froze nursing home rates. Nursing homes were the provider group most likely to be given a rate increase in both years, with increases in 33 states in FY 2003, and in 29 states in FY 2004. These increases often reflect preexisting state statutory requirements that dictate rate increases based on a cost index.

- *Managed Care Organizations*: Managed care organization (MCO) capitation rates were cut or unchanged in 21 states in FY 2003, including two states that cut and 19 states that allowed no annual change in the rates. In FY 2004, rates were cut or unchanged in 19 states, including five states that cut and 14 states that froze rates for MCOs. In states that set rates administratively, MCO rate reductions or freezes reflect actuarial adjustments made to account for the rate cuts, rate freezes or benefit cuts or restrictions that were made in the fee-for-service Medicaid program. MCO capitation rates were increased in 20 states in FY 2003, and also in 20 states in FY 2004.

Prescription Drugs

Cost-containment initiatives related to pharmacy were implemented by 46 states in FY 2003 (Figure 12). For FY 2004, a total of 44 states indicated that they would implement new or additional pharmacy-related initiatives. States continue to focus significant cost-containment attention on this area, reflecting on-going efforts to slow the multi-year double-digit cost growth for prescription drugs.



Comments of State Medicaid Officials on Pharmacy Initiatives:
"The resistance to cost containment initiatives for eligibility and pharmacy was significant and thwarted implementation, [but] all of those savings are assumed in this year's budget."
"We are still aggressively moving forward with pharmacy cost containment. We hope to enter into [supplemental] prescription drug rebates this year."

For FY 2004, there was a trend toward more states developing and implementing preferred drug lists (PDLs) and seeking supplemental rebates, and fewer states cutting the payment they allow for drug products. In addition, as described in a later section, a significant trend is toward greater use of beneficiary copayments for prescription drugs. See Appendix D for more detail on pharmacy cost containment actions for FY 2003, and Appendix E for FY 2004.

Changes to Benefits

Between FY 2003 and FY 2004, there is a slight increase in the number of states that are undertaking benefit reductions. Eighteen states restricted or reduced the availability of benefits in FY 2003, and 20 states plan to reduce or restrict benefits in FY 2004. Between FY 2002 and FY 2004, 35 states have taken actions to reduce benefits in at least one of those three years.

In general, the benefit reductions in 2003 and 2004 focused on reducing or eliminating "optional" services, which states offer at their discretion. These reductions and eliminations focused primarily on adults enrolled in Medicaid, and in most cases included seniors and people with disabilities. However, as discussed below, some of these benefit reductions involved benefits related to children. And while most states put in place fairly narrow benefit restrictions, two states Oregon and Utah, significantly restructured their entire benefits package through federal waivers to offer different benefits to different groups of people enrolled in the program. Three states (Connecticut, Massachusetts and Utah) dropped a range of optional services for all adults on Medicaid in FY 2003 (although Utah and Massachusetts restored some of the benefits in FY 2004) and Texas dropped a number of optional benefits for all adults in FY 2004.

Fiscal Year 2003

In FY 2003, a total of 18 states cut or restricted benefits. Half of these 18 states cut or restricted adult dental benefits and six states cut or restricted adult vision benefits. Most commonly, the dental benefit for adults was not completely eliminated but was restricted to emergency procedures while the vision services were usually described as being eliminated rather than reduced or restricted.[16] Other restrictions included:

- Eliminating chiropractic, podiatric, psychological and naturopathic services;
- Eliminating therapies (occupational, physical, speech and mental health);
- Eliminating orthodics and prosthetics;
- Eliminating audiology services;
- Eliminating dentures;
- Limits on hospital lengths of stay;
- Limits on the annual number of covered hospital days;
- New limits on long-term care home therapy, targeted case management, and personal care services;
- Eliminating coverage for circumcisions, and
- Reducing benefits covered through HMOs to parallel previous reductions in fee-for-service Medicaid coverage.

For a state-by-state summary of benefit reductions in FY 2003, see Appendix H.

Comments of Medicaid Officials on Benefit Reductions:
"When we cut a service, we don't really save what we thought we'd get because of the provider reaction. If they don't do the one thing, they do another."
"We don't have a lot of room to go before we are cutting bone."

Fiscal Year 2004

[16] Certain vision-related services are not "optional" and therefore cannot be eliminated. For example, the medical treatment of an eye condition by an ophthalmologist is a mandatory physician service. Eyeglasses and eye exams done to determine eyeglass prescriptions are optional services.

In FY 2004, 20 states cut or restricted benefits. This includes seven states that reduced adult dental services, seven states that reduced chiropractic services and five states that reduced vision or eyeglass coverage. Other cuts or restrictions included:

- Eliminating or restricting podiatric and psychological services;
- Eliminating or restricting therapies (occupational, physical, speech and mental health);
- Eliminating or restricting non-emergency transportation;
- Eliminating audiology services and hearing aids;
- Eliminating dentures;
- Eliminating or limiting home health, care management and personal care services;
- Eliminating respiratory care;
- Limits on number of physician visits;
- Eliminating coverage for circumcisions, and
- Limiting non-emergency outpatient scans (MRI, CAT and PET).

For a state-by-state summary of benefit reductions in FY 2004, see Appendix I.

Although most states focused on eliminating or restricting only one or two services, Connecticut, Massachusetts, Utah and Texas eliminated a broader array of optional services:

Connecticut. In FY 2003, the state eliminated chiropractic services, naturopathic services, podiatry, occupational therapy, physical therapy, speech therapy and psychology services for all adults impacting an estimated 100,000 people.

Massachusetts. In FY 2003, the state eliminated prosthetics, orthodics, eyeglasses, chiropractic services and dentures for all adults impacting an estimated 513,000 people. Coverage for prosthetics and orthodics was restored for FY 2004.

Utah. During FY 2003, the state eliminated podiatry, speech therapy, audiology, occupational therapy, physical therapy, and vision care and also reduced chiropractic services benefit for all adults impacting an estimated 60,000 people. Coverage for speech therapy, audiology, occupational therapy and physical therapy and limited coverage for podiatry was restored for FY 2004.

Texas. In FY 2004, the state eliminated eyeglasses, hearing aids, chiropractic services, podiatry and some mental health services for all adults in the state, including seniors and people with disabilities. The state estimates that these changes will affect 175,000 people in the Medicaid program.[17]

The changes Oregon undertook in 2003 and again in 2004 also stand out. Late least year, the state restructured the Oregon Health Plan (OHP) into three distinct benefit packages. For adults enrolled in "OHP Standard" (which includes parents of children enrolled in Medicaid and SCHIP and childless adults was well as seniors and people with disabilities whose incomes are at or above 75 percent of the federal poverty level), a number of optional services were eliminated in FY 2003, including vision, dental, non-emergency transportation, durable medical equipment, mental health services and chemical dependency services. Prescription drug coverage was eliminated for 13 days, until the state identified funds to use to restore this coverage. At the same time, the state also instituted an additional benefit reduction. Under the 1992 waiver that created the Oregon Health Plan,

[17] Texas also eliminated a range of benefits in its Children's Health Insurance Program.

Oregon set up a prioritized list of covered services. Although eliminating coverage of these services was controversial, Oregon reduced coverage for eight services on the list (from line 566 to line 558) in FY 2003.[18]

In FY 2004, Oregon will make additional significant benefit reductions. Oregon is seeking federal approval to amend its current Medicaid waiver to provide a primary care benefit package to its "OHP Standard" population, eliminating non-emergency hospital services, therapies and home health services for this group while also restoring coverage for mental health and chemical dependency services as well as medical supplies and emergency dental services. Oregon is also seeking federal approval to further reduce coverage under the OHP "Prioritized List" by 30 lines (from line 549 to line 519.)

Although states seem to have focused their benefit reductions on adults, seven of the 20 states that reduced benefits in FY 2004 reduced benefits that could affect families with children. These changes include reductions in non-emergency transportation coverage, limitations on orthodontic care, restrictions on dental coverage and limitations on the annual number of services covered, including limits on physician visits to 12 per year, chiropractic visits to 12 per year, occupational therapy to 20 per year, psychological therapy to 40 per year, speech therapy to 50 per year and physical therapy to 15 per year. It is not clear what affect these limitations will have on children, because under the requirements of the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) provisions of Medicaid, enrolled children are entitled to all services considered medically necessary, even if the Medicaid program in that state does not otherwise cover them.

Although many states undertook benefit eliminations and restrictions, a few states added benefits or lifted restrictions. In FY 2003, five states expanded or restored previously reduced coverage, including reinstating emergency dental services for adults, adding a new hospice benefit, adding case management for chemically dependent adults and adding other new services for waiver populations. In FY 2004, four states fully or partially restored benefit reductions that were made in the previous year, including adult dental services, orthotic, prosthetic, vision and audiology services. One state restored all benefits to levels previously in effect in 2002.

Changes to Eligibility

In FY 2003, twenty-five states reduced or cut eligibility for Medicaid enrollees. In FY 2004, 18 states made new plans to restrict or cut eligibility.[19] Between fiscal years 2002 and 2004, 34 states have made reductions to eligibility in at least one of those three years.[20] These changes are described in detail in Appendixes F and G.

In most cases, states' eligibility restrictions were targeted somewhat narrowly. States reduced continuous eligibility, reduced the length of time during which people can obtain transitional Medicaid, and increased transfer penalties for individuals receiving nursing home care. However, in a few cases states eliminated eligibility for large numbers of people.[21] In addition, three states have either eliminated or significantly reduced their medically needy programs, which allow people with low incomes and high medical bills to qualify for Medicaid.

At the same time, a number of states also made modest eligibility expansions. For example, states that had previously not done so took up recently available options to offer coverage to the working disabled and to

[18] For more information on Oregon's waiver, see the Kaiser Commission on Medicaid and the Uninsured's "Oregon Section 1115 Waiver" fact sheet, http://www.kff.org/content/2003/4101/4101.pdf

[20] For purposes of this survey, changes in eligibility include instituting premiums and changes made to the application and renewal process.

[21] The survey asked states to estimate the numbers of people who would be affected by eligibility and benefits changes. States did not respond consistently, but for those states that did respond, the results are reported in Appendixes D, E, F, and G. Because states did not respond consistently, these numbers cannot be aggregated across all states to obtain national estimates of the numbers of people who have lost or gained coverage.

uninsured women with breast and cervical cancer. These options typically benefit small numbers of people. A number of expansions provided prescription drug-only coverage to elderly Medicaid beneficiaries. These programs were created through federal waivers, and in most cases provide new federal financing for existing state coverage. Notably, as described below, three states adopted significant eligibility expansions.

Fiscal Year 2003

Twenty-five states reduced eligibility in FY 2003.[22] In most states, these reductions were targeted narrowly, and were expected to affect relatively small numbers of people. For example, states made slight reductions in income limitations, restricted Transitional Medical Assistance, instituted additional income testing, and imposed higher premiums for some groups.[23]

Of the 25 states that reduced eligibility in 2003, six states took actions that were intended to eliminate eligibility for large numbers of people:

- Missouri cut 32,600 people from Medicaid by lowering the threshold at which parents become eligible from 100 percent of the federal poverty level to 77 percent of the federal poverty level. It also reduced transitional Medicaid coverage and reduced women's health coverage, affecting an additional 11,000 people, and restricted the ability of people to "spend down" to Medicaid coverage, affecting another 24,000 people.
- Nebraska adopted eligibility reductions designed to cut 25,000 people from the Medicaid program, including about 13,000 children.
- Massachusetts enacted a budget that eliminated Medicaid coverage for almost 50,000 long-term unemployed individuals effective April 1, 2003.
- TennCare eligibility standards were modified as of July 2002 under a new Section 1115 waiver. As part of implementation, Tennessee initiated eligibility re-determinations that removed 200,000 persons from TennCare.
- Michigan adopted a December 2002 executive order intended to eliminate coverage for about 43,000 adults.
- Connecticut eliminated eligibility for 19,000 low-income adults with incomes between 100 percent and 150 percent of the federal poverty level.

The actions in these six states alone were intended to remove about 400,000 persons from Medicaid coverage. In the time since these actions were adopted, implementation of each one has been delayed or limited. Coverage was, for example, restored temporarily for some of the beneficiaries who lost coverage in Missouri and Nebraska by court order. The Michigan eligibility cut was blocked permanently by court order. In Connecticut, a court order has temporarily restored eligibility for approximately 16,000 low-income adults. In Tennessee, at the end of 2002 the court ordered reinstatement of all 200,000 individuals who lost coverage. An appeal by the state delayed this action. In March 2003, during the appeal, the state offered a twelve-month "grace period" during which 150,000 individuals that had failed to contact TennCare during the re-determination period could re-apply for TennCare. At the end of August 2003 a settlement was reached that offered the grace period to an additional 40,000 individuals. In Massachusetts the eligibility cut was implemented and affected

[22] This includes three states that made changes to their application and enrollment processes but did not otherwise reduce eligibility.
[23] States also eliminated the Qualified Individuals (2) program after the federal law authorizing the program expired. CMS informed states in a State Medicaid Director letter issued on November 6, 2002 that the expiration date for Qualified Individuals (2) (QI-2s) was not extended, thereby terminating the program as of January 1, 2003. QI-2s are a category of dual eligibles that have incomes from 135 to 175 percent of the federal poverty level and were enrolled in Medicaid only for assistance with their Medicare Part B premiums. Because this change was made pursuant to federal law, states' elimination of these programs was not counted as an eligibility change.

approximately 34,000 unemployed individuals. The state now has plans to restore this coverage, effective October 1, 2003.

The fact that these eligibility decisions have been partially or fully restored means that some of the 400,000 people who were slated to lose coverage will retain or regain coverage. How many of these beneficiaries will do so is unclear. In some cases, only some groups of beneficiaries were granted restored coverage. In other cases, beneficiaries will have to complete re-enrollment requirements.

In addition to these six states, two states, Oregon and Oklahoma, eliminated their medically needy programs in FY 2003. At their option, states can offer medically needy programs to allow people with high medical expenses whose incomes otherwise exceed program eligibility levels to qualify for Medicaid. As of the beginning of 2003, 35 states offered medically needy programs; with the decisions of Oregon and Oklahoma to end their programs, that number should fall to 33.[24] Oklahoma estimated that its elimination will leave 800 children, 6,500 parents and other adults, and 1,000 seniors without coverage.

Comments of Medicaid Officials on Eligibility Actions:
"It was a tough year. For 20 some years we were geared to building a program to help people and then we had to focus on cutting it back. It was kind of painful."
"All I've done since I got here was cut. Throughout the year we were asked to find new ways to cut. What I feel good about is that we made those cuts and didn't throw anyone off."

Fiscal Year 2004

In FY 2004, eighteen states plan to restrict or cut eligibility for Medicaid enrollees.[25] As in FY 2003, most of these changes were not broad and were expected to affect relatively small numbers of Medicaid enrollees. For example, states decreased resource allowance and income standards for nursing home and other long-term care, eliminated presumptive eligibility for children, and tightened disability criteria.

In FY 2004, three states plan to make eligibility reductions that will affect large numbers of beneficiaries:

- Massachusetts eliminated coverage for "special status" immigrants, affecting an estimated 9,850 people;
- Nebraska eliminated "Ribicoff" coverage for persons ages 19-20 (affecting 3,100 individuals); and
- Texas eliminated coverage for adults in the Temporary Assistance for Needy Families program who failed to meet personal responsibility agreement requirements.[26] It also reduced eligibility for pregnant woman to 158 percent of the federal poverty level (FPL) from its previous level of 185 percent of the FPL. It also dramatically reduced income eligibility for its adult medically needy program to 17 percent of the FPL from 24 percent. These changes together were estimated to affect over 44,000 Texans on the Medicaid program. In addition, although data on the SCHIP program was generally outside the scope of this survey, it is notable that Texas is making significant enrollment and eligibility changes to its SCHIP program. These changes have been estimated to result in over 150,000 children losing coverage.

[24] Jeff Crowley, "Medicaid Medically Needy Programs: An Important Source of Medicaid Coverage, Kaiser Commission on Medicaid and the Uninsured, January 2003, www.kff.org.
[25] This includes one state that increased the redetermination frequency from once every twelve months to once every six months, but did not otherwise make any other eligibility reductions.
[26] This change has been temporarily suspended by court order.

The impact of these eligibility changes will be felt by a wide variety of beneficiaries. Clearly, in terms of loss of coverage, parents seem to be most at risk, as states like Missouri, New Jersey,[27] and Connecticut have made changes designed to affect large numbers of beneficiaries who are parents.

Perhaps more significantly, a number of eligibility changes may also affect children, who have been a high coverage priority for states in recent years. In FY 2003, ten states implemented eligibility reductions that affected children (including reductions that affected families with children). In these ten states, reductions included eliminating continuous eligibility; reducing the amount of earnings disregarded and changing the treatment of household composition for eligibility; counting parental income for pregnant minors. Indiana eliminated continuous eligibility for children, and estimates that 32,000 children will be affected.

In FY 2004, seven states made eligibility reductions that specifically affected Medicaid coverage for children. These cuts included:

- Alaska reduced eligibility levels for its Medicaid expansion SCHIP program from 200 percent to 175 percent of the FPL, affecting approximately 1,300 children;
- Minnesota decreased income eligibility levels and reduced the eligibility period for newborns from 24 to 12 months (affecting approximately 5,000 individuals), and
- Nebraska eliminated presumptive eligibility for children and eliminated coverage for 19 to 20 year-olds, affecting approximately 3,400 children.

In addition, a number of states indicated that they intend to begin charging children and families premiums as a condition of coverage in their SCHIP and Medicaid programs. This change, which is available to SCHIP programs under law but requires a waiver to be implemented in Medicaid, is likely to make coverage unaffordable for some low-income families and reduce enrollment in Medicaid and SCHIP.[28]

At this time, states are not reducing income eligibility for the elderly and disabled in large numbers. They are, however, turning to a variety of more targeted measures, such as changing disability criteria, changing spend down and asset transfer policies, and changing spousal impoverishment criteria, that will affect the number of seniors and persons with disabilities who are eligible for Medicaid coverage of needed long-term care services. In addition, although few states had changed eligibility for immigrants, two states, Massachusetts and Colorado, recently made significant reductions in eligibility for immigrants.

Although some states have made major eligibility reductions, a number of states also undertook expansions. Generally, these expansions were quite modest and affected small numbers of people. States, for example, implemented new Breast and Cervical Cancer coverage or the new "Ticket to Work" coverage for the working disabled[29]. Other states, like Utah, implemented waivers that extended limited benefits coverage to new enrollees. A number of states implemented "Pharmacy Plus" waivers, which provide drug-only coverage to seniors. These waivers typically allow states to refinance their existing state-funded drug programs for seniors to qualify for Medicaid matching funds, as well as extending drug coverage to some new beneficiaries. States that have received these waivers have generally agreed to cap total spending on their elderly and disabled enrollees.

Comment of a Medicaid Official on His State's Eligibility Policy Direction:

[27] As of June 15, 2002, New Jersey stopped accepting applications from parents for Family Care, which provided coverage for parents with incomes up to 200 percent of the FPL, and also changed how it treats income under Section 1931 for parents applying for Medicaid.

[28] Because premiums affect individuals' enrollment in the Medicaid program, states that impose premiums are recorded as having made an eligibility change. Co-payments, which are reported later in the survey, do not include premiums.

[29] This optional category was created by the federal "Ticket to Work and Work Incentives Improvement Act of 1999" (P.L. 106-170).

"We are clearly focused on program expansion."

A few states enacted significant eligibility expansions for FY 2004:

- Illinois extended coverage through its SCHIP program to cover 15,000 adults in 2003 and an additional 12,000 children and 65,000 adults in FY 2004;
- Missouri extended eligibility for seniors and people with disabilities from 80 percent to 90 percent of the federal poverty level;
- The District of Columbia built on an FY 2003 eligibility expansion for childless adults to extend coverage to low-income adults between the ages of 19 and 21 and 50 to 64.

In addition, Maine recently enacted legislation that will expand Medicaid eligibility effective in FY 2005. Maine is extending Medicaid eligibility to parents with income up to 200 percent of the FPL and childless adults with income up to 125 percent of the FPL as part of its comprehensive health care reform plan that was enacted in June 2003, Dirigo Health.

Application and Renewal Process Changes

Throughout the late 1990s, states increasingly adopted measures intended to simplify and streamline the eligibility application and re-determination processes. However, in the face of budget shortfalls, fewer simplifications have occurred, and the recent direction has been to reverse some of the previous simplifications.

In FY 2003, eleven states modified the application or renewal process. In two cases, the action was to simplify the process for enrollees, including eliminating a face-to-face interview requirement for re-determinations and renewals, and simplifying the application forms. However, the other nine states reversed previous simplifications. These actions included reducing the amount of time allowed to respond for re-determinations and adding to the application form to obtain additional information about disability status and third party resources.

In FY 2004, nine states indicated that they would make changes to their application and renewal procedures. Unlike FY 2003, most of these changes are designed to simplify and streamline the process. Although one state eliminated phone centers, thereby stopping telephonic application and interviews and making it harder for beneficiaries to apply, that was the exception, rather than the rule. The other changes adopted for FY 2004 were positive for the beneficiary, including beginning online applications and implementation of call centers to assist with eligibility determination.

Co-payments

Over FY 2003 and FY 2004, increasing co-payments for services has become a central mechanism of state Medicaid cost containment. Federal Medicaid law specifies that copayments must be "nominal," and the law provides exemptions so copayments cannot apply to services provided to children or pregnant women. "Nominal" is generally a maximum of $3.00 per service. Federal law requires that a provider must render a service regardless of whether the copayment is collected. Limits on co-payment amounts in Medicaid law are supported by a substantial body of research indicating that even nominal copayments can deter low-income individuals from receiving needed care.[30]

[30] Julie Hudman and Molly O'Malley, Health Insurance Premiums and Cost Sharing: The Impact on Low-Income Populations, Kaiser Commission on Medicaid and the Uninsured, April 2003. See also Leighton Ku, Charging the Poor More for Health Care: Cost-Sharing in Medicaid, Center on Budget and Policy Priorities, May 2003.

In FY 2003, a total of 17 states imposed new or higher co-payments. Most frequently, in fourteen states, new or higher copayments were for prescription drugs. States also applied new or higher co-pays to non-emergency transportation, hearing, vision, dental and therapies, physician office visits and ambulatory services, and outpatient hospital services. In nine states the new co-pays applied to all adults (except pregnant women). Four states imposed new or higher co-pays for certain groups of adults or waiver recipients, and one state imposed co-pays for all adult populations, and intended to allow no exemptions for federally specified groups.

Comments of Medicaid Officials on Use of Copayments:
"The legislature wanted copays and limits on about everything we could do. We have a mandate from the legislature to do this."
"We have added copays on everything."

For FY 2004, a total of 21 states imposed new or higher copayments. In most but not all cases, states adopted the maximum allowed copayment of $3 per service. Prescription drugs were again the service most frequently subject to a new or higher copayment, with 17 states adding or increasing this copayment for FY 2004. States also imposed new or higher copays for hospital stays (three states), durable medical equipment or lab and x-ray services (three states), outpatient hospital visits (three states), hospital ER visits for non-emergency services (two states), physician office visits (two states), and on FQHC/RHC services, therapies, psychology, podiatry services and hearing tests/hearing aids. Of the 21 states adding or increasing copayments, 17 states imposed copayments for all adults for whom a copayment might be applied and four states imposed new or higher copays on specific certain groups of adults or waiver recipients. Some states reported that they would seek federal waivers to increase copayment amounts for subsets of the Medicaid population above levels currently allowed by federal law. Between 2002 and 2004, 32 states increased or added beneficiary copayments for one or more services.

Fraud and Abuse

In a program that spends as much public money as does Medicaid, it is always important to ensure program and fiscal integrity. In FY 2003, a total of 19 states indicated that they were undertaking new or enhanced fraud and abuse activities. These actions sometimes involved contracts with organizations that specialize in this activity, or the authorization to hire additional staff to focus on this area. For FY 2004, a total of 21 states plan new or enhanced fraud and abuse detection or prevention activities. Between 2002 and 2004 34 states have put at new fraud and abuse mechanisms in place in at least one of those three years.

Comment of Medicaid Official on Efforts to Control Fraud and Abuse:
"We had a great deal of support from our legislature for additional fraud and abuse and for our pharmacy savings."

Disease and Case Management

In FY 2003, thirteen states reported new disease and case management initiatives. For FY 2004, the number of states planning to undertake new disease or care management programs increased to 18. Between 2002 and 2004, 31 states put disease management program in place in at least one of those three years. These initiatives continue to focus on asthma, diabetes, hypertension, depression and congestive heart failure, with new initiatives focusing on case management for complex or high cost cases. Specific responses for FY 2003 included:

- Mississippi: diabetes, asthma and hypertension programs;
- Missouri: asthma, diabetes, depression, and congestive heart failure programs;
- Oregon: disease management for asthma, diabetes, congestive heart failure and case management for fee-for-service clients with annual costs exceeding $20,000;

- Washington: diabetes, renal care, congestive heart failure and asthma programs, and
- Wyoming: chronic care case management.

Specific responses for FY 2004 included the following:

- Idaho: diabetes, asthma and hemophilia programs;
- Massachusetts: high cost cases targeted for care management;
- New Jersey: disease management introduced under the pharmacy program;
- North Dakota: disease management efforts initiated through pharmacies for diabetes, asthma and heart disease;
- Ohio: care management for the aged and disabled population and other high cost cases;
- Oregon: expand to chronic obstructive pulmonary disease, and
- Wyoming: expanding chronic care case management to include prescription drug case management.

Comments of State Medicaid Officials on Cost Containment Actions:
"I'm concerned if we have to go further. We've gone about as far as we can go without negatively affecting other aspects of the program."
"The cost containment strategies proved more elusive in terms of our ability to implement them. This is not a program that lends itself to quick adjustments to respond to budget shortfalls. The problem came up very quickly and it was tough to respond."
"Savings were not as great as anticipated."
"They've [the legislature] taken what used to be just a complicated program and made it impossibly complicated."
"With all these changes, we know we have several [lawsuits] on the horizon."
"We had substantial administrative cuts last year and this year. [That makes it harder to implement these policy changes.]"

Long-Term Care and Home and Community Based Services

Long-term care is a substantial share of Medicaid spending. Yet, only a small share of state budget-driven policy actions were directed at controlling long-term care spending in FY 2003 and FY 2004. Most long-term care spending is for nursing home services, and Medicaid payment rates for nursing homes were increased in 33 states in 2003 and in 29 states for FY 2004. During these years many states have been seeking to enhance home and community-based services (HCBS) as a patient-preferred, lower-cost alternative to institutional nursing home care. At the same time, many states have tightened eligibility criteria to qualify for HCBS services.

In FY 2003 and FY 2004, about four-fifths of states reported policy actions relating to HCBS waivers and services. A total of 24 states expanded the number of HCBS waivers or expanded the number of HCBS waiver "slots,' which defines the number of persons who can be served in these programs. In 16 other states, there were budget-driven efforts to restrict the number of slots, decrease benefits covered under the waiver, institute waiting lists or use other means to limit caseload and expenditure growth in these programs. State officials from several states mentioned that they expected to continue increases in the number and proportion of Medicaid long-term care beneficiaries receiving home and community-based services. Between fiscal years 2002 and 2004, 18 states put restrictions on long-term care in place.

Comment of Medicaid Official on Long-Term Care Policies:
"One of the things we have a problem with is we are trying to do more alternatives to nursing homes...It is going to be a fight all the way."

5. Provider Taxes

In FY 2003, 10 states imposed new provider assessments or taxes. New provider taxes or assessments were most frequently imposed on nursing facilities (5 states), HMOs (2 states) and hospitals (2 states). At the beginning of FY 2003, a total of 21 states had a provider tax of some sort in place. Among those taxes already in place, the most common were taxes or assessments on nursing homes (14), hospitals (10), ICFs/MR (5) and pharmacies (2). In 16 states taxes or assessments applied to more than one category of provider tax.

For FY 2004, 18 states imposed one or more new provider assessments or taxes. Eleven states added a nursing home provider assessment, making it the most frequently imposed new provider assessment, as also had been the case for FY 2003. Three states imposed new assessments on HMOs, three on hospitals and three on ICFs/MR. Two states added new pharmacy taxes. Two states reversed existing provider taxes; one by decreasing a hospital assessment and another state planned to phase out a physician provider tax. States appear to be using the federal funds these provider taxes generate in a number of ways. Some states are devoting the resources to their overall Medicaid budgets. Others are using the funds to give some providers rate increases. Still others are using them to help fill holes in their overall state budgets.

6. Role of "Dual Eligibles"

Elderly and disabled Medicaid beneficiaries also enrolled with Medicare account for a large share of state Medicaid spending, and for a large share of expenditure increases. In this survey, states were asked to indicate the share of Medicaid spending in their state related to these "dual eligibles." The Urban Institute has calculated that spending on dual eligibles accounts for 40 percent of spending on Medicaid.[31]

State Medicaid spending typically is not recorded in a way that makes it easy to determine all spending related to dual eligibles. Although virtually all Medicaid officials expressed great interest in this percentage, many were unable to calculate the percentage from available data. Others offered a response based on the best available data but indicated they believed they were under-reporting this statistic. [32]

A total of 27 states responded to this question. In these states, dual eligibles on average accounted for 34 percent of total Medicaid spending in FY 2003. States indicated percentages that ranged from a high of 60 percent to a low of 13 percent, with the median being 35 percent. Despite the relatively low number of states that responded to this survey question, the results are consistent with other analyses of the share of Medicaid spending the dual eligibles represent.

7. Impact of 2003 Federal Fiscal Relief

The Jobs and Growth Tax Relief Reconciliation Act of 2003, enacted in June 2003, contained two provisions that provided a total of $20 billion in fiscal relief to states in federal fiscal years 2003 and 2004.[33] The legislation provided a total of $10 billion dollars in the form of a temporary 2.95 percentage point increase in each state's federal matching rate for Medicaid programs. The legislation also provided $10 billion in temporary grants for states to use for Medicaid or other state programs. A maintenance-of-effort provision said that only

[31] Jocelyn Guyer et al., "A Prescription Drug Benefit in Medicare: Implications for Medicaid and Low-Income Medicare Beneficiaries" Kaiser Commission on Medicaid and the Uninsured, September 2003.
[32] Twenty-seven states responded to the dual eligible question. Several of these states did a special data analysis to calculate this statistic. Other states did not have this information immediately available or were unable to obtain the information in the time available for this survey.
[33] The FMAP increase is in effect for the last two quarters of FY 2003 and the first three quarters of FY 2004.

states that maintain eligibility at the levels that were in effect as of September 2, 2003 will receive the fiscal relief.

The intent of this legislation was for states to use the additional funding to address both Medicaid and overall budget shortfalls for FY 2003 and FY 2004. To a great extent, the funds accomplished this purpose. This was the case even though the law was adopted and the funds made available to the states nearly at the end of FY 2003 and after more than half the states had adopted their budgets for FY 2004.

Twenty-nine states indicated in this survey that the additional funding was made available after the FY 2004 budget was adopted and thus not officially considered in developing the FY 2004 budget for Medicaid. Medicaid officials in 19 states indicated that their legislatures explicitly factored the additional funding into their Medicaid budget decisions before their legislative sessions came to a close and the FY 2004 budget adopted. However, even states where the legislature had completed the FY 2004 budget were able to describe how the FMAP adjustment would impact the program through the upcoming fiscal year.

In every state, Medicaid officials indicated the fiscal relief was needed and will have a specific positive impact on Medicaid. Indeed, Medicaid directors indicated that the additional federal funding could not possibly have arrived at a time when it was needed more. Twenty-one states indicated the enhanced FMAP would provide general relief within their Medicaid programs. In an additional 19 states, the enhanced FMAP was going to be used to soften or prevent cuts that otherwise would have been made, or to restore reductions that had already been made. Specific examples are provided below:

- Alaska reported that the state plans to delay Medicaid cuts by one year.
- In Arizona the fiscal relief prevented cuts for small optional programs, such as Ticket to Work for the working disabled, coverage for women with breast and cervical cancer, and Medicaid waiver expansion for parents of Medicaid and SCHIP children.
- In Louisiana, the fiscal relief reduced the severity of originally planned long-term care and pharmacy cuts that had been proposed to reduce state Medicaid funding by up to 15 percent.
- Missouri reported that the fiscal relief helped reduce the severity of eligibility cuts for parents, and allowed increase the state to increase eligibility for aged and disabled significantly, from 80 percent to 90 percent of the FPL.
- Ohio said that the fiscal relief allowed the state to prevent a planned parent eligibility rollback that affected approximately 60,000 people
- In Oregon, the fiscal relief reduced additional cuts that would have been made to the Oregon Health Plan
- According to South Carolina, the fiscal relief prevented cuts that otherwise were being considered to eligibility for SCHIP, to lower eligibility for the elderly and disabled, which could have been reduced from 100 percent to 85 percent of the FPL and to eliminate optional services.

In five states, officials said that the additional funding would be placed into a dedicated Medicaid trust fund or into the state general fund for future reserves. These are funds that support the program and from which funding might be drawn when a Medicaid budget shortfall occurs, so it may prevent future Medicaid cutbacks. Four states indicated that the enhanced FMAP would be used specifically to relieve the existing Medicaid shortfall. In two states Medicaid officials indicated that the enhanced FMAP would facilitate eligibility expansions that were being discussed.

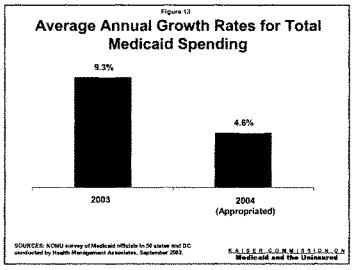
State officials reported that the temporary enhanced FMAP on Medicaid had helped them through a very difficult fiscal period. However, Medicaid officials did not see this temporary relief as addressing the longer-term significant problems of financing Medicaid. Medicaid directors expressed strong concern about FY 2005, after the fiscal relief expires. Because their FY 2005 budget preparation was already underway, many state

officials were keenly aware of the temporary nature of the enhanced FMAP, and the dramatic fiscal impact on states when the funding ends on June 30, 2004.

Comments of State Medicaid Officials on Federal Fiscal Relief:
"We were short of appropriations [for FY 2003]. Because of the new federal match, we know we are going to make it. It was a tight year."
"The fiscal relief package is a one year deal. After that it gets real bad."
"It should help us get back on track."
"The eligibility cut has been prevented by the new FMAP."
"We have a budget but we have a significant hole in that budget. There is a big cloud hanging over it, even after accounting for the FMAP relief."
"Had we not had that [fiscal relief], golly, I don't know what we would have done, because there is not other money laying around."
"We were being pushed very hard. This will take off some of the pressure."
"We are focused on program expansions and we are committed to them. The FMAP will help us in the overall picture."
"The special match rate really bailed us out this year."
"The federal relief has allowed us to step back from the brink."
"That [enhanced FMAP] is the only saving grace. People were looking at some pretty draconian cuts, that now we can put on the back burner."
"FMAP was a godsend to us."
"The increase in FMAP virtually assures that we will not have to make cuts even if we have increases in utilization. The outlook for '04 is much more positive now."
"The FMAP change has given us some temporary breathing room."
"They sent us the FMAP and it was gone before it got here."

8. The Outlook for FY 2004

The overall state budget picture is not expected to improve in the near term. State revenue collections will remain low, and spending pressures continue to build. At the same time, there is evidence that the FY 2004 growth rates states have adopted are optimistic. States expect Medicaid spending growth rates to fall further in FY 2004. For FY 2004, legislatures authorized increases in total Medicaid spending that averaged 4.6 percent (Figure 13). This is almost the same level as the 4.8 percent legislatures originally authorized for FY 2003[34], when actual spending turned out to increase by 9.3 percent. The FY 2003 experience illustrates that the FY 2004 authorization should not be interpreted as a projection of actual spending, even though it is the current legal limit on Medicaid spending.[35] Actual Medicaid spending growth is likely to be significantly higher.



[34] See 2002 survey, September 2002.
[35] In a few states, such as Kansas and Rhode Island, the legislative authorization for Medicaid is adjusted automatically to the required level based on a statutorily established periodic re-estimation process.

Because original FY 2003 Medicaid appropriations on average were substantially below actual spending levels, many states found themselves needing to appropriate additional funds for Medicaid during the fiscal year. In FY 2003, a total of 35 states experienced a Medicaid budget shortfall. A "Medicaid budget shortfall" occurs when the legislative appropriation is insufficient to cover expected actual expenditures. States closed their FY 2003 budget gaps through supplemental appropriations (in 16 states), from reserve funds (5 states), from savings from additional program reductions (6 states), from tobacco settlement funds (2 states) and from the temporary increase in the federal Medicaid matching rate (6 states).

At the outset of FY 2004, fewer Medicaid officials expected a Medicaid budget shortfall in the upcoming year: in 32 states Medicaid officials believed the likelihood of a Medicaid budget shortfall in FY 2004 was at least 50-50. Given an average appropriated growth rate of 4.6 percent, a significant number of states are likely to need additional funds or additional program cuts over the course of FY 2004.

Comments of Medicaid Officials Concerning Potential FY 2004 Shortfalls:
"We are going to have to manage the shortfall. We may have to take more drastic actions. Our state budget situation is not good and our Governor is committed to not draw from our reserves. We are not allowed to have a supplemental this year."
"The legislature believes it fully funded our budget request but we are concerned."
"We have made all kinds of assumptions for budget cuts. If the assumptions are not correct, we have no wiggle room."

Comments of State Medicaid Officials on Outlook into FY 2004:
"It is highly likely that sometime this year [FY 2004] we will be asked for more cuts."
"[FY 2003 was] a challenging year, but I think '04 will be even more challenging."
"I don't see it letting up. Everybody keeps placing new demands on us, but with no money. I don't know where it stops."
"A lot of funding for this year [FY 2004] was from non-recurring sources. If the economy picks up, we might not have to cut too much more in '04."
"'04 and '05 are all about controlling the rate of growth. We are still seeing rates of growth that are unsustainable."
"The real problem is '05. '05 will be huge. You have all this pent up demand, and we've used one-time money to plug the gaps in '03 and '04. Come '05, there is going to be a huge gap between available revenue and forecasted expenditures. You can keep the cork on the bottle only so long. I don't know where the cushion is going to come from to get us through '05."
"We are hoping to get stable. We've been in a state of flux for too long. We are hoping to do some positive things."
"It is going to be an interesting year. But it's a lot better than we'd anticipated in the middle of FY 2003."
"I don't have any extra money. I think '04 will be a horrible year. There is a cliff coming ['05] and they [the legislature] don't want to deal with it."
"There is so much uncertainty right now. I'm just looking to try to stabilize the program and to begin to look at new initiatives and program implementation, not just survival."
"The budget process this year was brutal. We've already started the process of '05. We don't even get a break. It's going to be just as tough or tougher next year."

Conclusion

States continue to face extraordinary budgetary pressures. With revenues declining and spending increasing, they have tried to contain costs in all programs in their budgets. Over the past several years, all states have focused on reducing Medicaid spending. This survey found the pace of state Medicaid spending growth declined in FY 2003 for the first time since 1996. Aggressive state cost containment efforts are believed to be the primary factor contributing to states' ability to hold Medicaid spending to just over 9 percent. The survey also found that all 50 states and the District of Columbia initiated new Medicaid cost containment action in FY 2003, and that all 50 states and the District of Columbia planned additional new cost containment strategies in FY 2004. While states have focused heavily on reducing provider payments and controlling spending on prescription drugs, they have also reduced benefits and eligibility and increased copayments. Together, these actions served to slow the rate of increase in overall Medicaid spending.

Medicaid is intended to be a counter-cyclical program, with higher enrollment and costs during times of economic downturn and depressed state revenues. Its recent spending rates have been substantial, and have been difficult for states to accommodate within overall state spending that has been flat. States' Medicaid cost containment efforts appear to have been successful in reducing Medicaid spending growth. Still, success in Medicaid cost control came at the price of freezes and cuts in already low provider rates, limits and restrictions on covered benefits, including prescription drugs, new and higher copayments, and scaling back on eligibility levels. The net result of these cuts is an increasing likelihood that providers will decide not to serve Medicaid patients, and that patients would not be able to get health care they need due to limits on benefits, access to some prescription drugs, and increased cost-sharing. And while program enrollment is still growing as a result of the weak economy, recent eligibility restrictions mean that the Medicaid program is not serving all the low-income, uninsured people who were previously eligible.

As states begin fiscal year 2004, they will be challenged to maintain Medicaid coverage while they work to address large budget shortfalls. Over the past three years, states have examined every possible cost reduction strategy as they have struggled with the difficult budget-driven cutbacks. A depressed economy, and little prospect for a near-term recovery in state revenues means the task will continue to be difficult. At the same time, Medicaid spending is expected to grow rapidly. If further cuts become necessary, the likely result will be declines in the accessibility, availability, and affordability of health care for low-income people.

Profiles of Selected State Medicaid Cost Containment Policies:

- **Connecticut**
- **Illinois**
- **Oregon**
- **Texas**

Profile of Medicaid Cost Containment Policies: Connecticut

In January 2003, the State of Connecticut faced a FY 2003 budget shortfall of $638.3 million due to declining state revenue collections and state expenditure increases largely driven by increasing Medicaid costs. The ongoing structural budget deficit for FY 2004 was estimated to be over $2 billion (based upon a FY 2004 total general fund current services budget of $13.6 billion). In early 2003, Governor Rowland and the state legislature took action to close the FY 2003 gap by enacting $350 million in ongoing and temporary tax increases and by making $223 million in spending cuts including the elimination of Medicaid coverage for 19,000 low-income adults and the elimination of continuous eligibility for children. Despite these actions, the state continued to face a structural budget deficit of over $800 million in FY 2004 and over $1.3 billion for FY 2005 as the Governor and state legislature continued to work to craft a state budget for the 2003-2005 biennium.

FY 2004 began on July 1, 2003 with the General Assembly still unable to come to agreement on the new biennial budget. As work on the budget continued, Governor Rowland operated state government by executive order. Although a budget was finally passed by the General Assembly on July 31, 2003, it went without the Governor's signature while lawmakers continued working on other bills that implemented various budget details. On August 16, 2003, one hour before the final deadline for signature, Governor Rowland signed the $27.5 billion biennial budget. Among other things, the new budget cuts cash assistance and medical benefits under the general assistance program, increases premium and copayment requirements for the HUSKY health insurance program (Connecticut's Medicaid/SCHIP program), and raises revenues by securitizing Connecticut's Tobacco Settlement Funds.

Due to ongoing litigation challenging the Medicaid eligibility cuts passed in FY 2003, Medicaid coverage for 16,000 low-income adults remains in doubt. In March 2003, a federal district court judge issued a temporary restraining order blocking the eligibility reductions. The legal action was later dismissed, however, and the Department of Social Services (DSS) proceeded to issue recipient notices to implement the eligibility cuts as of June 30, 2003. On June 26, 2003, the U.S. Second Circuit Court of Appeals granted a stay pending appeal that required DSS to restore coverage to 16,000 adults. The stay was later extended until such time as the court files an opinion on the appeal or upon further order. As of August 28, 2003, DSS expected coverage for the 16,000 adults to continue through at least September 30, 2003, and perhaps longer.

Provider Rates:
▪ Rates for hospitals, doctors and dentists frozen in '03 and '04 ▪ Intend to competitively bid DME, medical supplies and lab services in '04
Eligibility Reductions:
▪ Continuous eligibility for children eliminated in '03 ▪ Eligibility eliminated in '03 for 19,000 low-income adults between 100% and 150% of the FPL (although eligibility for approximately 16,000 subsequently restored by court order)
Benefit/Service Reductions:
▪ A number of optional services were eliminated for adults in '03 including chiropractic, naturopathic, podiatric and psychology services and occupational, physical and speech therapy.
Prescription Drug Controls and Limits:
▪ A $1 copay imposed in '03 ▪ Lower state MAC rates adopted in '03 ▪ Dispensing fee reduced from $4.10 to $3.60 in '03 ▪ In '03, prior authorization imposed in certain drug classes, and on prescriptions costing over $500, and in '04, prior authorization imposed on brand medically necessary prescriptions and on early refills ▪ Plan to implement a PDL and require supplemental rebates in '04.
Other:
▪ Enhanced home care agency audits ▪ Contracted with a vendor in '03 to develop a decision support system that will enable the state to enhance fraud and abuse prevention activities.

Profile of Medicaid Cost Containment Policies: Illinois

When Governor Rod Blagojevich took office in January 2003, he faced a projected state budget deficit of $1.2 billion for FY 2003 and $3.6 billion for FY 2004. Despite these shortfalls, Governor Blagojevich proposed a state budget for FY 2004 that increased funding for education and continued to build on previous health care expansions. In FY 2002, Illinois extended comprehensive drug benefits ("SeniorCare") to more than 150,000 seniors with incomes between 100% and 200% FPL under a Medicaid waiver. Also, Illinois implemented FamilyCare in FY 2003, which provided comprehensive medical benefits to 15,000 adult parents of Medicaid and SCHIP children.

The $52 billion FY 2004 state budget passed in May (including over $23 billion in General Funds) includes a $400 million increase in education funding, $66 million total funds to expand FamilyCare eligibility to an additional 65,000 working parents and $11 million total funds to expand KidCare eligibility to 20,000 more children. The FY 2004 budget shortfall was closed, in part, by funding 6,000 fewer state employees and by increasing revenues from higher riverboat taxes, the closing of certain corporate tax loopholes and increased non-consumer fees for state regulatory services and licenses. The budget also assumes pharmacy savings of $120 million resulting from an initiative to gain better prices on the nearly $2 billion worth of prescription drugs purchased by Illinois yearly. Finally, the budget also relies heavily on certain one-time revenue sources including $1.9 billion raised from a pension obligation bond financing, $350 million from the sale of the State's tenth riverboat casino license and $200 million from the "sale-leaseback" of certain state assets (including the James R. Thompson Center in Chicago).

Provider Payments:
▪ Rates for doctors, dentists, HMOs and nursing homes decreased by 2.6%, 3%, 5% and 5.9%, respectively, in '03 ▪ Rates for hospitals and home care providers were frozen in '03 ▪ Rates for HMOs were reduced by an average of 8.5% for '04 (due primarily to case-mix/actuarial changes) ▪ Nursing home reimbursement methodology changed to end bed reserve payments for hospital stays for '04 ▪ All other provider rates frozen for '04
Eligibility Changes:
▪ Prescription drug benefits ("SeniorCare," implemented June 2002) enrollment ramped up for seniors with incomes between 100% and 200% FPL in '03. ▪ FamilyCare implemented for parents with incomes up to 49% FPL in '03 ▪ FamilyCare expanded to cover parents with incomes up to 90% FPL in '04 ▪ KidCare income eligibility standard increased from 185% to 200% FPL in '04 ▪ SeniorCare income eligibility standard increased to 250% FPL in '04 (subject to federal waiver approval)
Benefit/Service Reductions:
▪ Copayments for physician, podiatry, optometric and chiropractic office visits were increased from $1 to $2 in '03
Prescription Drug Controls and Limits:
▪ Copayments for brand name drugs increased from $1 to $3 in '03 ▪ $1 copayment for generic drugs rescinded in '04 ▪ AWP discount increased from 11% to 12% for brand name drugs and from 20% to 25% for generic drugs in '03 ▪ Dispensing fee decreased from $4.00 to $3.40 for brand name drugs and from $5.10 to $4.60 for generic drugs in '03 ▪ Continued enhancements to state's PDL and supplemental rebate program in '03 and '04 ▪ Continued enhancements to state MAC list in '03 and '04

▪ In '04, prior authorization extended on new drugs by an additional six months and prior authorization added for brand medically necessary prescriptions
Other actions:
▪ Asset discovery initiative implemented in '03 to identify unreported or under-reported assets of persons applying for long term care ▪ In '03, pharmacies required to bill Medicare as the primary payor on select drug items ▪ Medically fragile and technology dependent children's HCBS waiver slots increased with the latest waiver renewal beginning with 450 in waiver year 1 (9-1-02 to 8-30-03) and phasing to 700 in waiver year 4 (beginning 9-1-03)

Profile of Medicaid Cost Containment Policies: Oregon

Like many other states, Oregon's efforts to adopt a state budget for FY 2004 were made all the more difficult due to the large cuts that had already been made to cover shortfalls in the 2001-2003 budget. Throughout 2002, Governor Kitzhaber and the Oregon Legislative Assembly struggled – through five special sessions – to enact legislation to rebalance the 2001-2003 biennial state budget. As they worked, the state revenue projections continued to worsen with each quarterly update. By the time of the fifth special session in September 2002, the forecast predicted $1.7 billion less than was assumed when the $12 billion 2001-2003 General Fund budget was passed.

When newly elected Governor Kulongoski took office in January 2003, over $1.4 billion in cuts had already been made throughout state government including significant cuts in K-12 education and the Oregon Health Plan. Also, a ballot measure that would have generated $313 million in additional General Fund revenues through a temporary income tax increase and allowed the state to restore some cuts was defeated by voters on

January 28, 2003. While Governor Kulongoski's proposed 2003-2005 budget included a 12 percent increase in General Fund spending over the 2001-2003 *reduced* budget, almost all of the increase was needed to replace one-time funds used to balance the 2001-2003 budget including $346.5 million in Medicaid Upper Payment Limit revenue, $333.2 million of Tobacco Settlement Funds and $150 million of Tobacco Settlement bond proceeds. State revenue collections continued to fall, however, forcing the Governor to propose a revised budget in April 2003 that was over $300 million lower.

The Oregon Legislative Assembly was unable to complete work on all agency budgets by the start of the fiscal year on July 1, 2003. In mid August 2003, 19 agency budgets still remained to be passed including budgets for K-12 education, higher education, human services and corrections. By that time, Oregon was the only state in the nation that had not yet fully adopted a state budget for FY 2004. A breakthrough finally occurred on August 20th when the Legislative Assembly narrowly approved a measure to raise $800 million in new revenue for the 2003-2005 biennium by temporarily increasing income taxes (for three years), increasing corporate taxes and imposing new taxes on certain healthcare providers. Governor Kulongoski stated his intent to sign the measure (although he had previously opposed any tax increases) stating:

> "The revenue forecasts over the last two years have forced us to reduce the general fund by 20%. We had to cut $3 billion out of this [2003-2005] budget and I cannot in good faith make that up in cuts in services for children, education, seniors and public safety. The fact is that we need additional revenue to keep the school doors open."

Legislative approval of the new revenue raising measure paved the way for the approval of the remaining agency budgets and the longest session in the history of the Oregon Legislative Assembly concluded on August 27, 2003. However, opponents of the new tax increases immediately stated their intent to wage a petition drive to obtain the 50,420 signatures needed to force a statewide election in February or March of 2004 to repeal the increases.

As part of its effort to contain rising health care costs, Oregon received federal approval in October 2002 to restructure the Oregon Health Plan ("OHP") – Oregon's groundbreaking Medicaid demonstration program. Oregon's HIFA waiver (the "Oregon Health Plan 2," or "OHP2") enables Oregon to utilize its unspent SCHIP funds and restructure the Oregon Health Plan into three distinct benefit packages:

- *OHP Plus* applies to all mandatory Medicaid populations and some optional populations (including pregnant women and children up to 185 percent of the FPL) and provides a comprehensive benefit package equivalent to that offered through the original OHP;
- *OHP Standard* includes a reduced benefit plan and higher cost-sharing requirements and covers low-income adults up to 100 percent FPL. This category includes the parents of children enrolled in Medicaid and SCHIP and childless adults as well as seniors and people with disabilities with incomes at or above 75 percent of the poverty line. In FY 2003, the reduced benefit plan excluded coverage for a number of optional services including vision, dental, non-emergency transportation, durable medical equipment, mental health, and chemical dependency services.
- *The Family Health Insurance Assistance Program ("FHIAP")*, a previously existing state-funded premium assistance program, has been folded into the OHP2 HIFA waiver enabling Oregon to receive federal matching funds. The FHIAP is available to families and individuals with income up to 200 percent of the FPL and will provide premium assistance on a sliding-scale basis for employer-sponsored insurance.

In FY 2004, Oregon will make additional significant benefit reductions. Oregon is seeking federal approval to amend its current Medicaid waiver to provide a primary care benefit package to its "OHP Standard" population, eliminating non-emergency hospital services, therapies and home health services for this group while also

restoring coverage for mental health and chemical dependency services as well as medical supplies and emergency dental services. Oregon is also seeking federal approval to further reduce coverage under the OHP "Prioritized List" by 30 lines (from line 549 to line 519.

Other health care cost containment and related policy measures are described below.

Provider Rates:
▪ Hospital rates cut by 12% and most outlier payments (excluding those for patients under age one in DSH hospitals) eliminated in '03 ▪ Rates for dentists, home care providers and most physicians frozen in '03 ▪ Rates for OB/GYNs increased by 31.6% and rates for anesthesiologists decreased by 30% in '03 ▪ Rates for nursing homes increased by 1.9% in '03 ▪ Rates for doctors, dentists and home health providers frozen in '04 ▪ Rates for nursing homes, residential and adult foster homes frozen in '04 at their June 30, 2003 levels ▪ Nursing home provider tax adopted for '04 that will result in a 14% increase in rates ▪ Rates for assisted living providers will increase by 2.95% effective September 1, 2003, and by another 2.6% on July 1, 2004 ▪ In '04, hospital rates will be increased to restore the 12% cut taken in '03 and to provide an additional increase (not yet calculated) ▪ Physical health MCO rates increased by 8.1% in '03 and will increase by 9.2% in October 2003 and by another 5.8% in April 2004 ▪ Behavioral health MCO rates increased by 4.9% in '03 and decreased by 17.2% in '04 ▪ Dental health plans frozen in '03 and increased by 1.2% in '04 ▪ Provider taxes levied on hospitals MCOs and nursing homes in '04
Eligibility Changes:
▪ In '03, the implementation of the OHP2 HIFA waiver included: o Moving 110,00 non-categorically eligible adults below the poverty level into the OHP Standard Plan o An expansion of SCHIP eligibility from 170% to 185% FPL o An expansion of eligibility for pregnant women from 170% to 185% o An elimination of retroactive eligibility for the OHP Standard population o A requirement that the OHP Standard population be uninsured for six months before becoming eligible o Folding into OHP2 a previously state-funded premium assistance program ▪ Eliminated the Medically Needy program in '03 ▪ Restricted eligibility requirements (number of "survivability levels" covered reduced) for long term care services in '03 ▪ A new prescription drug only program for seniors and disabled up to 133% FPL planned for '04 ▪ SCHIP eligibility expanded to 200% FPL in '04 ▪ FHIAP expanded to 200% FPL in '04 ▪ Statutory authority to expand OHP Standard eligibility above 100% FPL repealed in '04
Benefit/Service Reductions:
▪ Eliminated a number of optional services for the OHP Standard population in '03 including vision, dental, non-emergency transportation, DME, mental health, and chemical dependency services.

▪ Prescription drug coverage for the OHP Standard population eliminated for 13 days in '03. ▪ Coverage under the OHP Prioritized List reduced from line 566 to line 558 in '03 ▪ In '03, OHP2 imposed new mandatory copayments (ranging from $2 for a generic prescription to $250 for an inpatient hospital admission) and premium requirements (ranging from $6 to $20 per month per person) for the OHP Standard population ▪ Optional copayments for pharmacy and ambulatory services added for (non-OHP Standard) adults ▪ Coverage under the OHP Prioritized List reduced from line 549 to line 519 in '04 ▪ For the OHP Standard population in '04, non-emergency hospital services, therapies and home health services eliminated and mental health, chemical dependency, medical supplies and emergency dental services added.
Prescription Drug Controls and Limits:
▪ AWP discount increased to 15% for retail (non-institutional) pharmacies and decreased by 3.5% for institutional pharmacies in '03 ▪ Dispensing fee for institutional pharmacies increased by 2.9% in '03 ▪ Prior authorization imposed in certain drug classes in '03 ▪ PDL implemented for five drug classes in '03 and new classes will be added in '04 ▪ Voluntary mail-order incentive program implemented in '03 (AWP-21% for brand; AWP-60% for generic, and a $3.50 dispensing fee) ▪ Implemented a new point of sale claims processing system in '03 ▪ Copayment requirements added for OHP Standard population and certain OHP Plus eligibles in '03 ▪ Implemented cost-avoidance TPL policy for pharmacy claims in '03 ▪ Implemented pharmacy lock-in program for fee-for-service eligibles (restricting clients to one pharmacy) in '03 ▪ Supplemental rebate requirement added in '04 ▪ Authority to subject non-PDL drugs to prior authorization repealed in'04 ▪ In '04, prior authorization added for persons using more than 15 drugs in the preceding six month period
Other:
▪ Disease management programs for asthma, diabetes and congestive heart failure added in '03 ▪ Case management program added for highest cost eligibles (over $20,000 per year) in '03 ▪ Growth in home and community based services waivers to be capped at 5% in '04

Profile of Medicaid Cost Containment Policies: Texas

At the beginning of CY 2003, Texas had a projected budget shortfall of $1.8 billion for FY 2003 (5.8 percent o the General Revenue budget) and $8.1 billion of FY 2004 (12 percent of the General Revenue budget). On January 23, 2003, Governor Rick Perry directed all state agencies to immediately cut their 2003 General Revenue spending by at least 7 percent which would result in an estimated $700 million in savings. The only programs exempted from the mandatory cuts were the Foundation School Program, the Children's Health Insurance Program and acute care Medicaid services. At about the same time, Governor Perry submitted a proposed biennial budget for FY 2004 and FY 2005 to the Texas Legislature -- a spending plan that started at "zero" for every agency and every category of spending to allow state legislators to re-evaluate all state spending.

On June 22, 2003, Governor Perry signed into law a $117 billion state budget for FY 2004 and FY 2005. The new budget does not raise taxes and reduces general revenue spending $2.6 billion while at the same time drawing down more federal funds. Thus, the total budget increases by 1.4 percent while the General Revenue budget decreases by 4.3 percent. Among other things, the new budget cuts 10,000 state jobs, implements certai payment delays to schools (to shift some costs into FY 2006) and makes a number of significant reductions in the Medicaid and SCHIP programs. In particular, the FY 2004 budget eliminates Medicaid coverage (on an average monthly basis) for an estimated 7,800 pregnant women, 8,400 medically needy adults and 28,000 adul TANF recipients who fail to meet their personal responsibility agreement requirements. Also, by the end of FY 2004, the average monthly caseload of the SCHIP program is expected to fall by over 169,000 due to changes made to the SCHIP eligibility requirements including the imposition of an assets test for families with incomes over 150 percent of the FPL, the reduction of continuous eligibility from 12 months to six months, the imposition of a 90-day waiting period between eligibility determination and coverage and the elimination of income disregards. Other Medicaid cost containment measures are listed below.

Provider Rates:
▪ All provider rates frozen in '03
▪ Quality Assurance Fee (6% of gross receipts per occupied bed) imposed on mental health/mental retardation state schools in '03
▪ Rates for acute care providers such as hospitals, doctors and HMOs decreased by 5% in '04 (although partially restored to a 2.5% cut using new federal funds)
▪ Rates for non-acute care providers such nursing homes, community care providers and ICF/MR providers decreased by 2.2% to 3.5% in '04 (although partially restored to a 1.1 to 1.75% cut using new federal funds)
▪ Funding for Graduate Medical Education discontinued for '04
▪ Insurance premium taxes expanded to previously exempt contracted health plans on '04
▪ Quality Assurance Fee for ICFs/MR increased from 5.5% to 6% in '04
Eligibility Reductions:
▪ Coverage for pregnant women between 158% FPL and 185% FPL eliminated for '04
▪ Coverage for medically needy adults between 17% FPL and 24% FPL eliminated for '04
▪ Eligibility eliminated in '04 for TANF adults who fail to meet personal responsibility agreement requirements
▪ Personal Needs Allowance reduced for nursing home residents in '04
▪ SCHIP continuous eligibility reduced from 12 to 6 months for '04
▪ A 90 day eligibility waiting period imposed for SCHIP between eligibility determination and coverage in '04
▪ An asset test was added for SCHIP families over 150% FPL and the SCHIP income

test was changed to eliminate income disregards in '04 ▪ In FY 2004 for limited circumstances, reinstated policy of conducting face-to-face interviews on applications for children.
Benefit/Service Reductions:
▪ Copayments for drugs and emergency room services added in '03 (but were subsequently enjoined by court order) ▪ A number of optional services were eliminated for adults in '04 including eyeglasses, hearing aids and chiropractic, podiatric, psychology and counseling services. ▪ Number of service hours provided to home and community-based services recipients reduced by 15% in '04 ▪ The SCHIP benefit package was reduced in '04 to exclude most mental health services, dental, chiropractic, eye exams and glasses, substance abuse treatment, hospice care and skilled nursing ▪ Cost-sharing for Medicaid and SCHIP authorized at federal maximum levels for '04
Prescription Drug Controls and Limits:
▪ New state MAC rates added in '03 ▪ Drug Utilization Review activities increased in '03 ▪ Plan to implement a PDL with prior authorization required for non-preferred drugs in '04 ▪ Supplemental rebate requirement added for '04 ▪ Dispensing fee reduced in '04 ▪ Four brand-name limit and a 34-day supply limit authorized (if cost effective) in '04
Other actions in '04:
▪ Estate recovery authorized ▪ Increased program integrity and fraud and abuse efforts planned ▪ Prior authorization to be imposed on high-cost medical services ▪ Legislative requirement to implement disease management programs and expand managed care programs statewide if cost-effective to do so

Appendix A: Factors Contributing to Expenditure Growth in FY 2003—State Responses

State	Primary Factor	Secondary Factor	Other
Alabama	Increase in number of eligibles	Medical inflation	Mandated expansions/some lawsuits/technology change
Alaska	Cost of medical care	Increase number of enrollees	Home and Community Based services
Arizona	Enrollment growth	Medical inflation	Pharmacy
Arkansas	Increase in eligibles	Medical inflation	Prescription Drugs
California	Eligibles	Cost increases	Utilization (aged)
Colorado	Reduced budget	Caseload	
Connecticut	Pharmacy	Home care—Home and Community Based waiver	Nursing Home
Delaware	Pharmacy	Nursing homes	
District of Columbia	Increased utilization	Rate increases	
Florida	Prescription drugs	Cost of nursing home care	Increase in Inpatient and Outpatient Hospital costs including additional special payments
Georgia	Eligibility growth--enrollment	Utilization—Outpatient Hospital	Price
Hawaii	Pharmacy	Enrollment growth	
Idaho	Prescription drugs	Hospitals	Home and Community Based waivers
Illinois	Population expansion	Pharmacy	Intergovernmental Transfer
Indiana	Nursing Home	Prescription drugs	Inpatient Hospital
Iowa	Caseload--increase in number of eligibles	Prescription drug expenditures	Nursing facility
Kansas	Growth in beneficiaries	Utilization increases, especially Inpatient hospital and Mental Health	Prescription drugs, but held down by policy
Kentucky	Pharmacy	New eligibles (caseload)	Medical inflation
Louisiana	Utilization	Pharmacy	HCBW slots for nursing home alternatives
Maine	Prescription drugs	Behavioral Health	Hospital outpatient
Maryland	Enrollment	Pharmacy	Managed care organizations
Massachusetts	Utilization	Caseload	Rates
Michigan	Caseload	Pharmacy	Provider assessment based rate increases
Minnesota	Home and Community Based waiver caseloads	Children and parents	Prescription drug costs
Mississippi	Prescription drugs	Enrollment	Cost increases
Missouri	Pharmacy	Caseload growth	Utilization increase
Montana	Caseload	Utilization	Outpatient Hospital
Nebraska	Nursing facility expenditures	Drug expenditures	Outpatient expenditures
Nevada	Caseload increase	Pharmacy costs	Provider rate increases
New Hampshire	Prescription drugs	Outpatient Hospital	Enrollment growth,

			especially elderly
New Jersey	Pharmacy	Inflation (managed care capitation)	
New Mexico	Utilization	Enrollment	Prescription drugs
New York	Pharmacy	Enrollment	Hospital
North Carolina	Mental Health	Utilization of outpatient hospital service	Utilization of personal care services
North Dakota	Increase in number of eligibles	Hospital	Physician
Ohio	Aged Blind and Disabled price and utilization	Covered families and children caseload growth	Aged Blind and Disabled caseload growth and increasing utilization
Oklahoma	Enrollment	Drugs	
Oregon	Hospital costs	Prescription costs	
Pennsylvania	Pharmacy cost/utilization	Long Term Care	Caseload, increased number of eligibles
Rhode Island	Prescription drugs/pharmacy	Inpatient Hospital-fee-for-service and some managed care demand	
South Carolina	Number of recipients	Service cost	Pharmacy
South Dakota	Enrollment, increased number of new eligibles	Inpatient and Outpatient Hospital, increased per capita cost	Prescription drugs
Tennessee	Pharmacy	Cost/enrollee	Supplemental payments to providers exceed projections
Texas	Caseload	Prescription drugs	Increased utilization
Utah	Caseload growth and utilization	Pharmacy	PCM waiver
Vermont	Long Term Care	Inpatient Hospital	Mental Health
Virginia	Health care inflation	Pharmacy (new and higher cost drugs)	
Washington	Caseload	Prescription drugs	
West Virginia	Pharmacy costs	Enrollment	
Wisconsin	Caseload growth	Increasing service costs	Expansion of benefits (SeniorCare)
Wyoming	Caseload growth	Higher reimbursement rates	Prescription drugs

Appendix B: Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2003

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts*	Copays	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC
Alabama	X	X					X		
Alaska	X	X	X	X				X	
Arizona	X		X	X					
Arkansas	X	X		X					X
California	X	X	X					X	
Colorado	X	X	X	X			X	X	X
Connecticut	X	X	X	X	X			X	
Delaware	X	X			X				
District of Columbia	X	X						X	
Florida	X	X	X	X		X		X	X
Georgia	X	X					X		X
Hawaii	X								
Idaho	X	X	X			X	X		
Illinois	X	X			X			X	
Indiana	X	X	X	X		X		X	X
Iowa	X	X		X					
Kansas	X	X	X	X	X				
Kentucky	X	X		X	X		X		X
Louisiana	X	X		X		X	X		X
Maine	X	X							
Maryland	X	X			X				
Massachusetts	X	X	X	X	X			X	
Michigan	X	X							
Minnesota	X	X							
Mississippi	X	X	X	X	X		X	X	
Missouri	X	X		X			X	X	
Montana	X	X	X		X				
Nebraska	X	X		X	X				
Nevada	X	X		X					
New Hampshire	X	X					X		
New Jersey	X							X	
New Mexico	X	X							
New York	X	X						X	
North Carolina	X		X	X	X				
North Dakota	X	X	X	X	X				X
Ohio	X	X		X				X	
Oklahoma	X	X	X	X	X				
Oregon	X	X	X	X	X		X		X
Pennsylvania	X	X				X		X	X
Rhode Island	X	X		X			X		
South Carolina	X	X		X		X		X	
South Dakota		X							
Tennessee	X			X					
Texas	X	X						X	

Utah	X	X	X		X				
Vermont	X	X	X		X				
Virginia	X	X			X				
Washington	X	X		X			X	X	
West Virginia	X	X							
Wisconsin	X	X							
Wyoming	X	X					X	X	
Totals	**50**	**46**	**18**	**25**	**17**	**6**	**13**	**19**	**10**

Note: A blank indicates the state reported no action.
*Eligibility changes include instituting premiums and changes to application and enrollment processes.

Appendix C: Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2004

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts*	Copays	Managed Care Expansions	DM/ CM	Fraud and Abuse	LTC
Alabama	X	X							
Alaska	X	X		X				X	
Arizona	X			X					
Arkansas	X								
California	X	X					X	X	
Colorado	X		X	X	X			X	
Connecticut	X	X			X			X	
Delaware	X				X				
District of Columbia	X	X				X			
Florida	X	X	X		X	X			
Georgia	X	X	X		X				
Hawaii	X	X							
Idaho	X	X					X		
Illinois	X	X							X
Indiana	X	X		X	X	X	X		
Iowa	X	X		X	X				
Kansas	X	X					X	X	
Kentucky	X	X		X					
Louisiana	X	X	X						
Maine	X	X			X			X	
Maryland	X	X						X	
Massachusetts	X	X		X	X		X		X
Michigan	X	X	X		X			X	X
Minnesota	X	X	X	X	X				
Mississippi	X	X	X				X		
Missouri	X	X	X				X		
Montana							X		
Nebraska	X		X	X					
Nevada	X	X	X			X	X	X	
New Hampshire	X	X	X		X		X	X	
New Jersey	X	X	X		X		X	X	
New Mexico	X	X						X	
New York	X	X						X	
North Carolina	X	X		X		X			
North Dakota	X	X	X	X	X		X		
Ohio	X	X	X		X		X		
Oklahoma	X	X					X	X	
Oregon	X	X	X			X	X		X
Pennsylvania	X	X	X		X			X	
Rhode Island	X					X			
South Carolina	X	X				X			
South Dakota		X							
Tennessee	X	X					X	X	

Texas	X	X	X	X		X	X	X	
Utah	X	X	X	X					
Vermont	X	X		X	X				
Virginia	X	X	X	X	X				
Washington	X	X	X	X	X				X
West Virginia	X	X		X	X	X			
Wisconsin	X	X		X	X	X		X	
Wyoming	X	X					X	X	
Totals	**49**	**44**	**20**	**18**	**21**	**11**	**18**	**19**	**5**

Note: A blank indicates the state reported no action.
* Eligibility changes include instituting premiums and changes to application and enrollment processes.

Appendix D: Pharmacy Cost Containment Actions Taken in Each of the 50 States and District of Columbia as reported in the middle of FY 2003

State	AWP	New or Lower State MAC	Reduction in Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates	Limits on the Number of Scripts
Alabama							
Alaska				X			X
Arizona							
Arkansas							
California	X		X	X		X	
Colorado	X			X			
Connecticut		X	X				
Delaware	X	X		X			
District of Columbia					X		
Florida							
Georgia		X	X	X			
Hawaii							
Idaho		X		X			
Illinois	X	X	X	X	X	X	
Indiana				X	X		
Iowa		X		X			
Kansas	X	X	X	X	X	X	X
Kentucky	X	X			X		
Louisiana				X	X	X	X
Maine	X				X	X	
Maryland			X				
Massachusetts	X	X	X	X	X		
Michigan		X		X			
Minnesota	X	X		X	X	X	
Mississippi	X		X	X	X		X
Missouri		X		X			
Montana	X						
Nebraska	X			X			
Nevada	X			X			
New Hampshire				X			
New Jersey							
New Mexico			X				
New York				X			
North Carolina		X		X			
North Dakota							
Ohio				X	X	X	
Oklahoma				X			X
Oregon	X			X	X		
Pennsylvania				X			
Rhode Island				X			
South Carolina				X	X	X	
South Dakota		X					

Tennessee							
Texas		X					
Utah	X			X			
Vermont		X		X		X	
Virginia	X						
Washington	X	X		X	X	X	
West Virginia					X	X	
Wisconsin				X			
Wyoming		X		X			
TOTAL	**17**	**18**	**9**	**32**	**15**	**11**	**5**

Appendix E: Pharmacy Cost Containment Actions Taken in Each of the 50 States and District of Columbia as reported in the middle of FY 2004

State	AWP	New or Lower State MAC	Reduction in Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates	Contract with a PBM	Limits on the Number of Scripts
Alabama				X		X		
Alaska	X	X			X			
Arizona								
Arkansas								
California		X		X				
Colorado								
Connecticut				X	X	X		
Delaware								
District of Columbia				X	X			
Florida		X				X		
Georgia		X		X	X	X		
Hawaii								
Idaho		X		X	X			
Illinois		X		X	X	X		
Indiana		X		X	X			
Iowa	X		X	X	X			
Kansas		X		X	X	X	X	
Kentucky					X	X		
Louisiana				X	X	X		
Maine								
Maryland	X				X	X		X
Massachusetts	X	X		X	X		X	X
Michigan		X			X			
Minnesota	X	X		X	X	X		
Mississippi		X		X	X			
Missouri		X				X		
Montana								
Nebraska								
Nevada		X			X	X		
New Hampshire	X							
New Jersey						X		
New Mexico								
New York	X				X	X	X	X
North Carolina								
North Dakota			X	X			X	
Ohio				X	X	X		

Oklahoma				X	X			
Oregon				X	X	X		
Pennsylvania								
Rhode Island								
South Carolina				X	X			
South Dakota				X				
Tennessee					X	X	X	
Texas			X	X	X	X		X
Utah					X			
Vermont				X	X			
Virginia			X	X	X	X		
Washington		X		X	X	X		
West Virginia		X			X			
Wisconsin	X		X	X	X	X		
Wyoming		X		X	X			
TOTAL	**8**	**17**	**5**	**26**	**31**	**21**	**5**	**4**

Appendix F: Eligibility Actions Taken in the 50 States and District of Columbia in FY 2003

State	Eligibility Change
Alabama	**Other**: Added AL technology waiver (1915c) for adult private duty nursing (people who age out of EPSDT)
Alaska	
Arizona	**Disabled**: Implemented Freedom to Work (209)
Arkansas	**Parents/Adults**: Expansion – Pregnant Women and family planning to 200% of FPL; TEFRA category became a waiver instead of state plan. Now state is able to charge a premium, 1% of income.
California	
Colorado	**Other**: Eligibility expanded to BCC patients **Other**: Law passed to remove optional legal immigrants from Medicaid eligibility (those located in US for 5 years or more).
Connecticut	**Children**: Elimination of continuous eligibility **Parents/Adults**: Elimination of eligibility for low-income adults between 100% and 150% of the FPL (-19,000). Eligibility for approximately 16,000 people has been temporarily restored by court order through at least the end of September 2003. **Other**: Expansion to Breast and Cervical Cancer patients
Delaware	
District of Columbia	**Parents/Adults**: Childless adult (50-64 years) up to 50% FPL (+1065) **Disabled**: Elderly and physically disabled waiver (+290) **Other**: HIV Waiver
Florida	**Disabled and Aged**: Income standard for eligibility reduced from 90% to 88% of FPL (July 1, 2002) (-3400) **Other**: Implemented Silver Saver Drug Program for Seniors who are dually eligible with incomes up to 120% of the FPL (+58,000)
Georgia	
Hawaii	
Idaho	
Illinois	**Parents/Adults**: FamilyCare (+15,000) **Aged**: SeniorCare, seniors between 100-200% FPL, includes refinancing through Medicaid of existing state-funded program (+150,000)
Indiana	**Children**: Elimination of continuous eligibility (-32,000)
Iowa	
Kansas	**Disabled**: Working healthy expansion (ticket to work) effective July 1, 2002 (+571)
Kentucky	**Children**: Children needing psych care incur 30 days of treatment before parental income counts (-600) **Disabled and Aged**: Expansion **Other**: Aliens – Changed policy to reflect rest of southeastern states **Other**: TANF – Lose Medicaid card if not complying with work requirement
Louisiana	**Children and Disabled**: Expansion **Aged**: Expansion **Other**: Pregnant Women – expanded program January 2003 to 200% FPL (after 15% income disregard) (+2,795) **Other**: Medically Needy – Bills for services incurred more than 3 months prior to application were excluded beginning with applications dated January 1, 2003 (-2,000)
Maine	**Parents/Adults**: Waiver to cover non-categorical adults 100% FPL

	(+15,000)
Maryland	**Other**: Senior Pharmacy Waiver – took state-only program and converted to Medicaid expansion to 175% under waiver amendment (+48,000)
Massachusetts	**Other**: Elimination of services for certain long -term Unemployed (1115 waiver pop) (-33,832) **Other:** Implement new premiums for 1115 population (4,000)
Michigan	**Parent/Adults**: Childless adults under 35% FPL (+62,000). No caretaker relative proposed but blocked by litigation. Will not be done (25,000)
Minnesota	**Children**: Expansion – income eligibility to 170% of FPL (+12,000) **Parents/Adults**: income eligibility to 100% of FPL (+8,000)
Mississippi	
Missouri	**Children**: Extended presumptive eligibility to children (+1,685) **Parents/Adults**: Cut custodial parents over 77% (from 100%), cut all non-custodial parents, cut all parent's fair share participants, reduced transitional Medicaid to under 100% FPL and to one year extended coverage, reduced women's health to under 100% FPL and to one year extended coverage (47,297) **Disabled**: Expanded medical assistance to include workers with disabilities (ticket to work) (357) **Other**: Restricted spend down recipients by requiring out of pocket expense instead of incurring spend down amount (24,000)
Montana	
Nebraska	**Children**: Reduction in length of TMA (24 to 12 months), reduction in amount of earnings disregard (20% of earnings to flat $100), change in treatment of household composition for eligibility (17,500) **Parents/Adults**: Reduction in length of TMA, reduction in amount of earnings disregard, change in treatment of household composition for eligibility (7,000)
Nevada	**Parent/Adults**: Expansion of breast and cervical cancer coverage (+69) **Other**: ALL – eliminated unemployment insurance income exemption in eligibility determination (2,925)
New Hampshire	
New Jersey	
New Mexico	**Other**: Added breast and cervical cancer coverage in 2003 (+158)
New York	**Children**: Net income 100-133%, April 1, 2002 **Parents/Adults**: Gross income increase from 133% to 150%, October 1, 2002 **Other**: Breast and Cervical Cancer program added October 1, 2002 (+2,000)
North Carolina	**Children**: Count parental income for pregnant minors (650) **Other**: Impose transfer of asset penalties on persons receiving personal care services in their homes **Other**: Include real property held under a life estate or tenancy in common as a countable asset when determining Medicaid eligibility (3,000)
North Dakota	**Children and Parents/Adults**: Implemented 100 hour rule (2,400) **Disabled and Aged**: Implemented to only allow $15 for offset (i.e. limited to amount can write off) (256)
Ohio	**Other**: Breast and Cervical Cancer program for women (+200)
Oklahoma	**Children**: Eliminated Medically Needy (-800) **Parents/Adults**: Eliminated Medically Needy (-6,500) **Aged**: Eliminated Medically Needy (-1,000)

Oregon	**Children**: Expand CHIP kids from 170% to 185% FPL (OHP2) (+1,253); folded previously state funded premium assistance program into OHP2. **Parents/Adults**: Expand pregnant women from 170-185%, eliminate retroactive eligibility for standard population effective March 1, 2003, require standard population be uninsured for 6 months before becoming eligible for Medicaid (200,178); new premium policies, higher premiums and penalties for non-payment of premiums for standard population (192,832); moved non-categorical adults under the poverty level into OHP standard plan (110,000) **Disabled**: Reduced eligibility based on elimination of certain Medicaid LTC survivability levels, eliminated Medically Needy program **Other**: included ESI program under new Medicaid demonstration waiver (+7,716)
Pennsylvania	
Rhode Island	**Children**: higher premium (5% from 3%) on RiteCare for families at or over 150% FPL
South Carolina	**Parent/Adults**: Add a 185% gross income test of the TANF need standard for low income families (7,000) **Aged**: Refinanced existing state-only program to expand Medicaid eligibility for pharmacy coverage to 200% of the FPL for people age 65 and older under pharmacy waiver (+50,000)
South Dakota	
Tennessee	**Children**: Children in waiver population must now be below 200% of poverty and have no access to group health insurance. Kids with access to insurance who were enrolled as of 12/31/01 allowed to be "grandfathered" into the program, must meet income standards **Parents/Adults**: Uninsured adults must be < 100% poverty and without access to group health insurance. **Aged**: 40,000 individuals grandfathered, anyone applying after 12/31/01 with access to Medicare would be denied based on ability to access Medicare **Other**: Previously uninsured TennCare enrollees reduced to 200% FPL kids 100% FPL adults, uninsurable still open for under 100% FPL, enrollment slowed for uninsured **Other**: Implemented reverification process to reverify eligibility of entire waiver population and requested modification to existing waiver regarding benefits, copay, etc. (600,000)
Texas	
Utah	**Parents/Adults**: Expansion for PCN 1115 waiver for limited benefits (+25,000) **Disabled**: Working disabled, premium reduced (170)
Vermont	**Aged**: Added Healthy Vermonter (+5,100)
Virginia	**Children**: Increased income limit for children ages 6-19 from 100-133% FPL. **Parents/Adults**: Increased the income limits for the 1931 group by the increase in the CPI **Other**: Medically Needy Population – Increased the income limits by the increase in CPI **Other**: Pregnant Women – Implemented a Family Planning Waiver to provide up to 24 months of family planning services for women whose pregnancy was covered under Medicaid
Washington	**Parents/Adults**: Premiums on adults in 2nd six months of transitional medical benefits (3,500)

West Virginia	
Wisconsin	**Parents/Adults**: Family planning waiver (+20,446) **Aged**: SeniorCare waiver expansion (+94,383)
Wyoming	

Note: Numbers and parentheses are estimates of numbers of people affected by the policy described. Descriptions of policies and estimates of numbers of people affected were provided by state officials who responded to the survey in June 2003. This table does not describe changes to application and enrollment processes, which are included in Appendixes B and C.

Appendix G: Eligibility Actions Taken in the 50 States and District of Columbia in FY 2004

State	Eligibility Change
Alabama	
Alaska	**Children**: Reduction from 200% FPL to 175% FPL. Subsequent freeze of income level at 2003 value of 175% of FPL for expansion group (1,300) **Parents/Adults**: Income level frozen at 2003 value of 175% of FPL for optional group (300) **Other**: 300% of current SSI institutional group frozen at current dollar value of SSI
Arizona	
Arkansas	**Children**: Add coverage for undocumented aliens for pregnancy and child birth and child **Other**: Seeking federal approval of a Medicaid waiver to subsidize for employer health insurance
California	
Colorado	**Other**: Fees for waiver families
Connecticut	
Delaware	
District of Columbia	**Children**: Eligibility expansion under 1902 (r)(2) to 19-21 year olds up to 200% FPL (+500 to 1,000) **Parents/Adults**: Expansions: Pregnancy related State Plan Amendment; 50-64 year olds up to 100% of FPL; 21-27 year old up to 50% FPL
Florida	**Aged**: Silver Saver expanded and Lifesaver Rx discount program is authorized for certain seniors with incomes up to 200% of the FPL, includes refinancing through Medicaid of existing state-funded program (+100,000)
Georgia	
Hawaii	
Idaho	
Illinois	**Children**: Kids with family income up to 200% FPL eligible for SCHIP (+12,000) **Parents/Adults**: Parents with family income up to 90% eligible for FamilyCare (+65,000) **Aged**: Seeking federal approval to expand SeniorCare eligibility from 200-250% (+50,000)
Indiana	**Disabled and Aged**: Spend down days
Iowa	**Disabled**: Premium increase of MEPD – working disabled (1,500)
Kansas	
Kentucky	**Parents/Adults**: Premium on KCHIP for 150% to 200% FPL. Premium on 2nd sixth months of TMA **Disabled and Aged**: For NH or LTC eligibles, decrease resource allowance and income standards for community spouse. Looking at transfer of asset issue in addition to Miller trust
Louisiana	**Children**: Counting unborn in need standard when determining eligibility for siblings (+250) **Disabled**: Expansion on more liberal resources methodology, cost neutral. Optional program for people with working disabilities (ticket to work)
Maine	
Maryland	**Parents/Adults**: New program for Traumatic Brain Injury (+10) **Other**: Maryland Pharmacy Program – 2nd phase discount program.

	Open up eligibility to Medicare up to 185%. **Other**: General Assembly has made the following changes to the MCHP and MCHP Premium effective July 1, 2003. (1) Non-Medicaid now starts at 185% - Lowered the upper income limit for free MCHP coverage from 200% FLP to 185% FPL so that for those families whose income falls between 185% and 200% FPL will have to pay a monthly premium. (2) The MCHP Premium, which covers families with income between 200% FPL and 300% FPL, will no longer accept any new enrollments after July 1, 2003. Children enrolled in MCHP before that date would continue to be covered, however, If these children lose eligibility, they will not be reenrolled. (3) The employer sponsored insurance option for enrollees in the MCHP Premium, whereby the program subsidizes private insurance premium to keep MCHP Premium children enrolled in private insurance rather than HealthChoice, will be discontinued effective July 1, 2003.
Massachusetts	**Children**: Greater use of premiums (150,000) **Parents/Adults**: Asset test Restriction – Enrollment Freeze/Cap Reduction – Elimination of Benefits for Special Status Immigrants (24,600) **Disabled**: Reduction: Tightening of the Disability Criteria – **Reduction**: – Asset test Restriction – Enrollment Freeze/Cap Reduction – Elimination of Benefits for Special Status Immigrants (26,050) **Aged**: Reduction – Elimination of Benefits for Special Status Immigrants **Other**: Cost Shifting – Compulsive application to Medicare (adults, disabled and aged) **Other**: Cost Shifting – Investigation of employer sponsored insurance (adults, disabled and aged) (30,000)
Michigan	**Other**: HIFA family planning waiver, SCHIP funded plan
Minnesota	**Children**: Rolled back to 150% from 170% FPL. Auto newborn eligibility reduced from 24 to 12 months (-5,000)
Mississippi	
Missouri	**Disabled and Aged**: Increase from 80-90% FPL October 1, 2003
Montana	
Nebraska	**Children**: Presumptive eligibility for children no longer available effective 9.1.03, eliminate Ribicoff coverage for 19-20 year-olds, eliminate presumptive eligibility for children (3,440)
Nevada	
New Hampshire	
New Jersey	
New Mexico	**Parents/Adults**: Proposed Medicaid waiver to expand coverage of working adults (+10,500)
New York	**Disabled**: Adding a working disabled buy-in up to 250% (+2,500)
North Carolina	**Children and Parents/Adults**: Eliminate 12 month State Transitional Medicaid Coverage for families and children who are working and no longer receiving welfare payment
North Dakota	**Disabled**: Buy-in program for working disabled – expansion (+300) **Aged**: Spousal asset limit (spouse not residing in an institution can retain half of joint assets, up to a max (200)
Ohio	**Parents/Adults**: To receive federal relief, parent coverage for 90-100% FPL will not be eliminated. 100% FPL will not be eliminated. Reduction in eligibility at a later date is still under consideration (60,000)

Oklahoma	
Oregon	**Children**: Expand SCHIP from 185% to 200% FPL (+4,030) **Disabled and Aged**: Planned new eligibility program for seniors and disabled that will be an Rx program only and will probably cover up to 133% FPL (+7,000) **Other**: FHIAP expanded to 200% FPL **Other**: Statutory authority to expand OHP standard eligibility above 100% FPL repealed
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	
Tennessee	
Texas	**Parents/Adults**: Reduced eligibility to pregnant women to 158% from 185% FPL (+7,831); Eliminated TANF adults who fail to meet personal responsibility agreement requirements (-28,000). This TANF penalty has been temporarily stayed by court order. **Aged**: Eliminated adult medically needy program between 17% and 24% of FPL (-8,472) **Other**: Reduced the personal needs allowance for nursing home residents **Other**: Monthly cost sharing will be imposed
Utah	**Disabled and Aged**: Spend down eligibility threshold increased 50% to 100% for ABD (4,000) Other: Blind – Eligibility increase 75% to 100% (+12)
Vermont	**Parents/Adults**: Ended 6-month guaranteed eligibility for PCCM enrollees **Disabled and Aged**: Changed LTC asset rule to cover bonds **Other**: Waiver Population – replaced copayments with premiums as of January 1, 2004
Virginia	**Parents/Adults**: Eliminate 12 months TMA provided for VIEW participants who lost financial asset under welfare reform (-3,750) **Other**: Medically Needy Populations – Froze CPI adjustment to income limits for FY 2004
Washington	**Parents/Adults**: Parents and children who used to benefit from 12 months continuous eligibility now have a status review every six months. (-4,800) **Disabled**: Raising functional requirements and eliminating services for clients needing minimal assistance with one or two activities for Medicaid personal care program. No new applicants with lower level of care admitted **Other**: Co-premiums on children over 100% FPL (62,000)
West Virginia	
Wisconsin	**Parents/Adults**: Require verification of health insurance and wages for employed BCC applications/recipients as a condition of eligibility. Increase premiums for BadgerCare enrollees with income above 150% FPL to 5% of net income, from current 3% of net income (18,439) **Aged**: Provide that annuities be treated as countable asset if there is a market in which the annuity could be sold and tighten policies related to transfers to a community spouse to ensure assets so transferred are for the sole benefit of the community spouse and increase the required annual enrollment fee for SeniorCare applicants from $20 to $30 per person. Condition of eligibility (108,156)

	Other: Families addition – Eliminate 100 hour rule for 2 parent families (+500) and expand eligibility for women with BCC to include women diagnosed with precancerous conditions and women eligible for HIS (+13)
Wyoming	

Note: Numbers and parentheses are estimates of numbers of people affected by the policy described. Descriptions of policies and estimates of numbers of people affected were provided by state officials who responded to the survey in June 2003. A blank indicates the state reported no action. This table does not describe changes to application and enrollment processes, which are included in Appendixes B and C.

Appendix H: Benefit Related Actions Taken in the 50 States and District of Columbia in FY 2003

State	Benefit Change
Alabama	
Alaska	**Parents/Adults**: Limit length of hospital stay to 4 days without PA except maternal and newborn hospital stays related to childbirth which are limited to 48 hours IPH following normal vaginal delivery and 96 hours IPH following cesarean
Arizona	**Other**: No more circumcisions
Arkansas	
California	**Parents/Adults, Disabled and Aged**: Restricted dental to one exam per lifetime and one cleaning
Colorado	**Other**: Reduction of home health LTC therapies
Connecticut	**Parents/Adults, Disabled and Aged**: Optional cuts – chiropractic, naturopathic, podiatry, occupational therapy, physical therapy, speech therapy, psychology (100,000)
Delaware	
District of Columbia	**Disabled**: Added 7 new services to MR/DD waiver (365) **Aged**: Added 2 new services to Elderly/Physical Disabilities Waiver (299)
Florida	**Parents/Adults, Disabled and Aged**: Eliminate dental services for adults except for emergency dental services (7.1.02) (82,000)
Georgia	
Hawaii	
Idaho	**Parents/Adults, Disabled and Aged**: Reinstated Emergency Dental and decreased TCM from 8 hours to 4 hours for MI and 5 hours to 3hours for DD (18,114)
Illinois	
Indiana	**Parents/Adults, Disabled and Aged**: Dental cap at $600. Added buy-in
Iowa	
Kansas	**Parents/Adults**: Eliminate vision, audiology and diapers – effective 1.03 to 6.03 (10,000)
Kentucky	**Disabled and Aged**: Expansion
Louisiana	**Children, Disabled and Aged**: Expansion
Maine	
Maryland	
Massachusetts	**Parents/Adults, Disabled and Aged**: Eliminate adult optional services: prosthetics, orthotics, eyeglasses, chiropractor services and dentures. (513,000)
Michigan	
Minnesota	
Mississippi	**Other**: Pregnant Women – Eliminated vision and dental (21,200)
Missouri	
Montana	**Parents/Adults**: Dental restricted to emergency and previous procedures (7,000) and restrictions on MH therapies and eyeglasses
Nebraska	
Nevada	
New Hampshire	
New Jersey	
New Mexico	
New York	

North Carolina	**Other**: Limit PCS to 3.5 hrs/day while maintaining 80 hr/month limit **Children and Parents/Adults**: Reduce case management services by reducing rates, streamlining services, and eliminating duplicative services
North Dakota	**Parents/Adults, Disabled and Aged**: Reduction in adult dental (services still available, include exams, x-rays, cleaning and fillings) (27,712)
Ohio	
Oklahoma	**Parents/Adults**: HMOs reduced benefits, reduced number of hospital days, eliminated adult dental (46,000) **Disabled and Aged**: HMOs reduced benefits and number of hospital days (120,000)
Oregon	**Parents/Adults**: Reduced benefits for OHP standard clients (eliminated vision, partial dental, non-emergency transport, partial DME) effective February 1, 2003; Eliminated drug coverage for 13 days (100,000) **Other**: Reduction of services by 8 line movement on OHP prioritized list form 566-558
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	**Children, Parents/Adults, Disabled and Aged**: Added hospice benefit effective January 1, 2003 (58)
Tennessee	
Texas	
Utah	**Parents/Adults, Disabled and Aged**: Eliminated dental (6/02), podiatry, speech and audiology (7/02), OT/PT and vision (2/03). Chiropractic services were scaled back around 10/02.
Vermont	**Parents/Adults, Disabled and Aged**: Eliminated chiropractic services and dentures for all adults
Virginia	
Washington	**Other**: DASA – Added CM for chemically dependent clients
West Virginia	
Wisconsin	
Wyoming	

Note: Numbers and parentheses are estimates of numbers of people affected by the policy described. Descriptions of policies and estimates of numbers of people affected were provided by state officials who responded to the survey in June 2003. A blank indicates the state reported no action.

Appendix I: Benefit Related Actions Taken in the 50 States and District of Columbia in FY 2004

State	Benefit Change
Alabama	
Alaska	
Arizona	
Arkansas	
California	
Colorado	**Children, Parents/Adults, Disabled and Aged**: Non-emergency Medical Transport reduction
Connecticut	
Delaware	
District of Columbia	
Florida	**Parents/Adults**: Vision and hearing services were eliminated, effective 7.1.03 (82,000) **Other**: Eliminate reimbursement for circumcision services (14,100)
Georgia	**Children, Parents/Adults, Disabled and Aged**: Dental restriction
Hawaii	
Idaho	**Parents/Adults, Disabled and Aged**: Restore adult dental limitations (1,450)
Illinois	
Indiana	
Iowa	
Kansas	**Parents/Adults**: Restore vision/audiology and diapers
Kentucky	
Louisiana	**Other**: No longer reimburse for circumcisions
Maine	
Maryland	
Massachusetts	**Parents/Adults, Disabled and Aged**: Restored orthotics and prosthetics
Michigan	**Parents/Adults**: Elimination in ambulatory benefits for dental; Elimination in option ambulatory – podiatry, chiropractic, dentures, non-emergency dental, personal care services, non-emergency transport, care management, and respiratory care.
Minnesota	**Parents/Adults, Disabled and Aged**: $500 dental cap (100,000)
Mississippi	**Parents/Adults**: Designed benefits packages for certain groups (85,000) **Disabled**: Designed benefits packages for certain groups (130,000) **Aged**: Designed benefits packages for certain groups (72,000)
Missouri	**Parents/Adults**: Expand psychologist services to adults, restore adult dental and optical (22,908) **Other**: Set limits and PA for counseling therapies
Montana	**Children, Parents/Adults, Disabled and Aged**: All restored back to 2002 levels
Nebraska	**Children**: Orthodontic care limited to extremely severe conditions (1,800) **Parents/Adults**: Chiropractic visits and eye glass replacements limited (500) **Disabled**: Community based expenditures for high needs individuals capped (20)
Nevada	**Disabled and Aged**: Limit personal care aide IADL hours (34,248)
New Hampshire	**Children**: Reduced orthodontic coverage
New Jersey	**Parents/Adults, Disabled and Aged**: Proposed to eliminate dental

	and chiropractic for all adults, exclude federally exempt populations (14,000)
New Mexico	
New York	
North Carolina	
North Dakota	**Children**: Limit physician visits to 12/year, chiropractic visits to 12/year, OT to 20/year, psychological therapy to 40/year, limit SP to 50/year, and limit PT to 15/year; EPSDT will allow exceptions (54,000) **Parents/Adults, Disabled and Aged**: Limit physician visits to 12/year, chiropractic visits to 12/year, OT to 20/year, psychological therapy to 40/year, limit SP to 50/year, limit PT to 15/year, and limit adult glasses to once every 3 years
Ohio	**Parents/Adults, Disabled and Aged**: The executive budget proposed elimination of optional benefits for adults – dental, vision, chiropractic, podiatry, and psychology. Based on most recent information, all but chiropractic services will be restored. (800,000)
Oklahoma	
Oregon	**Parents/Adults**: For OHP Standard population, eliminated non-emergency hospital services, therapies, home health services. Added mental health, chemical dependency, medical supplies and emergency dental services. **Other**: Native Americans -- Submitting waiver amendment to CMS to give OHP+ package to all eligible AI and Alaskan Native clients (3,000) **Other**: All -- Reduction of services by a 30 line movement of the OHP prioritized list from 549-519
Pennsylvania	**Parents/Adults**: Elimination of podiatry, optometry and chiropractic services for all adults
Rhode Island	
South Carolina	
South Dakota	
Tennessee	
Texas	**Parents/Adults, Disabled and Aged**: Eyeglasses, hearing aids, chiropractic services, podiatry, counselors and psychologists cut (175,000)
Utah	**Children**: Circumcision eliminated **Parents/Adults, Disabled and Aged**: Occupational therapy, physical therapy, speech and audiology restored for all non-pregnant adults, further restrictions in chiropractic visits, 2nd podiatry restoration of certain surgeries (60,000)
Vermont	
Virginia	**Children, Parents/Adults, Disabled, Aged**: Prior authorization will be required for home health, outpatient rehab and outpatient mental health services after the fifth visit; prior authorization will be required for non-emergency outpatient scans (MRI, CAT, PET).
Washington	**Parents/Adults, Disabled and Aged**: Dental scaled back
West Virginia	
Wisconsin	
Wyoming	

Note: Numbers and parentheses are estimates of numbers of people affected by the policy described. Descriptions of policies and estimates of numbers of people affected were provided by state officials who responded to the survey in June 2003. A blank indicates the state reported no action.

Appendix J: Survey Instrument

Medicaid Budget Survey
for Fiscal Years 2002, 2003 and 2004

State of: Name: Date:
Phone: Email:

ction I. Medicaid Expenditures for State Fiscal Years 2002, 2003 and 2004

A. Below, please indicate Medicaid expenditures, excluding administration, and the source of funds. A consistent definition for spending across all three years is important for the calculation of annual percentage changes. Please note here your definition of Medicaid expenditures (e.g., does it include or exclude mental health, long term care, etc.):

	Source of Funds			
	State Funds	Local or Other Funds	Federal Funds	Total: All Fund Sources
2002				
edicaid Expenditures tual)				
2003				
riginal Medicaid ropriation				
urrent Projected dicaid Expenditures				
ercentage Change: FY 3 Medicaid Projected enditures over FY 2002 ual Expenditures e 3 over line 1)				
2004				
egislative Appropriation Medicaid (If adopted; erwise expected)				
ercentage Change: FY 4 Medicaid ropriation over FY 2003 jected Expenditures e 5 over line 3)				

This space is provided for any comments or explanations:

If FY 2003 projected spending is greater than the original appropriation (i.e., if line 3 above is greater than line 2), how is your state covering the shortfall?

Section II. State Fiscal Year 2003

Cost Drivers:

a. What would you consider *the most significant factor* contributing to the increase in Medicaid spending in FY 2003?_____
_____
b. What would be the *second most significant factor*? _____
c. Other significant factors? _____

Enrollment increases in FY 2003, and their contribution to Spending Increases:

a. Overall % enrollment growth, FY 2003 over FY 2002: _____%
b. What would you consider *the most significant eligibility group* contributing to the increase in Medicaid *expenditures* in FY 2003? _____
c. What would be the *second most significant group*? _____
d. Other significant groups? _____

Dual Eligibles: If available, what percentage of your spending can be attributed to dual eligibles?
_____%

Provider payment rates: For each provider type, please describe any rate increases, decreases, or freezes in FY 2003 (e.g. indicate % increase, or % decrease, or X under Freeze for no change):

Provider Type	+ % Increase	-% Decrease	X=Freeze
a. Pharmacy			
b. Inpatient hospital			
c. Outpatient hospital			
d. Doctors			
e. Dentists			
f. Managed care organizations			
g. Nursing homes			
h. Home health providers			
i. Home and community-based waiver providers			
j. Others:			

Provider Taxes/Assessments:
Please describe any provider taxes that were in place in FY 2003, and indicate which were first used in FY 2003.

Provider Group subject to Tax in	Was this tax new in FY 2003? (Yes or No)	Description
a.		
b.		
c.		
d.		

Changes in Eligibility Standards or Application/ Renewal Process in FY 2003:
In the table below please describe any expansion, reduction, restriction or other change in ***eligibility standards*** (e.g., income standards, asset tests) *implemented* during FY 2003.

Eligibility Category	**Nature of Eligibility Change: Expansion, Reduction, Restriction or Other Change**	**How many people were affected? ***
a. Children		
b. Parents/ Adults		
c Disabled		
d. Aged		
e. Other		

*For this and following questions, please indicate your *estimate* of the number of persons.

6.f. Did your state make any changes to the ***application or renewal process*** in FY 2003 (e.g., changes in verification requirements, face to face interview requirements, application forms, re-determination process, etc.)?
Yes ____ No ____ If "yes," please describe those changes, and the estimated number of people affected:
_____
_____

Changes in Benefits or Services in FY 2003: Please describe below any expansion, reduction, restriction or other change in benefits or services *implemented* during FY 2003.

Populations affected by change in benefits	**Nature of Benefit or Service Change Expansion, Reduction, Restriction or Other Change (E.g., for adults, dental coverage ended 1/03)**	**How many people were affected?**
a. Children		
b. Parents/ Adults		
c. Disabled		
d. Aged		
e. Other		

New or Higher Copayments: Please describe any beneficiary cost sharing that was *newly implemented or increased* in FY 2003:

Populations affected by new or higher cost sharing	**New or Higher Beneficiary Copays (or other cost sharing requirements) by Service, e.g., for prescription drugs, dental, etc.**	**How many people were affected?**
a. Parents/ Adults		
b. Disabled		
c. Aged		
d. Other		

Prescription Drug Program Changes: What new actions were *implemented* during FY 2003 to slow the growth in Medicaid expenditures for prescription drugs? Please briefly describe those that apply.

Program or Policy Actions	Description
a. Payment for Rx @ AWP less a greater discount *or* WAC plus a smaller discount	
b. New/lower state MAC rates	
c. Reduction in dispensing fees	
d. More drugs subject to prior authorization	
e. Preferred drug list	
f. Supplemental rebates	
g. Limits on the number of Rx per month	
h. Requirements to use generics	
i. Mail order pharmacy contract	
j. Contract with PBM	
k. Long term care pharmacy initiative	
l. Other	

10. Other Cost Containment Measures: Were other program or policy actions *implemented* during FY 2003 to slow the growth in Medicaid expenditures? Please briefly describe those that apply.

Program or Policy Actions	Description	How many people affected?
a. Expansion of managed care (e.g. geographic expansion of PCCM or MCOs, enrollment of additional eligibility groups, mandatory enrollment.)		
b. Disease management or case management		
c. Enhanced fraud and abuse controls		
d. Long-term care changes (excluding rate changes listed in Question 4 above.)		
e. Medicare crossover claims policies		
f. Accounting change (e.g., shift to cash acctg.)		
g. Other:		

Notes on above actions: _____

_____

_____

_____

. **Estimate of FY 2003 Savings**: What is your *estimate* of the amount of savings from the cost-containment activities listed above for FY 2003?

Total Savings $_____Millions (all fund sources)

State General Fund Savings $_____Millions

mments? _____

12. **Reflections on FY 2003 Cost Containment**: As you look back on actions taken in FY 2003, could you comment on whether any cost containment activities were blocked or delayed by litigation, whether savings were as great as anticipated, whether you received support or opposition from the advocate community, or anything else that may have surprised you, etc.?

_____

_____

_____

Section III: State Fiscal Year 2004

Next, let's talk about Medicaid for next year, FY 2004:

. **Legislative Action**: Has your legislature approved the Medicaid budget for FY 2004? Yes_____ No _____

. **Cost Drivers:** Do you expect the factors that will contribute to Medicaid expenditure growth in FY 2004 to be the same as or different from those that contributed in FY 2003?

a. Same cost drivers as in FY 2003 _____
b. Different in FY 2004, in this way:

_____

_____

. **Enrollment increases in FY 2004 and their contribution to Spending Increases**:

a. Projected overall % enrollment growth in FY 2004 over FY 2003: _____%
b. What would you consider *the most significant eligibility group* contributing to the increase in Medicaid *expenditures* in FY 2004? _____
c. What would be the *second most significant group*? _____
d. Other significant groups? _____

. **Provider payment rates**: For each provider type, please describe any rate increases, decreases, or freezes to be implemented in FY 2004 (e.g. indicate % increase, or % decrease, or X under Freeze for no change). If a rate increase is a restoration of a previous rate cut, please write "**R**" after the indicated % increase.

Provider Type	+% Increase (R?)	-% Decrease	X=Freeze
a. Pharmacy			
b. Inpatient hospital			
c. Outpatient hospital			
d. Doctors			
e. Dentists			
f. Managed care organizations			
g. Nursing homes			
h. Home health providers			
i. Home and community-based waiver providers			
j. Others:			

7. **Provider Taxes or Assessments**: Please describe briefly any provider taxes (or provider tax increases) that are new for FY 004:

a._____
b._____
c._____
d._____

- **Changes in Eligibility Standards or Application Process in FY 2004:**
  Standards: Please describe below any expansion, reduction, restriction or other change in ***eligibility standards*** (i.e., income or asset tests) to be adopted during FY 2004. Please indicate with an "**R**" if any change is a restoration of a previous reduction.

Eligibility Category	**Nature of Eligibility Change: Expansion, Reduction, Restriction or Other Change (R = Restoration)**	**How many people will be affected?**
a. Children		
b. Parents/ Adults		
c. Disabled		
d. Aged		
e. Other		

18.f. Process: Is your state making any changes to the ***application or renewal process*** in FY 2004 (e.g., changes in verification or face to face interview requirements, applications, renewal process, etc.)? Yes ___ No ___ If "yes," please briefly describe those changes, and the estimated number of people affected:

_____
_____
_____

- **Changes in Covered Benefits in FY 2004:** Please describe below any expansion, elimination, restriction or other change in *benefits or services* that are to be adopted during FY 2004. Please indicate with an "R" if any change is a restoration of a previous reduction.

Populations	**Nature of Benefit or Service Change: Expansion, Reduction, Restriction or Other Change (R = Restoration)**	**How many people will be affected?**
a. Children		
b. Parents/ Adults		
c. Disabled		
d. Aged		
e. Other		

. **Prescription Drug Program Changes:** What program or policy actions are to be adopted for FY 2004 to slow the growth in Medicaid expenditures for prescription drugs?
Please briefly describe those that apply.

Program or Policy Actions	Description
a. Payment for Rx @ AWP less a greater discount or WAC plus a smaller discount	
b. New/lower state MAC rates	
c. Reduction in dispensing fees	
d. More drugs subject to prior authorization	
e. Preferred drug list	
f. Supplemental rebates	
g. Limits on the number of Rx per month	
h. Requirements to use generics	
i. Mail order pharmacy contract	
j. Contract with a PBM	
k. Long term care pharmacy initiative	
l. Other	

. **New or Higher Copayments**: Please describe any beneficiary cost sharing that is *newly implemented or increased* for FY 04:

Populations affected by new or higher cost sharing	New or Higher Beneficiary Copays (or other cost sharing requirements, e.g., for Rx, dental, etc.)	How many people will be affected?
a. Parents/ Adults		
b. Disabled		
c. Aged		
d. Other		

3. Home and Community Based Services in FY 2003 and FY 2004: Please describe if and how the provision of Home and Community Based Services changed in FY 2003 and how you expect it to change in FY 2004. (E.g. addition or reduction of slots, refinancing under waiver authority, new waiver groups, etc.)?

Other Cost Containment Measures: What other actions are to be used for FY 2004 to control the growth in Medicaid expenditures? Please describe those that apply.

Program or Policy Actions	Description	How many people affected?
a. Expansion of managed care? Specify type of expansion (e.g. geographic expansion of PCCM or MCOs, expansion of eligibility groups, mandatory enrollment, etc.)		
b. Disease management or case management		
c. Enhanced fraud and abuse controls		
d. Long-term care changes (excluding rate changes reported in Question 16?		
e. Medicare crossover claims policies		
f. Accounting change (e.g., shift to cash acctg.)		
g. Other		

Notes on above actions: _____

_____

. **Potential Shortfall:** When you look now at the amount appropriated (or that you expect to be appropriated) for FY 2004 for Medicaid, how likely do you believe it is that your state will experience a Medicaid budget shortfall in FY 2004? (Indicate with an **X**.)

Almost Certain To be No Shortfall	Not Likely	50-50	Likely	Almost Certain to be a shortfall

. **Other Comments:** We are interested in your brief comments on the outlook for Medicaid in your state in FY 2004, and what you see as the most important issues Medicaid will face over the next year?

_____

_____

_____

Do you have any documents that you could send that describe the factors associated with increasing Medicaid costs, and the actions you are taking in your state to control Medicaid costs?

Please send the survey and any documents to:

Vernon K. Smith, Ph.D.
Health Management Associates
120 N. Washington Sq., Suite 705
Lansing, MI 48933

Phone: 517-318-4819
Fax: 517-482-0920
E-mail: Vsmith@hlthmgt.com

Thank you very much. Please feel free to call if you have any questions.

This survey is being conducted by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured. The report based on this survey of all 50 states will be sent to you as soon as it is available.

Appendix K: 2003 Legislative Regular Session Calendar

State	Convenes	Adjourns
Alabama	Mar 4	Jun 16
Alaska	Jan 21	May 21
Arizona	Jan 13	June 19
Arkansas	Jan 13	April 16
California	Dec 2, 2002	Mid-Sept
Colorado	Jan 8	May 7
Connecticut	Jan 8	Jun 4
Delaware	Jan 14	Jun 30
Florida	Mar 4	May 2
Georgia	Jan 13	April 25
Hawaii	Jan 15	May 1
Idaho	Jan 6	May 3
Illinois	Jan 8	*
Indiana	Jan 07	Apr 27
Iowa	Jan 13	May 2
Kansas	Jan 13	May 6
Kentucky	Jan 7	Mar 25
Louisiana	Mar 31	Jun 23
Maine	Dec 4, 2002	Jun 14
Maryland	Jan 8	Apr 7
Massachusetts	Jan 1	*
Michigan	Jan 8	*
Minnesota	Jan 7	May 19
Mississippi	Jan 7	Apr 6
Missouri	Jan 8	May 16
Montana	Jan 6	April 26
Nebraska	Jan 8	May 30
Nevada	Feb 3	Jun 3
New Hampshire	Jan 8	Late June
New Jersey	Jan 14	*
New Mexico	Jan 21	Mar 22
New York	Jan 8	*
North Carolina	Jan 29	Early July
North Dakota	Jan 7	Apr 25
Oklahoma	Feb 3	May 30
Oregon	Jan 13	Mid-July
Pennsylvania	Jan 7	*
Rhode Island	Jan 7	Late June
South Carolina	Jan 14	Jun 5

South Dakota	Jan 14	March 24
State	**Convenes**	**Adjourns**
Tennessee	Jan 14	May 29
Texas	Jan 14	Jun 2
Utah	Jan 20	Mar 5
Vermont	Jan 8	May 30
Virginia	Jan 8	Feb 22
Washington	Jan 13	Apr 27
West Virginia	Jan 8	Mar 16
Wisconsin	Jan 6	*
Wyoming	Jan 14	March 6
American Samoa	Jan 13	
District of Columbia	Jan 2	*
Guam	Jan 13	*
Puerto Rico	Jan 13	Jun 30
Virgin Islands	Jan 13	*

*=Legislature meets throughout the year

SOURCE: National Conference of State Legislatures, 2003 Legislative Session. Accessed September 12, 2003 at:
http://www.ncsl.org/programs/legman/about /sess2003.htm

Ms. ROWLAND. For the most part, we see that the struggle for State revenues and for Medicaid financing is having its greatest impact on primarily the parents of young children. Many of the States, including New Jersey is one example, have had to roll back their coverage in that area. All States are struggling with how to restrain the cost of prescription drugs and how to better purchase those pharmaceuticals, but they are beginning to institute some curbs on the prescription drug utilization. That tends to affect the elderly and disabled population because they account for about 80 percent of all the prescription drug use in the States.

We are seeing, obviously, provider payment reductions going on across the board in most States, which is one of the first places States turn to try to trim spending. That is affecting nursing home payment rates, managed care payment rates and other hospitals and other providers.

I think we are going to see some erosion of managed care coverage in the States as some of the plans decide to pull out of the Medicaid market just as we saw them pull out of the Medicare market in the past as they see frozen or reduced payment rates, and we are clearly seeing changes in how prescription drugs are being used in the States.

Mrs. WILSON. Thank you.

I want to thank both of the witnesses today and thank all of you who have joined us for some of your morning.

We will hold the record open for testimony and other statements, including Members' statements.

I also wanted to let folks know we are close to finalizing the date and subject for our next hearing on Medicaid, which is likely to be on the coordination of care and on the management of chronic disease, to take a look at the challenges facing Medicaid with respect to those two issues.

I thank all of you again. This hearing stands adjourned.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MD
November 10, 2003

The Honorable JOHN DINGELL and SHERROD BROWN
The Committee on Energy and Commerce
Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

DEAR CONGRESSMAN DINGELL AND BROWN: This correspondence is in response to your inquiry regarding Medicaid reform and the culture of dependence that has been created by the current system. You requested specific examples that keep families on Medicaid when they have had comparable and affordable coverage in the private market. Let me share a few quick thoughts with you.

First of all, the Medicaid system we have developed is growing. In our attempt to make healthcare affordable, accessible, and available, we have created a situation that is both positive and negative. We probably have more children, moms, some dads, the disabled and seniors receiving health care via Medicaid than ever before. Income levels have been expanded when previously only those at certain poverty levels were eligible. Several years ago Maryland participated in the waiver to offer health care to children and pregnant moms through the Children's Health plan. During the debate there was concern that as we increased the income levels for eligibility, we did not create a situation in which those mothers and children currently enrolled in a health care plan thru private insurance dropped their existing coverage to then obtain free coverage with the CHIPS program as the CHIPS program

would be much less expensive than private insurance. For instance, state employees who would make up to 200% FPL would be, technically speaking, eligible for the CHIPS coverage. To avoid this situation, anyone who had existing employer-sponsored health coverage was not eligible. As a result, there were many state employees who were paying much more for their coverage than those on the CHIPS program; even though they had the same income. This seems to me to be inequitable and becomes a disincentive for citizens.

As the cost of healthcare/coverage continues to rise, increasing numbers of employers are finding it harder to continue to provide health insurance for their employees. Co-pays and the employee contribution of premiums are increasing and both employers and employees find themselves in a difficult situation. For those individuals who have taken advantage of the CHIPS program and who are working off of welfare, it becomes harder and harder to find health insurance affordable or even available through the workplace other than Medicaid. Therefore, there is no incentive to take those jobs with employer sponsored coverage. As long as individuals do not incur the costs of health care there is no incentive to seek jobs with employer-sponsored coverage.

Another situation has occurred over the years. Those individuals struggling with severe mental illness or with multiple disabilities who are receiving disability may want to work. Because of the earnings limitation requirement, they do not work for fear of losing disability health benefits. I know several who did exceed their earnings limitation and received fines with the payback to the extent that it was so overwhelming that relapse occurred. One young woman told me that it is to hard and discouraging to break out of the cycle—it is easier to be sick. The Federal program will be help for these individuals as we implement a pilot in Maryland.

I hope my thoughts are helpful. If I can be of further assistance please call my office 1-410-221-6561.

Sincerely,

ADDIE C. ECKARDT
Maryland State Representative

RESPONSE FOR THE RECORD FROM DIANE ROWLAND, SC.D., EXECUTIVE VICE PRESIDENT, HEALTH POLICY, KAISER FAMILY FOUNDATION

Representative Towns' Question. "Can you share with the Committee some specific examples of how the 'culture of dependence' has kept families on Medicaid when and where they have had comparable and affordable insurance coverage in the private market?"

Diane Rowland's Answer. The population Medicaid covers are many of the poorest and most vulnerable Americans.

With employer-sponsored insurance premiums experiencing annual double-digit growth; the average family premium costing over $9,000, of which the employee pays on average $2,400 annually; and premiums on the individual market being even higher, private health insurance coverage is financially out of reach for families whose incomes are low enough to qualify for Medicaid. Further, data show that low-wage workers are not likely to be offered health insurance through their employer. Therefore, low-income families on Medicaid generally do not have access to affordable comprehensive coverage in the private marketplace.

The 13 million elderly and disabled individuals who rely on Medicaid are even less likely to have an opportunity to secure coverage through private plans. They often have severe chronic conditions that make them largely uninsurable through the private market. Medicaid thus serves as the insurer of last resort for many of these individuals who otherwise would simply go without any coverage.

In addition, for the low-income elderly, long-term care coverage is not available or affordable at their age. Even for Medicare beneficiaries, Medicaid currently helps with drugs for which private plans are not available or prohibitive in cost.

PREPARED STATEMENT OF THE ALZHEIMER'S ASSOCIATION

Decisions about Medicaid policy are among the most important decisions Members of Congress make that affect the lives of Alzheimer families. Medicaid is the single largest public payer for long term care services in the United States, and a last resort for persons with Alzheimer's who have no other way to pay for the help they need. Many Medicare beneficiaries with Alzheimer's also receive Medicaid to help pay for long term care, prescription drugs and other medical care.

Medicaid is a critical program for people with Alzheimer's because it helps to cover the cost of nursing home care for persons who are poor or who "spend down" their resources on long term care. It also covers home and community based services for low income persons requiring nursing facility levels of care. Medicaid is the only "safety net" for long term care.

Medicaid also provides basic protections that Congress has carefully written into the law—including nursing home quality standards and protections against spousal impoverishment. These are also essential elements of the current Medicaid program.

Medicaid is close to the breaking point in many states—called upon to do too much, for too many people, with too little money. It is not so different for Alzheimer families, and when Alzheimer families reach their breaking point, Medicaid is the only place they can turn for needed assistance.

The following stories about Alzheimer families illustrate why the Medicaid program is so critical to the people we represent:

Mavis Gilpin

Mavis Gilpin is 86 and she lives with her daughter, Yvonne Ager, age 61, in Georgia. She has lived with her daughter for about 10 years. Since her mother's diagnosis of Alzheimer's Ms. Ager states that her "life has been a disaster," especially now that her mother is invalid. Her mother requires 24-hour supervision. Ms. Ager is unable to cope with full-time employment because of her caregiving responsibilities. Prior to her mother qualifying for Medicaid, Ms. Ager had to take personal loans to pay for medical bills.

Ms. Ager says the services provided by Medicaid are "priceless and appreciated." Her mother receives medical and pharmaceutical benefits, as well as a home health aide. Ms. Ager stated that any reduction in her mother's Medicaid services would be "disastrous." She is unable to transfer her mom without assistance. If the home health aide services were reduced or stopped, her mother's basic care would be compromised. Ms. Ager believes that the Medicaid prescription drug benefit has helped to keep her mom out of both the doctor's office and the hospital.

Margaret and George Isaac

Margaret Isaac is 65 and provides care for her husband, George, who is 72 and diagnosed with Alzheimer's disease. He was diagnosed in 1999. Although he is still at home, over the years, Mrs. Isaac has watched the disease rob her husband of everything, and has seen her own caregiving responsibilities increase. Today, George "doesn't understand anything more or less" when she speaks with him. Mrs. Isaac assists him daily with his self-care and toileting. He requires constant supervision because of his cognitive impairment and confusion.

The Isaacs rely on the monetary and program services provided by Medicaid. SOURCE, a Medicaid program in Georgia, sends a caseworker to their home. Mr. Isaac is able to attend adult day care, and receive home care and light housekeeping as part of his Medicaid services. The Isaacs also rely on Medicaid for their transportation to medical appointments and his participation in the adult day program. Mrs. Isaac believes that without the assistance from Medicaid that they "wouldn't be able to afford to do anything". They are in the process of selling their home and moving into HUD housing.

There are many more stories of Alzheimer families who have exhausted their resources and turned to Medicaid as a last resort. And until researchers find a way to prevent or delay the onset of this disease, there will be many more such families in the future. A recent study published in the Archives of Neurology predicts the prevalence of Alzheimer's disease will increase 27% by 2020, an astonishing 70% by 2030, and nearly 300% by 2050, unless science finds a way to slow the progression of the disease or prevent it.

As the Committee works to improve the Medicaid program, the Alzheimer's Association urges you to maintain the Medicaid long term care safety net that is so important to people with Alzheimer's and their families.

PREPARED STATEMENT OF THE AMERICAN HEALTH CARE ASSOCIATION

The American Health Care Association is a non-profit federation of state long term care associations, together representing nearly 12,000 non-profit and for-profit nursing facility, assisted living, developmentally-disabled and sub acute care providers that care for 1.5 million elderly and individuals with disabilities nationwide.

As the nation's largest publicly funded health care program, Medicaid now accounts for 16 percent of federal spending on health care. The program provides health and long term care coverage to 51 million low-income Americans, and fills in Medicare coverage gaps—primarily to meet seniors' prescription drug and long-

term care needs. In 1989, Medicaid became the largest payer of long-term care. In 2001, of the $98.9 billion spent on nursing home care, Medicaid accounts for $47 billion of those dollars. Approximately two-thirds of nursing home patients rely on Medicaid to fund their care.

Unfortunately, however, a "perfect storm" is brewing that threatens the financial viability of Medicaid and the long term care our less fortunate frail, elderly and disabled depend upon. Demographic changes will soon bring 77 million baby boomers and their need for care and services into a system policy experts representing all points of view argue will not be able to handle the exponential increase in demand for care.

From 2010 to 2030, the number of baby boomers age 65 to 84 will grow by an estimated 81 percent while the population aged 85 and older will grow by 49 percent. As large numbers of the imminent tidal wave of baby boomers begins to require long term care, the Medicaid program will not be prepared to financially sustain the needs of this cohort—especially if they rely mainly upon Medicaid to pay for their long term care. In addition, the life spans of individuals with MR/DD have increased dramatically and while the extra years are welcome and wonderful, the additional expense of this costly population is not addressed under the current Medicaid budgets.

Seniors are often forced to rely on Medicaid for coverage of nursing home care because Medicare provides only a very limited long-term care benefit. Medicare's coverage of skilled nursing facility services is limited to 100 days following a three-day hospital stay. The average beneficiary stays 23 days in the nursing home and then returns home while others have needs requiring skilled nursing care beyond their 100 day Medicare benefit. Others may lose their Medicare eligibility due to a change in their acuity—yet still require facility care. These Medicare beneficiaries are then responsible for the costs of their care, which can exceed $50,000 annually. Many apply for Medicaid benefits at this time.

Because Medicaid is a means-tested entitlement program, they must meet Medicaid's resource requirements. Often this group has more resources than Medicaid allows, and must qualify for coverage by "spending down,"—thus impoverishing themselves to the point where they finally "qualify" for Medicaid coverage. In a typical U.S. nursing home, 67 percent of patients now rely on Medicaid for their care.

Prior to 1997, states were required to pay rates that were "... reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws..." as required by the so-called Boren Amendment. States were successful in repealing Boren by arguing they should have maximum flexibility to design coverage parameters and set provider reimbursement rates. Yet, if government has the responsibility to set care standards, then it logically must have the obligation to pay for them. This places long-term care providers in an impossible conundrum: they are held accountable to federal standards while the state sets the provider reimbursement rate. As is increasingly the case, states simply do not keep up with the costs required to meet federal standards—and the problem becomes worse annually.

At the same time, governors and state legislators face growing political pressures to expand their programs and cover more uninsured populations—especially during challenging economic times. States will also continue to face increasing costs in their Medicaid budgets as more people require nursing home care and as states expand home and community-based care options. States have struggled and will continue to struggle to identify more dollars for their Medicaid programs. In many states, governors, state legislatures and state Medicaid agencies have worked with the long-term care profession to pursue Medicaid maximization proposals. The American Health Care Association (AHCA) believes strongly that there must be adequate dollars for quality care. In some states, economic times have been grave enough that states have faced a tough choice between resorting to cuts to eligibility, reimbursement rates or benefits and therefore, placing care for seniors and people with disabilities in danger or pursuing such programs as upper payment limits involving intergovernmental transfers. AHCA recognizes that if it were not for states pursuing all possible funding avenues, long term care in many states would have seen more desperate cuts and seniors and people with disabilities may have lost their access to care.

States Will Continue to Face Medicaid Funding Challenges

At a time when our nation should be preparing for the coming retirement tidal wave, states are, instead, struggling to fund services for current beneficiaries. The most recent Kaiser Commission survey found that for many states, FY2004 marked the third consecutive year they were forced to take new actions to reduce spending

growth in their Medicaid programs. This has resulted in provider reimbursement freezes and new coverage limitations on vulnerable populations.

In May, Congress passed and the President signed legislation that provided $20 billion in temporary fiscal relief to the states. Of that amount, $10 billion was earmarked for state Medicaid programs. AHCA strongly supports this legislation as temporary relief as states are continuing to see Medicaid cost growth and populations increase.

According to Kaiser, states have also exhausted many one-time measures they have used to balance their budgets, and Medicaid budget shortfalls are likely in a majority of states for FY 2004. Continued expectations of low revenue growth as the economy remains sluggish combined with the growth in demand for Medicaid services means that states will continue to look for ways to cut programs, and limit coverage and benefits.

Kaiser Report Does Not Reflect True Picture of Rate Adequacy

Results from the Kaiser survey show that reimbursement rates for nursing home care in fiscal year 2003 were cut or frozen in 17 states. For FY 2004, 19 states either cut or froze rates for nursing home care; 33 states were able to increase rates for nursing home care in FY 2003; 29 states were able to do so in FY 2004. It is important to note, however, that the increase or decrease of reimbursement rates is not a true barometer of whether Medicaid is effectively and efficiently paying for quality nursing home care; the key is determining whether reimbursement rates are keeping up with the real costs in the health care marketplace to provide those services.

To identify and specifically quantify the shortfall between the Medicaid reimbursement rates and allowable costs of nursing homes in individual states, AHCA has engaged BDO Seidman, LLP, the independent public policy research firm. For the third consecutive year, BDO has reviewed the extent to which reimbursement rates have kept pace with the costs to provide care. Using a database of Medicaid rates and cost report information, comparisons of Medicaid rates and allowable costs from 2001 (the most recent audited or desk-reviewed cost report data available) were derived for 34 states—representing 70 percent of all Medicaid patient days in the country.

While preliminary, indications are consistent with past studies and show that nationwide, the average shortfall in Medicaid reimbursement has grown to $10.39 per day for every Medicaid patient. In 2001, un-reimbursed Medicaid-allowable costs exceeded $2.5 billion for these 34 states, and exceeded $3.7 billion when the results are extrapolated to all 50 states. Rate increases in fiscal 2003 were, in many states, far less than the higher costs of providing quality care. In still other states, rates were either frozen or reduced—falling even farther below costs. The picture in fiscal 2004 does not improve.

The Necessity of Long Term Care Financing Reform

AHCA praises the Bush Administration and the House Energy and Commerce Committee for recognizing that the Medicaid program needs reform, and for initiating a much-needed policy discussion. We are concerned, however, that the Administration's Medicaid Modernization Proposal alters the program to the detriment of our most vulnerable senior population and Americans with disabilities.

The Administration's proposal establishes an annual funding allotment—in effect, a cap—to fund services for optional Medicaid populations. As an estimated 85 percent of Medicaid beneficiaries in nursing homes have optional Medicaid eligibility, they would be directly threatened by a plan that locks-in existing under funding and further forces states to ratchet down services and benefits. All residents of ICFs/MR, our most vulnerable Americans, would be under threat as the ICF/MR program is only an optional program under Medicaid. It is neither fair nor good public policy to force states to make care decisions based on economics—not what is best for the patient.

The real need is to reform the long-term care financing system in a manner that brings about necessary funding stability and that ensures the supply of care meets a certain, growing demand. This nation's current system for financing long term care consists of an unstable patchwork of federal and state programs, with little private insurance participation and few meaningful incentives for individuals to take personal responsibility for their own long term care planning.

While no available policy option can reduce the growing need for long-term care services and public spending, relative to current law, there are decisions that can be made regarding how public and private resources can be more effectively utilized.

We are encouraged Congress and the Administration are exploring legislation that will provide an "above-the-line" deduction (S. 1335 and H.R. 2096) of the premium

costs for long-term care insurance. Research shows this deduction will encourage the purchase of private long term care insurance—from about 10% today to about 25% in five years—and help reduce government spending on Medicaid long term care services. AHCA supports enactment of the above-the-line deduction

The costs of implementing an above-the-line deduction, though, can be quite high. At a time when government's discretionary dollars are tight, AHCA would propose an incremental expansion of tax incentives for private long term care insurance beginning with the introduction and passage of a refundable tax credit targeted toward low-income individuals. This refundable tax credit offers the greatest potential for achieving savings to the Medicaid program because it could be targeted at those individuals who are most likely to become dependent on Medicaid for their long term care needs. Because the refundable tax credit is progressive (meaning that it can provide increased premium support when an individual's income declines because of retirement, disability or loss of employment (it has the effect of creating a "financial safety-net" to prevent the lapsing of those policies purchased under existing law without a substantial increase in current government spending. By ensuring that those policies purchased under current law remain in force, the "financial safety-net" created by the refundable tax credit, further enhances consumer choice and the individual's ability to control where and how their care needs will be met in the future.

Conclusion

As their exists a substantial federal and profession-wide effort to improve the quality of care in our nation's nursing homes and homes for persons with MR/DD, AHCA believes quality improvement is an ongoing, permanent mission that necessarily requires adequate, reliable investment from the federal and state government.

AHCA supports Medicaid reform that maximizes patient choice in the health care marketplace while concurrently providing and paying for high quality care. The status quo of subjecting seniors to a process forcing them to impoverish themselves to "qualify" for nursing home care is not sustainable; neither is it good public policy.

We look forward to working with this Committee, and this Administration, to continue improving the quality of care in America's long term care facilities, and to maintain a collaborative dialogue that puts the special care needs of our frail, elderly and disabled always first.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

The National Association of Community Health Centers (NACHC) appreciates the opportunity to submit the following statement for the record on the important relationship between community health centers and the Medicaid program. NACHC is the advocate voice for our nation's over 1000 Community, Migrant, and Homeless Health Centers and Public Housing Primary Care Centers, and the patients and communities served by them.

For almost 40 years, health centers, alongside public hospitals, public health departments and free clinics, have been providing high quality, cost-effective, primary and preventive health care to millions of people living in medically underserved communities regardless of their ability to pay.

The reality is that community health centers play a critical role in building bridges to better care and serve as an intricate part of the health care safety net, in place to catch those who fall through the cracks. In fact, today, health centers serve as the family doctor and health care home for 14 million Americans in over 4,000 urban and rural communities across the country.

One in nine Medicaid recipients, one in six low-income children, one in eight uninsured individuals, and one in ten rural Americans benefit from health centers (known in Medicaid law as Federal Qualified Health Centers, or FQHCs). Among the millions of people served by health centers:

- 40% depend on coverage through Medicaid or SCHIP, the State Children's Health Insurance program;
- 40% lack health insurance coverage; and
- 86% are living in families with incomes at or below 200% of the Federal Poverty Level (FPL).

As critical as they are for the health care they provide, health centers are much more to their communities:

- They are a major source of jobs and meaningful employment—most of the 60,000+ employees of health centers are community residents—and in many of their neighborhoods or towns, they are often the largest employer.
- They are engines of economic development for their communities, spending nearly $6 billion a year, with combined payrolls exceeding $4 billion, and they generate more than $20 billion in economic output for low-income communities across America.
- Health centers also serve as critical "anchors" in their communities, helping to attract or retain other businesses, including other physicians, pharmacies or diagnostic services—even local hospitals, but also other local businesses, and playing a pivotal role in sustaining a sense of community, giving residents a feeling of pride and helping to revitalize communities.

Additionally, many health centers are involved in special initiatives to monitor and address community-specific health problems, such as diabetes, asthma and cancer management, boosting infant immunization rates, keeping patients' blood pressure under control, and reducing the number of low birth-weight babies.

As testament of the success and commitment of health centers in improving access to affordable, quality health care to our nation's medically underserved, Congress has shown broad bipartisan support for a multi-year initiative to expand the health center program to meet an ever-growing need across the country. In fact, over the past 5 years, Congress has increased federal investment for health centers by almost $700 million.

Beyond this, for each of the past three years, President Bush (who pledged to grow this program during his campaign for office) has requested and received the largest increases in funding over the program's entire history. This combined effort on the part of the Congress and Administration has enabled health centers to reach out and serve more than 3 million new people, and it will eventually increase or expand health center access points by 1,200 over five years as well as eventually double the number of people served. In addition, when Congress established the Medicaid prospective payment system for health centers in 2000, it reaffirmed the importance and need of health centers as safety net providers.

All told, however, for the vital mission of community health centers to be sustained, and for the President's initiative to be ultimately successful, Congress must recognize, understand and preserve the unique interrelationship between these centers and Medicaid as it considers reforming the joint federal-state program for the poor.

THE IMPORTANCE OF HEALTH CENTERS AND MEDICAID

Health centers are a major provider of primary and preventive care services to nearly 5 million Medicaid recipients. In fact, Medicaid is currently the single largest beneficiary of health center services, as well as health centers' single largest source of financing. Keenly recognizing the importance of health center services to Medicaid beneficiaries, Congress in 1989 required that the services of a FQHC be a guaranteed Medicaid benefit offered to beneficiaries in every State Medicaid program. Most important, Congress recognized and acknowledged that Medicaid reimbursement to FQHCs must be sufficient to assure that health centers were paid their full reasonable costs for serving Medicaid patients (so that they would not have to use their Public Health Service Act grant funds to subsidize low Medicaid payments). Two years ago, under the leadership of Congressmen Richard Burr and Edolphus Towns, and with the support of the overwhelming majority of the Energy and Commerce Committee, Congress reaffirmed the continued importance of adequate Medicaid reimbursement to health centers by creating a prospective payment system (PPS) for FQHCs that (1) assures continued access to care for Medicaid patients, (2) protects Federal grant funds to provide care for the uninsured, and (3) gives state Medicaid agencies greater flexibility in designing their Medicaid programs and predictability in the cost of payments to health centers.

MEDICAID AS A SIGNIFICANT SOURCE OF INSURANCE

Health center patients are more much more likely than the general US population to have Medicaid or be uninsured. Nationally, 11% of the population has Medicaid and another 15% is uninsured. In 2002, 36% of all health center users had Medicaid while 39% were uninsured. This disproportion stems from the fact that health center users are overwhelmingly at less than 200% of poverty; two-thirds of users are under 100% FPL. To be sure, Medicaid coverage and uninsurance varies by age group. Children under age 20 are much more likely to have Medicaid and less likely to be uninsured than adults age 20 and over. This is due to eligibility rules that are more favorable to children. In fact, over half or 54.6% of all health center chil-

dren have Medicaid while less than a quarter or 23.4% of adults are covered under the program.

MEDICAID AS AN IMPORTANT SOURCE OF REVENUE

By ensuring adequate Medicaid reimbursement to FQHCs, the Congress clearly recognized the potential impact of low Medicaid payments on health centers' ability to care for uninsured patients. In the 14 years since enactment of this payment system, health centers have increased their capacity for uninsured care by 2.5 million people—double the number of uninsured patients served in 1990, a rate of growth that is more than twice that for the nation's uninsured population. Currently, Medicaid represents 35% of total revenue for health centers—the largest of any single source and noticeably higher than the second largest source, federal grants revenue (25%). Indeed, Medicaid makes up 63% of all patient-related revenue, significantly larger than any other insurance source.

HEALTH CENTER PARTICIPATION IN MEDICAID

Health centers are unique in the health care system because, as part of their grant requirements, they must be located in areas of high need and be open to all patients seeking care. This explains Medicaid's other role with regard to health centers: just as health centers rely on Medicaid revenues, Medicaid beneficiaries rely on health centers for their care. To illustrate this point, consider that although more than a third of all health center patients have Medicaid, Medicaid represents only 9% of private, office-based physician visits. It is also important to consider that only half of physicians are willing to accept all new Medicaid patients, and the proportion of private physicians willing to provide charity care has declined, according to one recent study. Thus, health centers are a significant provider of primary care to Medicaid beneficiaries, and tend to provide specialty care and enabling services that go beyond the care provided at office-based physician settings. In fact, according to a recent report by the Kaiser Family Foundation, the number of Medicaid patients served by health centers nearly tripled, from 1.3 million to 3.6million persons in the years between 1980 and 2001, compared to 50 percent growth in total Medicaid enrollment in this period. Moreover, 99% of patients reported in 2001 that they were satisfied with the care they receive at health centers.

DELIVERING MEDICAID SAVINGS THROUGH QUALITY CARE

Health centers deliver savings to all payers, especially Medicaid. They control health care costs by providing primary and preventive services, reducing the need for more costly hospital care down the road. According to one recent study, communities served by health centers had 5.8 fewer preventable hospitalizations per 1,000 people over three years than other medically underserved communities not served by a health center. Another study found that Medicaid beneficiaries who seek care at health centers were 22 percent less likely to be hospitalized for potentially avoidable conditions than beneficiaries who obtained care elsewhere. Moreover, these patients were 16 percent more likely to have outpatient visits for such conditions. Several studies over the years have found that health centers save the Medicaid program at least 30 percent in annual spending for health center beneficiaries due to reduced specialty care referrals and fewer hospital admissions. Based on that data, it is estimated that health centers already save almost $3 billion annually in combined federal and state Medicaid expenditures—$1.8 billion in federal spending alone. That amount is greater than the total of all Medicaid payments to health centers last year.

GROWING DEMAND AND DIMINISHING RESOURCES

Current budget shortfalls threaten state and local financial support of health centers, even though their cost of care is among the lowest of all providers. Reductions in Medicaid eligibility, benefits, and other areas potentially jeopardize the ability of health centers to continue to provide care to all patients, including Medicaid patients. Initiatives from the Bush Administration and Congress to boost health center funding cannot compensate for reductions in state Medicaid programs or in direct State health center grant support. A recent state-by-state survey revealed that at least 20 states have enacted or are considering significant cuts in dedicated state funding for Health Centers. The sum of those cuts exceeds $40 million annually, or nearly 14% of all state funding Health Centers received last year. Loss of support in any form exacerbates the already strained financial condition of health centers, and will result in their inability to serve new patients or even many of their current patients. Compounding this problem is an increased patient load—nearly 800,000

new uninsured patients in the last three years have turned to health centers for care.

CHALLENGES FOR THE FUTURE

Medicaid plays an important role at health centers by providing patients access to comprehensive services beyond those available at health centers. Time and time again, these centers have demonstrated their ability to provide effective care—reducing infant mortality, decreasing hospital admissions and lengths of stay. However, as the health care needs of low-income individuals continue to grow, so do the challenges to health centers in sustaining their ability to provide quality care to Medicaid beneficiaries and other patients.

As Congress moves forward on considering ways in which to reform Medicaid, it is critical that it keep in mind the important role health centers play in their communities and the unique relationship between these centers and the Medicaid program. Indeed, as the Kaiser Family Foundation points out, "[t]he fundamental interrelationship between Medicaid and health centers . . . suggests, by extension, that dynamics in one domain are bound to have important impacts in the other." It is therefore imperative that lawmakers working on Medicaid reform consider the following significant issues for FQHCs:

The Burden of Medicaid Cutbacks on FQHCs

To further increase the accessibility of primary and preventive health services for low-income people living in medically underserved areas, Congress created the Medicaid prospective payment system for FQHCs. By creating this system, Congress helped to provide stability and assure access to FQHCs by ensuring that grant dollars intended for providing care to the uninsured were protected.

Yet according to reports filed by health centers for 2001, 19 states cut their Medicaid payments for care provided to enrolled individuals by an average of about 9 percent from the previous year. Overall, Medicaid payments to health centers grew by less than 1 percent per Medicaid patient, well below the 4.6% growth in the cost of care for each patient served, producing a net loss of more than $60 million for the year. Beyond this, there has already been great shift of discretion to the states in the operation of their Medicaid programs through HHS' issuance of Section 1115 waivers—under which State Medicaid agencies are permitted to reduce benefits, increase cost sharing requirements, and adjust reimbursement rules.

Health centers have already experienced the impact of this increased state flexibility in some 15 states during the 1990s. In most cases, the ability of health centers to care for both their Medicaid and their uninsured patients was impacted negatively when their Medicaid payments were reduced to in some case significantly below the cost of providing care. In many of those states, other providers decided not to participate or limited their care to only a few Medicaid patients, leaving health centers as one of the few remaining sources of primary and preventive care to this population. Given this experience, health centers urge Congress to keep in mind the important role that safety net providers have in their communities as they move forward on considering Medicaid reform proposals, and to assure that the current federal FQHC Medicaid payment system is not eroded in the process.

The Safety Net for the Safety Net

Potential cutbacks in State Medicaid payments to health centers are only a portion of the issue. Cutbacks in Medicaid eligibility levels or benefits, caps in enrollment, or forgone expansion plans also have presented significant difficulties for FQHCs. These actions are occurring at the same time as employers have been forced to either shift more of the rising cost of health insurance onto their workers or to drop the coverage altogether, and as other health care providers have begun cutting back on the uncompensated or charity care they provide. The result is that health centers are serving an ever-increasing number of uninsured individuals who previously were covered under Medicaid or through their employers. While these and other dramatic changes in the health care system have put a tremendous strain on the overall health center program, health centers remained committed to providing access to care for everyone that walks through their doors, regardless of their health status, insurance coverage, or ability to pay for services. Put simply, health centers provide care for those whom other providers cannot or will not serve.

As Congress begins to consider possible reforms to Medicaid, we urge that any flexibility extended to states to alter their Medicaid and SCHIP programs:

- Include the resources and standards to assure that such flexibility is used to expand the number of people receiving health insurance coverage under those programs without reducing the scope of essential services that are covered today, and

- Clearly recognize the key role of health centers and other core safety net providers who care for significant numbers of Medicaid and SCHIP recipients and those who remain uninsured, and ensure that these providers are adequately paid for the reasonable costs of health care they provide to enrollees.

Failure to address these principles could inevitably increase the number of the uninsured as well as impact the very safety net providers whose mission is to serve them.

Reaching out to Those Who are Eligible but not Enrolled Today

Even as the numbers of uninsured Americans rises to unprecedented levels, millions of those individuals are eligible for coverage under the Medicaid and SCHIP programs, yet remain unenrolled. In greatest part, this is due a lack of action in the part of several States to use all available tools available to improve enrollment. For example, in 1990, Congress amended the Medicaid statute to require that, as a condition of program participation, States provide for the initial receipt and processing of applications for low-income pregnant women, infants, and children at outreach locations other than welfare or government offices, including FQHCs and Disproportionate Share (DSH) Hospitals. Congress specifically named FQHCs as required outstationing sites because "they are, by definition, providers that serve large substantial numbers of low-income women, infants, and children."[1] Some States were quick to implement the provisions of the new law and have been in full compliance with its requirements. However, many more States have not complied with the Federal Medicaid outstationing law either in whole or part. Indeed, two separate evaluations of state outstationed enrollment programs during the 1990s found that only 57 to 61 percent of all FQHCs operated outstationed programs.[2] Health centers reported that the availability of State support was the most important factor in their decision to set up or expand outstationing activities. Of those FQHCs with enrollment workers, more than one-quarter found it necessary to pay for the position themselves, with no funding assistance from the State.

Recent Center's for Medicare and Medicaid Services' guidance to State Medicaid programs has clarified the States' responsibilities to place outstationed Medicaid enrollment workers at each DSH hospital and each FQHC participating in the State's Medicaid program. CMS also makes clear that "[s]taffing and resource limitations do not relieve States of the obligation to comply with and pay for the outstationing requirements of the law and regulations." However, more than 3 years after that this guidance, a survey of states by NACHC revealed that only 7 States are fully compliant with the law's requirements; these States have placed outstationed enrollment workers at all FQHC sites and pay all costs associated with the outstationing. Another 20 States are partially compliant, placing workers at some FQHC sites and paying at least some of the costs. But 22 States remain completely non-compliant, placing no State workers at any FQHC sites and failing to cover the costs of health center workers who are performing the outstationing functions.

Overall, many States continue to not recognize that outstationing at FQHCs and DSH hospitals is a mandatory part of the Medicaid eligibility process. As a result, millions of individuals eligible to receive coverage under Medicaid regrettably remain unenrolled. Accordingly, we urge the Congress to take the necessary steps to ensure that people who currently qualify for coverage under either the Medicaid or SCHIP programs have all available opportunities to enroll in, and receive the benefits of, that coverage.

We thank the Committee for holding this important hearing, and we look forward to working with Members to assure the enactment of reforms consistent with positions outlined in this statement.

PREPARED STATEMENT OF VOICE OF THE RETARDED

OPPOSITION TO BLOCK GRANTING THE MEDICAID PROGRAM: WHAT IS REALLY "OPTIONAL?"

Voice of the Retarded, an advocacy organization representing thousands of families of individuals with mental retardation nationwide, is opposed to any Medicaid

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[1] House Report No. 101-881, at 104

[2] Sara Rosenbaum et al, "Initial Findings from a Nationwide Study of Outstationed Medicaid Enrollment Programs at Federally Qualified Health Centers." Center for Health Services Research and Policy, George Washington University Medical Center, February 1998; and U.S. Department of Health and Human Services, Office of the Inspector General. "Federally Funded Health Centers and Low Income Children's Health Care: Improving SCHIP enrollment and Adapting to Managed Care." December 2000. (OEI-06-98-00321).

proposal that would "block grant" or otherwise "cap" services and funding for Medicaid eligible individuals.

Block grant proposals to reform Medicaid places the availability of all optional services at great risk. It does not add any permanent new money to the program. Over time it will limit the program, resulting in the denial of eligibility for those most in need. Of great concern is the notion that the Medicaid program should be a capped block grant that will be incapable of helping our most vulnerable citizens, including people with mental retardation, in current and future economic crises. Arbitrary growth limits to achieve predictable Medicaid costs would destroy its ability to help in the times when it is most needed. These reform principles, if enacted, would permanently undermine the integrity of the Medicaid program.

Medicaid is the primary and largest public source of funding for long term services and supports for over 7 million people with disabilities, including people with mental retardation. 200,000 more people with mental retardation and developmental disabilities are on waiting lists for services.

Most Medicaid services for people with mental retardation are considered "optional." This list of services includes such basic acute health care benefits as prescribed drugs, clinic services, dental care, physical therapy, prosthetic devices, and specified medical and remedial care. Longterm care "optional" benefits include home and communitybased services (HCBS) waiver, personal attendant care, case management, and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

"What the Medicaid program calls 'optional' services are, in reality, mandatory disability services for the children and adults who need them." (Consortium for Citizens with Disabilities, February 14, 2003 letter to President Bush). Policymakers must consider quality of life. Most people now living in ICFs/MR, for example, experience severe and profound mental retardation with complex medical conditions and/or behavioral challenges. Without the essential skilled care they now receive they might perish. These "lifeline" services are not considered "optional" by recipients and must not be curtailed.

Solutions

The significant challenges of individuals with mental retardation and developmental disabilities accessing quality medical, dental and other health care services in the community is well-documented in the media, in publicly funded studies, research by Special Olympics (http://www.specialolympics.org/healthy—athletes/THE—HEALTH—STATUS.htm) and in scholarly publications, including the recent report of the Surgeon General, "Closing the Gap: A National Blueprint to Improve the Health of Persons with Mental Retardation" (February 2002) (http://www.surgeongeneral.gov/topics/mentalretardation).

In response to this crisis, and in the context of Medicaid reform, VOR urges Congress and the Administration to consider the establishment of university-based Community Resource Centers (CRCs). This is a cost-effective system which utilizes the existing service infrastructure to expand the delivery of health care services and supports to Medicaid eligible individuals with disabilities who receive home and community-based residential services.

University-based CRCs provide desperately needed quality medical, dental, and other therapeutic services to Americans with mental retardation and developmental disability living in communities, who have significant difficulty obtaining these services. CRCs also function as universitybased centers of education, training, and research for medical and dental students, residents, externs, fellows, and professionals.

The CRC model, already implemented in several states, establishes developmental medicine and dentistry training fellowships in mainstream medical and dental schools, utilizing preexisting, communitybased primary care clinics, Intermediate Care Facilities (ICFs) and other private service delivery systems (such as the Special Olympics Healthy Athletes program) as education and training sites.

As Congress and the Administration consider Medicaid reform, there will be pressure to eliminate ICFs/MR in a misguided attempt to "broaden" choice and reduce costs. Eliminating ICFs/MR will not save costs nor increase quality outcomes, and is counter to real choice. A peer-reviewed study, published in Mental Retardation (April, 2003), found that transitioning people from large Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) to community based programs was not an effective strategy for reducing overall costs. Peer reviewed studies, the Surgeon General, state audit reports, and media investigative series have all documented systemic problems relating to the ability to provide safe and high quality care to people with profound mental retardation who are also medically-fragile. Furthermore, eliminating ICFs/MR would remove an important existing infrastructure that, as ex-

plained above, can be utilized to allow for more successful and happy community-based placements.

Eliminating ICF/MR options is also counter to the landmark Olmstead decision which clearly establishes the right of individuals with mental retardation and their families to choose a setting that best meets individual needs, whether in the community or an ICF/MR. "We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings . . . nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it." *Olmstead v. L.C.,* 119 S. Ct. 2176, 2187 (1999).

Thank you in advance for respecting choice and embracing the need for a full array of Medicaid services and supports. VOR looks forward to working with Congress to protect and strengthen the Medicaid program.

Statement Submitted to the
House Energy and Commerce Committee
Subcommittee on Health

For a Hearing Entitled:

"Challenges Facing the Medicaid Program in the 21st Century"

October 8, 2003

The American College of Obstetricians and Gynecologists (ACOG), and its 46,000 physician partners in women's health care, thanks the House Energy and Commerce Committee, Subcommittee on Health Chairman Michael Bilirakis (R-FL) for holding this important hearing. Medicaid is a vital health care safety net that ensures essential services for low-income women, including prenatal care and preventive screening tests such as mammograms and pap tests, and provides coverage annually for approximately one-third of all deliveries. Medicaid is a successful health care program for America's women and ACOG is committed to ensuring the program's viability as a source of these important services.

We recognize that many challenges lie ahead for states and the federal government as severe budget shortfalls impact Medicaid expenditures. As Congress examines ways to reform Medicaid, however, we urge caution regarding any proposal that may reduce access to necessary services. Medicaid serves our most needy populations, and, we urge this Committee to look for ways to enhance, not reduce, access to care.

Over the last decade, expansion of Medicaid services has led to increased access to prenatal care for many uninsured women, and modest improvements in low-birthweight babies. Recent statistics show that the U.S. infant mortality rate also has dropped again to 6.8 percent deaths per 1,000 live births. Disparities remain, however, and the United States still lags behind other industrialized countries when it comes to both maternal and infant mortality.

Any new Medicaid reforms should focus efforts to improve the current disparities and seek to improve the United States' standing in the industrialized world with regard to maternal and infant mortality. In particular, African American women, Hispanic women who have immigrated to the United States, and American Indian and Alaska Native women are at greatest risk for maternal mortality. CDC statistics note that African American women are four times as likely to die of pregnancy complications compared with white women, and American Indian and Alaska Native women are nearly twice as likely to die. Poverty and lack of insurance certainly

play a significant role in these alarming statistics. As this Committee examines Medicaid to identify improvements, we urge a commitment to promote solutions to reverse these trends and ensure greater availability of proven care to more uninsured women.

To best achieve these goals, ACOG believes an increase in federal resources is needed to help states meet the needs of the Medicaid program. Without a federal commitment to assist states, which are experiencing increased unemployment and a growing demand for more Medicaid services, services may ultimately be cut. In fact, many states are reducing services already.

In addition, without fair and adequate reimbursement levels for provider services, more physicians may be forced to stop serving Medicaid patients. A recent ACOG Economic Survey noted that as a result of skyrocketing medical liability premiums, and reduced reimbursements, ob-gyns are being forced to stop accepting all Medicaid patients. Although ACOG has a long history of promoting volunteerism and serving the underserved and uninsured population, intense practice pressures continue to mount for physicians. The ability to care for the Medicaid population is growing increasingly difficult. We urge Congress to reject reforms that would result in further reductions to provider reimbursements.

Finally, ACOG has long recognized that a full spectrum of health services is necessary to ensure healthy pregnancies, healthy deliveries, and a postpartum period free of complications. A healthy start in life helps prevent future difficulties. It is important that Medicaid continue to provide these important services. While flexibility is helpful to states that reach out to needy populations, we believe that the comprehensive services offered by Medicaid, including family planning, prenatal, labor and delivery and postparturm care, must remain intact. Congress must not allow states to reduce care to optional, or non-mandatory populations, or not provide recommended pregnancy-related services to pregnant women. We urge continued adherence to care that includes a full complement of services that ensure a healthy mother and child.

We thank Chairman Bilirakis for holding this hearing to examine possible Medicaid reforms. We look forward to working with the Committee to review and identify solutions for Medicaid reform.

Preserving the Financial Safety Net by Protecting Medicaid & SCHIP Dental Benefits

Dental Benefits Improve Access for Vulnerable Populations

Quality dental coverage is essential to assuring access to dental services and improving oral health:

- The 29 million children in Medicaid and SCHIP are 1.5 times more likely to access dental care than are uninsured children.[i]
- Children covered by Medicaid are 3.5 times less likely to have an unmet dental need than uninsured children.[ii]
- 72% of adults not obtaining dental care report that the major reason is financial.[iii]

Dental disease remains a chronic problem among low-income populations who qualify for Medicaid and SCHIP. The Surgeon General reports that

> *"Those who suffer the worst oral health include poor Americans, especially children and the elderly. Members of racial and ethnic groups also experience a disproportionate level of oral health problems. And, those with disabilities and complex health conditions are at greater risk for oral diseases that, in turn, further complicate their health."*[iv]

Nearly 4 million children and 2 million adults received dental services through Medicaid in 2000.

Dental Benefits are Eroding

Medicaid While dental spending in Medicaid comprises only 1% of Medicaid expenditures[v], states' current fiscal demands have led to cuts or eliminations of dental benefits for adult and disabled Medicaid beneficiaries as cost savings measures. Comparing 2003 with 2000, the number of states offering comprehensive dental benefits to adults in Medicaid has dropped from 14 to 8.[vi] In 2003, 9 states cut or restricted adult dental benefits. In 2004, 7 states reduced adult dental benefits, despite the influx of $10 billion allocated to Medicaid in the Bush tax cut plan.[vii] These dramatic cuts leave millions unable to access care even in the face of dental pain and infection.

Number of States with Adult Medicaid Dental Benefits

	2000	2001	2002	2003
No dental benefit	7	8	8	9
Emergency only	13	16	17	18
Limited	17	14	14	16
Comprehensive	14	9	12	8

SCHIP Although dental benefits for children in SCHIP are optional, all but one state includes dental services in their plans. Unlike Medicaid's EPSDT benefit that provides for comprehensive dental services, many SCHIP plans provide more limited benefits.[viii]

Because dental benefits in SCHIP are optional, beneficiaries are at risk of losing their dental coverage at any time. Texas, the first state to eliminate pediatric dental benefits in SCHIP, has sustained these cuts despite later retaining $144 million in funding when Congress passed the "SCHIP Fix".

Sustaining the Dental Safety Net Requires Dental Benefits in Medicaid/SCHIP

Erosion of the dental benefit contributes to the "silent epidemic" of oral disease and causes

> *"needless pain and suffering, complications that devastate overall health and well-being, and financial and social costs that diminish the quality of life and burden American society."*[ix]

To prevent further weakening of the dental care financing safety net:

- Dental benefits for children in Medicaid EPSDT must be maintained.
- Dental benefits in SCHIP should be retained and legislation implemented to require at least basic dental care for all SCHIP beneficiaries.
- States should consider the increased emergency room costs to Medicaid that result from eliminating dental benefits.[x]
- Medicaid must require at least basic dental services for adults that address pain, infection, and dysfunction.

Children's Dental Health Project September 2003
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[i] Kenney, et al. *Children's Insurance Coverage and Service Use Improve.* Urban Institute Series, Snapshots of America's Families III, No. 1, 2003. Accessible at http://www.urban.org/url.cfm?ID=310816. Data from the National Survey of America's Families.

[ii] Newacheck, P.W., Peraly, M. and Hughes, D.C. *The Role of Medicaid in ensuring children's access to care.* Journal of the American Medical Association, 280(20):1789-93, 1998.

[iii] Warren, Rueben C., D.D.S., Dr.P.H. *Oral Health For All: Policy for Available, Accessible, and Acceptable Care.* Center for Policy Alternatives: September, 1999.

[iv] USDHHS. *Oral Health in America: A Report of The US Surgeon General.* National Institute for Dental and Craniofacial Research: 2000.

[v] MSIS Statistical Report, *Medicaid Expenditures-Fiscal Year 2000: By Type of Service for Maintenance Status and Basis of Eligibility.* Accessed on 9/24/03 at http://cms.gov/medicaid/msis/msis99sr.asp.

[vi] American Dental Association data, September 2003.

[vii] Smith, V. and V. Wachino, *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004.* Kaiser Commission on Medicaid and the Uninsured, 2003.

[viii] Wooldridge, J. *Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program.* Mathematica Policy Research, Inc. and The Urban Institute, February 26, 2003.

[ix] USDHHS. *Oral Health in America: A Report of The US Surgeon General.* National Institute for Dental and Craniofacial Research: 2000.

[x] Cohen, L. Manski, R., Magder, L. and Mullins, D. *Dental Visits to hospital emergency rooms by adults receiving Medicaid.* Journal of the American Dental Association, 133:715-24, June 2002.

Understanding Dental Medicaid: Mandatory & Optional Populations & Benefits

Medicaid is administered by the states within federal guidelines which require that certain populations are covered for certain specified benefits. States have the flexibility to cover additional ("optional") populations and to extend additional – "optional" -- benefits beyond the federal minimum requirements. The distinction between "mandatory" and "optional" populations and benefits in Medicaid is important to understand now, when the Administration is proposing a momentous Medicaid reform program that would change federal requirements.

"Mandatory" versus "Optional" Populations

The following chart outlines groups of people who are eligible by federal mandate and groups that are optional at each state's discretion.[1]

Mandatory Populations

- Children under age 6 from families with incomes less than 133% of poverty (FPL)[2]
- Children age 6 and older ≤ 100% FPL
- Children in foster care
- Parents with incomes below state-established minimums (median: 59% FPL)
- Elderly & disabled SSI beneficiaries (incomes ≤ 74% FPL)
- Low-income Medicare beneficiaries

Optional Populations

- Children & parents above minimum income requirements
- Pregnant women >133% FPL
- Disabled & elderly people > 74% FPL, including those in nursing homes
- Disabled & elderly people served under Home and Community Based waivers
- Women with breast & cervical cancer
- Certain disabled people who are employed & buy into coverage

"Mandatory" versus "Optional" Dental Benefits

Dental is not a mandatory benefit in on its own. However, children, adolescents, and young adults up to their 21st birthday who are covered by Medicaid currently must be enrolled under EPSDT (Early and Periodic, Screening, Diagnostic, and Treatment Services Program) which mandates comprehensive dental benefits. Other than the EPSDT dental benefit, dental services are optional in Medicaid.

How the Administration's Medicaid Reform Proposal Could Impact Dental Services

The Administration has not yet defined the "comprehensive set of benefits" that would be required for mandatory populations under the proposed "State Health Care Partnership Allotments" program. If EPSDT is not maintained, dental coverage would become optional for children under 21 as it is now for adults. Under budgetary pressure, all but 14 states have eliminated comprehensive dental coverage for adults. If children's dental services become optional, states may seek to reduce or eliminate dental coverage for children as well. Since spending on children's dental care in Medicaid is less than 1% of State Medicaid budgets, not much money would be saved and children would suffer needlessly.

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[1] Mann, Cindy, "The Bush Administration's Medicaid and State Children's Health Insurance Program Proposal," February 10, 2003, Georgetown University, Institute for Health Care Research and Policy.

2 Federal Poverty Level (FPL) The 2003 FPL for a single person is $8,980; for a family of 4 it is $18,400.

Impact of the Administration's Medicaid Reform Proposal on Dental Services

The Administration's fiscal year 2004 budget includes a Medicaid/SCHIP reform proposal that would make fundamental changes to these public insurance programs that currently cover 47 million low-income Americans. The proposal, "State Health Care Partnership Allotments," mirrors recommendations set forth in a letter from Governors Jeb Bush (FL), John Rowland (CT) and Bill Owens (CO) to President Bush and Secretary Thompson, calling for increased flexibility for the states to reform their Medicaid programs. The Administration's proposal would give states the option of gaining the flexibility they seek and more federal funds short-term in exchange for capped federal funding over a 10-year period. The combination of diminished funds in the out-years and the options to drop coverage can drastically reduce or eliminate access to already restricted dental services for these vulnerable populations.

How might the proposed Medicaid "flexibility" affect dental services?

• Loss of dental benefits for "optional" beneficiaries. The proposal ends federal "minimum benefit standards" for "optional beneficiaries," thereby allowing states to drop dental coverage for one-of-five children and 22 percent of people with disabilities who are now covered by Medicaid. States currently have the choice of dropping or severely limiting adult dental benefits and more than half have already done so. Under the new proposal, it is likely that many states would also drop dental coverage for all but the poorest children.

• Loss of dental benefits for mandatory beneficiaries. The benefit package for mandatory beneficiaries has not yet been defined. If EPSDT is not maintained, states would have the option to drop dental benefits for mandatory child beneficiaries.

• Increased premiums and cost sharing for "optional" beneficiaries. The reform proposal removes all limits on premiums and cost sharing for optional beneficiaries and is unclear on limits for mandatory groups. Increases in out-of-pocket expenses may force low-income families to delay or neglect needed dental care.

• Lower reimbursement to dental providers. Payments to dentists – already widely recognized as inadequate to attract sufficient numbers of providers – will likely decline as low-income families become responsible for part of the bill through co-payments. Access for dental services will be severely restricted if dentists decide not to participate in Medicaid because of difficulties collecting these co-payments.

Why is it important to maintain dental services for all Medicaid beneficiaries?

• To alleviate unnecessary pain and suffering. Poor children are two to three times as likely to suffer from untreated dental disease and are already half as likely to have access to dental services as middle and high income children.

• To help low-income people get jobs. Poor dental appearance can make it harder for low-income people to find work in service jobs.

• To ensure that children are ready to learn. Children miss over 50 million hours of school annually due to dental concerns. Dental pain limits children's ability to attend to learning.

• To save money in Medicaid. Failure to cover cost-effective basic dental care only shifts costs to more expensive treatment for pain relief in the hospital emergency room. Ending emergency dental coverage in Maryland caused ER visits for dental problems to increase by 12%.

• To improve general health. Increasing evidence of oral-systemic connections suggest that attending to oral health reduces the incidence, severity, and costs of a number of medical conditions.

Children's Dental Health Project February 10, 2003
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October 8, 2003

Medicaid Works for Children and Adults with Disabilities and Their Families: It Must Not Be Block-granted

The Consortium for Citizens with Disabilities is a Washington-based coalition of over 100 national disability organizations. The CCD is strongly supportive of Medicaid because often it is the only source of comprehensive and appropriate coverage that addresses the health care and long-term services needs of people with disabilities. Indeed, more than 10.5 million children, adults, and seniors with disabilities count on Medicaid. Medicaid is recognized as the driving force behind the individual supports and services people with disabilities need to lead fuller, healthier, and more productive lives in their communities. The Medicaid entitlement, the strong federal commitment demonstrated by open-ended financing, and the existing extensive state flexibility has helped Medicaid adapt and be innovative in meeting the individual needs of children and adults with disabilities.

While CCD is on record in support of the critical role that Medicaid plays in the lives of people with disabilities, we appreciate the important role it plays in the lives of many other Americans. The Medicaid program is crucial to the viability of the nation's health care infrastructure. According to a recent report by the Census Bureau, the ranks of those individuals without health insurance grew from 41.2 million in 2001 to 43.6 million in 2002. The primary cause for this dangerous drop in coverage was the erosion of private health insurance coverage. This, in turn, was driven by the weak economy, growing unemployment, and ever increasing health care and health insurance costs. However, at the same time enrollment in both Medicaid and the SCHIP program rose in response to this loss of coverage and the ever-growing number of families with low incomes. Medicaid enrollment grew by 3.2 million in 2002 and if it was not there, the number of Americans without health insurance would have been much higher. Individuals with disabilities and families with children with disabilities are the most likely people to face disaster as the economy weakens and as private health insurance plans become even more limited and even more expensive.

Medicaid Works

The following are critical features of Medicaid that allow it to work effectively for children and adults with disabilities.

- For children with all types of disabilities, access to the cost-effective Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, with its screenings, services and therapies, can often make a major difference in their lives. Access to these important services is what enables them to lead healthy and more active lives; avoid additional disabilities; continue to live at home with their families; make it through school; get and keep a job; and participate actively in the community in which they live.

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- Medicaid is the primary public source of funding for long-term services and supports for people with disabilities of all ages. It is the largest funder of state and local spending on mental health, mental retardation, and developmental disabilities services in the country.

- For people with epilepsy, mental illness, HIV, and a variety of other conditions, Medicaid is very often the only source of access to essential prescription drug coverage.

- For people with a variety of physical disabilities, such as spinal cord injuries, traumatic brain injuries, cerebral palsy, or amputations, Medicaid usually is the only way they can get access to durable medical equipment like wheelchairs or prosthetic devices, as well as assistive technology.

- For many people with cognitive and other types of disabilities, Medicaid generally is the only source of funds for them to live and work in the community with friends and families and avoid more costly and segregated nursing homes or institutions.

Current Threats to the Medicaid Program

The CCD is extremely worried by inaccurate statements made about Medicaid by its critics – many of whom portray it as broken in their zeal to "restructure" Medicaid. We are strongly opposed to any proposal that would remove the individual entitlement to Medicaid and that would move Medicaid away from an open-ended financing system to one that provides for fixed allotments. We also oppose any federal legislative or administrative actions that would limit the federal resources that are currently available for providing the broad range of services needed by people with disabilities in Medicaid.

The Administration and some in Congress are proposing reforms that give only one stakeholder in the Medicaid program — the states — virtually unchecked flexibility at the expense of beneficiaries and providers. Removing the entitlement to Medicaid for children and adults with disabilities and their families– and capping funding -- will give states unlimited discretion to limit access to health and long-term services and supports that these individuals need. For many individuals with disabilities in Medicaid, including so-called "optional" beneficiaries, access to Medicaid has life-altering implications. Undermining well-reasoned and time-tested beneficiary protections as though they were responsible for current challenges in financing Medicaid is dangerous for children and adults with disabilities. Federal oversight of state programs is often the only way to ensure fairness and non-discrimination. It is often the only way to protect the most vulnerable individuals from abuse, as well as demand accountability for this taxpayer-supported program.

Moving Medicaid Into the Future the Right Way

The CCD supports numerous positive approaches that would strengthen rather than weaken Medicaid. These include:

- Ensuring that states effectively implement the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit. EPSDT is a critical tool to prevent and minimize disability and to ensure that children get the best possible start in this world so they can grow up to be contributing members of society.

- Enacting the bipartisan Family Opportunity Act, which would let moderate-income families with children with disabilities buy into Medicaid for the essential services they need and which are not covered by private insurance. This would allow families to stay together instead of forcing parents to put their children in inappropriate and unwarranted institutional settings because they cannot get the supports they need in the community.

- Establishing mandatory coverage for home and community-based long-term services that provide a viable alternative to institutional living for people with disabilities and the elderly.

- Increasing the federal responsibility for the cost of providing services to Medicare beneficiaries. This includes increased federal support for prescription drug coverage, durable medical equipment, and long-term care services for low-income persons eligible for both Medicaid and Medicare.

Any changes to Medicaid must recognize the unique populations enrolled in Medicaid, including seven million people with severe disabilities – both children and adults. SCHIP and private market benefits packages are not only inadequate for these individuals, but they often are completely unavailable. What the Medicaid program calls "optional" benefits are, in reality, mandatory disability services for the children and adults who need them. These services often are not only life-saving, but the key to a positive quality of life – something everyone in our nation deserves.

As reported above, currently Medicaid is one critical solution to the nation's problem of the uninsured. Until there are not millions of uninsured or underinsured children and adults, Medicaid will continue to play a critical role in mitigating the health care crisis we face as a nation. Very often it is families with children, the elderly, and people with disabilities — some of the most vulnerable and poorest individuals in the country -- who are in the worst circumstances and who would be completely without any coverage without Medicaid.

The CCD wants to work with the Congress to ensure that any modifications to the program are in the best interests of children and adults served by Medicaid -- which in the long run would be in the best interests of our nation.

ON BEHALF OF:

Adapted Physical Activity Council
Advancing Independence: Modernizing Medicare and Medicaid
American Academy of Child and Adolescent Psychiatry
American Association on Mental Retardation
American Association of People with Disabilities
American Congress of Community Supports and Employment Services
American Council of the Blind
American Foundation for the Blind
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Network of Community Options and Resources
American Occupational Therapy Association
American Therapeutic Recreation Association
Association for Educators of Community-Based Rehabilitation Programs

Association of Maternal & Child Health Programs
Association of Tech Act Projects
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
Brain Injury Association of America
Center on Disability and Health
Center on Disability Issues & the Health Professions
Council of Parent Attorneys and Advocates
Council for Learning Disabilities
Disability Service Providers of America
Easter Seals
Epilepsy Foundation
Federation of Families for Children's Mental Health
Family Voices
Inclusion Research Institute
Inter/National Association of Business, Industry and Rehabilitation
Lutheran Services in America – Disability Network
National Association for the Advancement of Orthotics and Prosthetics
National Association of Developmental Disabilities Councils
National Association of Orthopaedic Nurses
National Association of Protection and Advocacy Systems
National Association of Rehabilitation Research and Training Centers
National Association of School Nurses
National Association of School Psychologists
National Association of Social Workers
National Association of State Directors of Special Education
National Coalition on Deaf-Blindness
National Council for Community Behavioral Healthcare
National Down Syndrome Congress
National Mental Health Association
National Organization of Social Security Claimants' Representatives
National Respite Coalition
NISH
Rehabilitation Engineering and Assistive Technology Society of North America
Research Institute for Independent Living
School Social Work Association of America
Spina Bifida Association of America
TASH
The Arc of the United States
United Cerebral Palsy
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FamiliesUSA
The Voice for Health Care Consumers

FOR IMMEDIATE RELEASE
Wednesday, October 8, 2003

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THREATS TO BLOCK GRANT MEDICAID ENDANGER VITAL HEALTH CARE FOR MILLIONS

Program Provides Health Care Safety Net for Children, Seniors and People with Disabilities in Sluggish Economy

Ron Pollack, executive director of Families USA, released the following statement today with regard to the House Energy & Commerce Committee, Subcommittee on Health's hearing: Challenges Facing the Medicaid Program in the 21st Century:

"Medicaid provides vital health care coverage for more than 43 million children, seniors and people with disabilities who would otherwise be forced to go without medical treatment. Paying for much-needed medical treatments out of their own pocket is not an option for many, leaving Medicaid as their only source of vital health care. Over half of those who depend on the Medicaid program are children.

"The most recent Current Population Survey (CPS) showed that rising health care costs and a job-losing economy have led to a dramatic increase in the number of people without health coverage. However, the CPS also showed an increase in the number of people covered by Medicaid, making this program a health coverage safety net in a sluggish economy and preventing the number of uninsured Americans from rising even higher.

"Recent proposals to reform the program have centered on block-granting Medicaid. These proposals will destroy the program's ability to provide safety net health care coverage in times of economic downturn. Not only is this bad health care policy, this is bad economics. These caps on funding will force states to make difficult decisions and cut valuable health care services to those who depend on them most.

"Any proposal to block-grant Medicaid must be rejected. As we face the daunting task of covering nearly 44 million Americans already without health insurance, we must protect the Medicaid program as a safety net of health coverage for all Americans."

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Families USA is the national organization for health care consumers. It is nonprofit and nonpartisan and advocates high-quality, affordable health care for all Americans.

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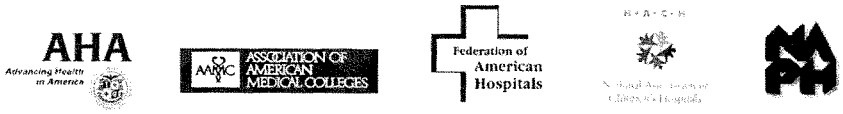

Statement for the Record
for the
Health Subcommittee
of the
House Energy and Commerce Committee
on the
"Challenges Facing the Medicaid Program in the 21st Century"

October 8, 2003

On behalf of our member hospitals, health care systems, networks and other providers of care, we appreciate the opportunity to submit this statement for the record regarding the future of our nation's Medicaid program. During its 40-year history, Medicaid has become the nation's health care safety net. Today, more than 51 million poor, disabled and elderly individuals rely on Medicaid for their health care. More than half of all Medicaid beneficiaries are under age 18, making it one of the nation's largest insurance programs for children.

And it is more critical today than ever, as more people are without work and without health insurance. In the past, Medicaid served as a buffer to the perils of an uncertain economy by providing health care coverage and services to those who could not afford it. Today, however, state governments are facing significant budget shortfalls. While we applaud Congress and the President for their efforts earlier this year to help states alleviate the most serious fiscal crisis in 50 years, we believe it is imperative that any further corrective federal action neither put additional pressure on states nor diminish the guarantee of coverage for our most vulnerable patients. In fact, we believe that any discussion of restructuring or reform must include all stakeholders.

The Medicaid disproportionate share hospital program (DSH) is a critical component of Medicaid and our nation's health care infrastructure. Medicaid DSH is a primary source of fiscal support for our safety net hospitals and helps to fund a variety of essential services for uninsured or underinsured children and adults, such as chronic disease management, preventive care, dental care and child abuse screening. These funds also help assure continued access to essential community services such as trauma and burn care, pediatric intensive care, high-risk neonatal care, emergency psychiatric services and disaster preparedness resources.

According to an analysis by the Lewin Group, Medicaid DSH funding (while a significant revenue stream) does not fully compensate for the major payment shortfalls faced by safety net hospitals serving poor, disabled and uninsured patients. In 2001, the most recent year for which data is available, hospitals lost over $9 billion caring for Medicaid and uninsured patients, even after state and local government contributions to fund indigent care. Adequate funding for provider payments is essential for a viable program.

The future of the Medicaid program is intrinsically linked to the future of our health care system. Any steps to reform or restructure the program must be done in a deliberate and meaningful way and we are ready to assist the committee as it works to assure a viable Medicaid program.

American Hospital Association
Association of American Medical Colleges
Federation of American Hospitals
National Association of Children's Hospitals
National Association of Public Hospitals and Health System

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
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Statement of Larry S. Gage
President
The National Association of Public Hospitals and Health Systems
The U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Hearing on Challenges Facing the Medicaid Program in the 21st Century

October 8, 2003

The National Association of Public Hospitals and Health Systems (NAPH) appreciates this opportunity to submit a statement for the record to the House Energy and Commerce Committee Subcommittee on Health on the subject of challenges facing the Medicaid program. This topic is especially relevant now, as tight state budgets increasingly jeopardize the ability of states to fully support the Medicaid program and as the U.S. Census Bureau has just confirmed that the number of Americans living in poverty continues to rise. Medicaid provides critical support to people who are eligible for Medicaid as well as to the safety net providers who serve the nation's rising numbers of uninsured.

NAPH represents more than 100 of America's metropolitan area safety net hospitals and health systems. The mission of NAPH members is to provide healthcare services to all individuals, regardless of insurance status or ability to pay. Approximately 58 percent of the patients served by NAPH members are either Medicaid recipients or patients without insurance. Medicare covers another 21 percent of the patients of NAPH members, who rely on governmental sources of financing to cover over three-quarters of their costs.

Medicaid is as important to our nation's safety net hospitals as it is to the 51 million low-income Americans for whom Medicaid provides coverage. Arguably, given the well-known gaps in Medicare benefits, Medicaid is an even more important and successful governmental health care program than Medicare. Medicaid covers 55 percent of all poor children (20 percent of all children in the nation) and pays for one third of all births. It is far and away the nation's largest purchaser of long term care services. It is also an essential lifeline for low-income elderly individuals and those who are blind and disabled. Indeed, any effort to address challenges to the Medicaid program and to strengthen Medicaid must start with the recognition that over two-thirds of Medicaid spending today is devoted to the elderly, blind and disabled.

Medicaid is also a major source of essential financing for America's institutional health safety net. Thirty eight percent of the net revenues of NAPH member hospitals are Medicaid revenues. In particular, Medicaid Disproportionate Share Hospital (DSH) payments are the cornerstone of financial support for hospital services to all low-income Americans, including the rising numbers of uninsured. Medicaid reimbursement is also important to Federally Qualified Health Centers (FQHCs), which provide a significant amount of services to Medicaid patients and patients without insurance.

New data from the Census Bureau indicates that 43.6 million people lacked health insurance for all of 2002, a 2.4 million increase from the prior year. Despite the growing demand, states are increasingly constrained from making DSH payments to needy hospitals. In fiscal year 2003, Medicaid DSH allotments (statutory limits on the amount of federal dollars each state can spend on DSH in each fiscal year) decreased for many states, putting additional pressure on already strained hospital finances. Other states have suffered for years with unconscionably low DSH allotments.

In 2001 (the latest year for which data are available), Medicaid DSH payments covered 25 percent of the otherwise unreimbursed costs incurred by NAPH member systems in treating the uninsured and underinsured, despite the fact that DSH payments constituted less than 6 percent of overall Medicaid spending. With regard to the uninsured, Medicaid is a true partner to state and local governments, whose payments and subsidies to NAPH members account for another 38 percent of such unreimbursed costs.

We acknowledge that Medicaid is not without problems and challenges. Medicaid's funding and benefits (including DSH payments) are spread unevenly across the states. Eligibility and covered services vary widely as well. The fact that Medicaid has become the fastest growing part of many state budgets has been especially problematic for states that are confronted with reduced revenues and fiscal crisis as a result of the current economic downturn. Efforts to address challenges to the Medicaid program should not result in further pressure on states that are already facing such crises.

These and other concerns about Medicaid can and should be addressed by the Congress, and NAPH is willing to work with this Committee, the Administration and all other stakeholders to address needed reforms. Last spring, in preparation for a similar Committee hearing on Medicaid reform, NAPH prepared a set of "Principles for Medicaid Reform," which we believe holds continuing relevance to efforts to address problems in Medicaid. We attach a slightly updated version of that document to this statement. While this statement bears substantial relationship to those earlier Principles, we are pleased that progress has been made in this Committee and in Congress on many of our recommendations for immediate action.

As this Committee considers options to address challenges in the Medicaid program, NAPH would like to provide a few words of caution regarding various targets mentioned in the Committee's recent letter to the Budget Committee regarding elimination of waste, fraud and abuse:

Medicaid DSH. As stated above, Medicaid DSH provides critical support to safety net hospitals. Medicaid DSH is the primary federal mechanism for providing additional support to hospitals that serve large volumes of Medicaid beneficiaries and persons without insurance. Regardless of any state abuse associated in the past with Medicaid DSH, the program has undeniable benefits for the patients served by hospitals that receive and retain the funds. Federal DSH dollars are already limited. The federal government could spend no more than $8.75 billion on Medicaid DSH in 2003, regardless of any state actions. This is far less than the $21.5 billion the American Hospital Association estimates is spent annually by hospitals on uncompensated care and in fact represents a reduction of nearly 15 percent since 1998. DSH allotments must increase to meet the growing demands caused by economic distress and the

increasing numbers of uninsured patients. NAPH is pleased that the Committee included provisions to increase DSH allotments in the Medicare prescription drug legislation.

Medicaid Upper Payment Limits (UPL). Over three years ago, a number of news reports surfaced regarding state level abuses involving Medicaid upper payment limits (UPLs). Some states would make excessive payments to certain public providers, most often to nursing homes, but providers would not retain these payments. Such states would instead use these payments for non-Medicaid and often non-health care purposes. NAPH supported agency action to restrain these abuses, although we expressed concern that new regulations retain sufficient state flexibility to make legal and appropriate payments to at-risk Medicaid providers providing crucial access to Medicaid and low income patients. Eventually, CMS and its predecessor agency issued three new regulations which were estimated to save the federal government over $80 billion. NAPH appreciates the Committee's desire to avoid state abuse of the Medicaid program and shares the Committee's concern that providers were not retaining Medicaid payments prior to the new regulations. However, NAPH remains very concerned that additional reforms in this area in the name of reducing waste, fraud and abuse will primarily result in reductions in essential and legitimate payments to providers serving the neediest patients.

Intergovernmental Transfers (IGTs). NAPH believes that much of the attention of the HHS Office of the Inspector General (OIG) and others has been misdirected at intergovernmental transfers (IGTs). Federal Medicaid law and regulations explicitly ***permit*** entities other than states to contribute some portion of the non-federal share of Medicaid payments through IGTs. Existing federal law allows states to fund ***up to 60%*** of the non-federal share of Medicaid costs through such expenditures. 42 U.S.C. § 1396a(a)(2). Those claiming that IGTs effectively "change the federal matching percentage" inappropriately undervalue local public expenditures. When a city, county or public hospital transfers money to a state Medicaid agency for use as the non-federal share of Medicaid expenditures (or certifies such expenditures), those local dollars are every bit as real a public expenditure as state general revenue funds. It is simply the local government rather than the state government that absorbs the cost. The use of local as well as state funds for the non-federal share of Medicaid expenditures has been a fundamental part of the Medicaid program since its inception. Efforts to reform IGTs should respect the existing and historical local role in financing the Medicaid program.

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NAPH applauds the Committee for including provisions on Medicaid DSH and 340B drug pricing in the Medicare prescription drug bill passed by the House earlier this year, and currently in conference with the Senate. These provisions build on suggestions contained in the attached principles for Medicaid Reform and we believe will improve the Medicaid program. We strongly encourage the Committee to urge the Committee on Conference to include these provisions in the final Medicare prescription drug legislation. In particular, we urge the following:

Providing Urgent DSH Funding Relief to Safety Net Providers. Inadequacies in DSH funding pose a potentially devastating risk to safety net hospitals and patients in many states at a time when the number of uninsured is increasing and other funding sources are eroding. We greatly appreciate the Committee's efforts during markup and consideration of the Medicare

prescription drug bill to include Medicaid DSH funding improvements and the Committee's ongoing support of these provisions in the conference discussions on that bill. NAPH strongly urges that Section 1001 of H.R. 1, which would help stem severe cuts DSH allotments, be retained in the conference agreement. In addition, NAPH also strongly urges that Section 602 of S.1, which would allow a temporary increase in federal DSH allotments for "extremely low-DSH states" to 3 percent of total Medicaid expenditures, also be retained in the conference agreement.

Allowing Section 340B Hospitals to Negotiate Better Prices for Inpatient Drugs. Drug prices are one of the major issues that face all providers, including public hospitals. Extending the best price exemptions to inpatient prices charged to 340B hospitals would allow safety net hospitals to negotiate better discounts on inpatient pharmaceuticals. We applaud the Committee for including language on this issue in H.R. 1 (Section 1002) and encourage the committee to support its inclusion in the conference agreement.

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NAPH appreciates the opportunity to share our observations and concerns about the future of the Medicaid program. As the number of Americans living in poverty rises, strengthening the Medicaid program is critically important. We look forward to working with the Committee to develop legislative solutions to the problems confronting our nation's poor and uninsured and the safety net providers that serve them.

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The National Association of Public Hospitals and Health Systems
Principles for Medicaid Reform

Protect the Guarantee of Coverage to Medicaid Recipients. Medicaid reform efforts should not result in reducing or eliminating the entitlement of our most vulnerable populations to coverage. A federally enforceable entitlement to coverage is the foundation of Medicaid's success. Eroding that entitlement for current recipients would be a major step backwards for a country that must already confront the dilemma of nearly 44 million uninsured residents.

Expand Coverage Beyond Current Levels. Health care coverage is recognized as the primary way to provide access to needed health services for low-income populations. Medicaid reform should not be enacted in a vacuum. Rather, Medicaid reforms must be carefully tied to renewed efforts to expand coverage, as one important tool in an anticipated combination of public program improvements and private sector initiatives. Moreover, it is important that the impact of Medicaid reforms on all populations among the uninsured (including, e.g., legal and illegal immigrants, persons with AIDS, etc.) be taken into account in crafting effective reforms.

Ensure the Availability of Comprehensive Benefits to Covered Individuals. States currently provide essential health benefits to both mandatory and optional populations through their Medicaid programs. Of particular concern to NAPH is the erosion of coverage of optional services such as prescription drugs for the poor, elderly, and disabled. To the extent Medicaid reform permits states to limit essential services to enrollees, it will merely shift even more of the burden for providing those services to safety net providers, at a time when the health care safety net is already in crisis. Rising numbers of uninsured, worker shortages, increased drug costs, and expanded community-wide responsibilities (including an expanded role as emergency responder in the event of chemical and biological terrorism) are increasing costs. At the same time, current sources of federal, state and local funding are being eroded. Forty-three percent of NAPH members had negative margins in 2001, up from one-third with negative operating margins in 1995.

Strengthen Safety Net Providers. Particularly at a time when the number of Medicaid enrollees and uninsured are increasing, further reducing or eliminating direct payments to safety net hospitals, like Medicaid DSH, could rapidly destroy our nation's fragile system for providing care to the uninsured. Medicaid DSH is one of the most important funding sources for many hospitals – often the major (if not only) reason they can continue serving the uninsured and providing essential community-wide services like trauma care. The Institute of Medicine (IOM) in its March 2000 report recommended that "Federal and state policy makers should explicitly take into account and address the full impact

(both intended and unintended) of changes in Medicaid policies on the viability of safety net providers and the populations they serve."

Future Medicaid Spending Must Be Based on Need, Not an Arbitrary Base Year. Some Medicaid reform proposals have included capped annual funding amounts. Spending caps constitute little more than "price controls" at the state level. They are completely arbitrary and do not reflect one of the great strengths of Medicaid, which has been its ability to respond to changing needs. While it is true that health costs have been rising rapidly in recent years, those costs are largely beyond the control of states or providers, who would instead be forced to respond to arbitrary caps through reduced eligibility or coverage.

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STATEMENT
FOR THE RECORD

SUBMITTED TO THE
HOUSE ENERGY & COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH

"CHALLENGES FACING THE MEDICAID PROGRAM IN THE 21ST CENTURY"

BY LAWRENCE A. McANDREWS
PRESIDENT AND CEO
NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS

OCTOBER 8, 2003

The National Association of Children's Hospitals (N.A.C.H.) is a not-for-profit trade association, representing more than 120 children's hospitals across the country. Its members include independent acute care children's hospitals, acute care children's hospitals organized within larger medical centers, and independent children's specialty and rehabilitation hospitals. As the Committee discusses the challenges facing Medicaid, we appreciate the opportunity to submit this statement for the record describing the critical role Medicaid plays in the lives of our nation's children and the ability of children's hospitals to care for them.

Medicaid is the largest health coverage program for children.
It is important to recognize that Medicaid is the largest single source of health coverage for children, covering nearly one in four children. Children comprise more than half of the nation's 50.8 million Medicaid beneficiaries. As such, the future of Medicaid is of special concern to children's health, and therefore to the nation's children's hospitals as well. As hospitals devoted exclusively to the health and well-being of all children, children's hospitals are integral to the pediatric health care safety net, providing both inpatient and outpatient care to a disproportionate share of children enrolled in Medicaid. Although only 3% of all hospitals, children's hospitals provide nearly 40% of the hospital care required by the 25.5 million children assisted by Medicaid.

Medicaid coverage for children is low-cost.
Children are a relatively inexpensive group to cover. In FY 2000, children under 19 (including SSI disabled children) accounted for only 21% of Medicaid spending. Children's coverage is not fueling the growth in Medicaid spending. In fact, Medicaid spending for children accounts for only 10% of the annual growth in total Medicaid spending. In addition, more than 50% of children in Medicaid are already enrolled in managed care plans, and Medicaid per capita spending for children is comparable to private coverage.

Medicaid coverage works effectively for children.
During the recent economic downturn, Medicaid has been an important safety net for children whose parents have lost employer-sponsored coverage. Recently released U.S. Census Bureau data on the uninsured indicates that the number and percentage of children (under 18 years of age) without health insurance did not change in 2002, remaining at 8.5 million or 11.6%. The Census Bureau's report, *Health Insurance Coverage in The United States: 2002*, states that a decline in employment-based health insurance coverage of children was offset by an increase in coverage by Medicaid and the State Children's Health Insurance Program. The result suggests that the program – the financing structure of which is designed to accommodate fluctuations in the economy – is working as intended.

Medicaid's benefits are essential to meet children's unique health care needs.
Medicaid's benefits structure, unlike any other health insurance program, is designed specifically to meet children's unique health care needs, including children with special health care needs. The health care needs of all children are special and distinct from those of adults, but the term "children with special health care needs" (CSHCN) refers to a group of children who require specialized health care, habilitation and rehabilitation services. Frequently children with special health care needs are limited, or have potential limitations, in their ability to function because of a chronic or congenital illness, a major trauma, a developmental disability, or exposure to a serious or life-threatening condition.

For CSHCN, simply having access to health insurance may not be adequate for their healthcare needs because health insurance policies, like children, come in all sizes and shapes. Private insurance often lacks the comprehensive benefits needed by this population, such as physical and speech therapy, durable medical equipment, behavioral health services, home health care and some medications. Private insurance benefits may require that an individual be improving, a definition that doesn't fit for a child with cerebral palsy who may need a service to maintain function or a child with a congenital condition who may need a service to maximize their developmental potential.

Preservation of the Medicaid program's federal guarantee of accountability for children's health insurance needs under the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit package is an essential part of sustaining the health care safety net for children. EPSDT requires that, for children only, states cover all Medicaid services that are determined to be medically necessary by their physician during a regularly scheduled EPSDT screening visit. These can include preventative services, developmental/habilitation services for very young children, eyeglasses and hearing aids to ensure that children may learn, as well as prostheses, orthotics and wheelchairs that can be provided and changed as children grow.

Medicaid affects the ability of children's hospitals to serve all children. Medicaid is not only the single largest program of public assistance for children's health care, it is the single largest payer of care delivered by children's hospitals - paying, on average for nearly half of the inpatient care provided at children's hospitals. Children's hospitals also provide the vast majority of inpatient care required by children with serious illnesses and conditions. For example, children's hospitals perform 99% of organ transplants and 88% of cardiac

surgeries, and provide 88% of the inpatient care for children with cystic fibrosis. In some regions, they are the *only* source of pediatric specialty care, which makes children's hospitals essential not only to the children in their own communities but to all children across the country.

Medicaid generally falls far short of reimbursing children's hospitals for the cost of providing these essential services. As a consequence, Medicaid disproportionate share hospital (DSH) payments, which average more than $6 million per children's hospital, are extremely important to the financial health of these institutions. In hospital FY 2001, Medicaid, including DSH payments, on average reimbursed only 84% of the costs of care in children's hospitals, a percentage that fell to 76% without DSH payments. This crucial source of funding for children's hospitals aids in their ability to serve all children

The specialty and critical care and trauma services that children's hospitals maintain, including staffing and equipment, carry costs that are not completely covered. But this "stand by" capacity assures that these services will be there when any child needs them. Because Medicaid is a vital revenue stream for children's hospitals, any single reduction in funding presents financial difficulties, which in turn can lead to curtailing or elimination of programs – programs relied upon not only by Medicaid-dependent children, but *all* children.

All children benefit from the work carried out at children's hospitals – regardless of whether they ever step foot inside their doors. The nation's children's hospitals serve all children by fulfilling a variety of critical public needs – training most of our nation's doctors devoted to children, providing continuing advancements in children's care, performing some of the most important, cutting-edge pediatric research and serving as centers of excellence for the sickest children in the country. Medicaid is a partner in fulfilling those public needs, and a partner in fulfilling children's hospitals' mission of providing quality care to all children.

Children should be central to any consideration of the future of Medicaid. Medicaid plays a special role in not only providing health insurance for low income Americans but by filling in gaps in other coverage, whether for Medicare or private insurance. In this capacity, it is a major payer for long term and home and community-based care, as well as for mental health services, among others. Any consideration of Medicaid's future must recognize its many important roles, including its absolutely critical role in the financing of health care for children.

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Hard-Won Protections of Nursing Home Residents Must Not Be Eliminated Through Medicaid "Reform"

Over the past several decades, the Congress of the United States has made tremendous strides in legislation to preserve the dignity, health and safety of Americans when they need long term care. These laws were enacted, often, after years of government studies and congressional testimony demonstrated the tragic consequences of the federal government's failure to use its protective authority. The National Citizens' Coalition for Nursing Home Reform urges Congress not to weaken or eliminate these hard-won protections under the guise of Medicaid "reform."

Any proposal to grant states flexibility in the care of optional beneficiaries must recognize that eighty-five to 90 percent of Medicaid recipients in nursing homes are optional beneficiaries. Many of these are "medically needy," people whose incomes are too high for public assistance but who qualify for Medicaid because their life savings are depleted and their nursing home costs exceed their income.

Why Current Medicaid Law Is Important to Nursing Home Residents and Their Families

- Medicaid supports the care of about 70 percent of nursing home residents. About half of these Medicaid beneficiaries spent their life savings on nursing home care before they became eligible for Medicaid.
- Medicaid provides the foundation for the regulation of nursing homes through the Nursing Home Reform Amendments of 1987. This foundation includes health and safety standards, resident assessment and data collection, residents' rights, annual inspections, and enforcement. All residents of Medicaid facilities benefit from these protections, whether or not they receive Medicaid benefits.
- "Spousal impoverishment" provisions enacted by Congress in 1988 ensure that spouses of nursing home residents can retain enough of the couple's resources to meet their own needs. Before Congress changed the law, elderly women, especially, were forced into dire poverty so their spouses could qualify for Medicaid nursing home benefits.
- Current law protects the adult children of nursing home residents – who may be paying for their children's education or even be retired or near retirement themselves – from being forced to contribute to their parents' nursing home care.
- Under current law, states cannot discriminate in the amount or adequacy of services they provide. All beneficiaries must receive the same benefits, and benefits must be sufficient in "amount, duration and scope."

NCCNHR believes Medicaid should provide greater options for the elderly and disabled to receive long term care in non-nursing home settings. However, expanding coverage of home and community-based care will not work if the only purpose is to give people less expensive

services, rather than to provide viable, safe alternatives to nursing homes. People who qualify for Medicaid long term care coverage have multiple health care problems, frequently including dementia. Nursing homes are regulated and inspected at least annually to ensure that health and safety standards are met. Assisted living and personal care homes, on the other hand, are poorly regulated in most states and often admit or retain residents whose needs they cannot safely meet.

Congress should not encourage redirection of Medicaid funds to home and community-based care until it enacts minimum federal standards to ensure that beneficiaries do not have to forfeit access to services and protections they need.

Finally, NCCNHR urges Congress not to approve any Medicaid plan that would diminish federal funds over time or force children and the elderly and disabled to compete with each other for services that both need.

It has been NCCNHR's privilege over the years to work with the Energy and Commerce Committee on efforts to improve the care of long term care residents. There is still much to be done. A year-and-a-half ago the Department of Health and Human Services issued a report showing that 90 percent of nursing homes are understaffed, more than half of them critically so. With the population rapidly aging, Congress must find real solutions to funding long term care and ensuring the quality of services for all who receive them.

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Responses for Record of Hon. Thomas A. Scully

Question 1: from Congressman Joe Barton

I would like the rationale behind why Medicaid through the Institution of Mental Disease (IMD) exclusion includes substance abuse services as an excluded service for individuals who are in community residential substance abuse programs like therapeutic communities?

Medicaid pays for outpatient substance abuse care and costly hospital detoxification. Why not include a program like a therapeutic community or a community-based residential substance abuse program as a reimbursable cost since research shows non-hospital community-based residential alcohol and drug abuse treatment to be one of the most effective substance abuse treatments with demonstrated positive outcomes?

A: This Administration is committed to community-based alternatives and Federal financial participation (FFP) is indeed available for programs in the community like you describe. As you know, the IMD exclusion was intended by Congress to avoid the cost of long-term hospitalization of the mentally ill from becoming a Federal responsibility. While current substance abuse residential programs are not like the long-term mental hospitals of decades ago, the IMD exclusion by statute restricts Medicaid payment for certain substance abuse treatment facilities as well as for psychiatric facilities. Since the International Classification of Diseases (ICD) considers alcoholism and related disorders a mental disease, facilities that provided residential substance abuse treatment that met the IMD test were considered as such and services were not available for FFP.

As I noted, though, states may create other community-based outpatient treatment services for persons with substance abuse services through Medicaid State Plan mandatory and optional services. For example, all States must provide benefits for mandatory services and, in addition, may provide benefits for optional services. While Medicaid does not have a specific substance abuse benefit, benefits for these mandatory and optional services can be used to support substance abuse services. Each state has a state Medicaid plan; the plan sets forth the extent to which the state Medicaid program covers substance abuse treatment services. And each state has considerable flexibility in designing and implementing its state Medicaid plan as it sees fit. The flexibility accounts for the wide range in coverage of substance abuse services, and levels of funding, from state to state. Some states, for example, have programs of comprehensive rehabilitative substance abuse treatment services, with coverage of full continuum of care. Others, however, offer only minimal services. In addition to optional and mandatory benefits for substance abuse that a state may have in its Medicaid plan, states may also fund services in other ways such as with 1915(b) waivers for managed care, 1915(c) waivers for home and community based services, and section 1115 demonstration projects.

In sum, states use various Medicaid delivery models to provide Medicaid substance abuse treatment services. States use various Medicaid delivery models to provide Medicaid substance abuse treatment services despite the IMD exclusion.

Question 2: from Congressman Nathan Deal

I appreciated your explanation of the Administration's position on the dual eligibles with regard to prescription drugs. I am still concerned, however, about the financing of long-term care over the next few decades. What is the administration's position on the dual eligibles with regard to long-term care?

A: The Administration will continue to support the need to educate consumers to financially plan ahead for long-term care, including promoting the use of long-term care insurance. Continued reliance on public funding is problematic and the need for expanded long-term care financing options must be addressed. This is an issue of significant concern for the Medicaid program, which today bears the brunt of the cost for financing long-term care.

We are strongly committed to working with states to better control growth of long-term care costs in the Medicaid program. The promotion of a safe and affordable long-term care insurance product and awareness of other non-Medicaid long-term care financing options will likely empower the consumer to financially plan for long-term care. Promotion of these options could reduce the number of those individuals who become dual eligibles mainly because of their need for assistance in paying for long-term care services. Such a shift in financing long-term care could greatly improve the ability of states to provide essential care and services to their most vulnerable populations.

Finally, we want to continue working with states to provide additional flexibility in the way long-term care is provided so that more individuals may be served in the community, based on their needs and preferences. Encouraging states to expand community-based long-term care services is not only cost effective, it is in keeping with the spirit of the Americans with Disabilities Act and the President's New Freedom Initiative, which is geared to ensuring that all individuals with disabilities can more fully participate in community life by giving individuals more control over the long-term care supports and services they receive. Such personal and family control over services and supports also promotes rational and cost-effective purchasing of long term care services and supports.

Questions for the Honorable Thomas Scully
Administrator, Centers for Medicare and Medicaid Services
from The Honorable John D. Dingell

1. Mr. Scully, in your testimony on page 8, you mention the 24 states that CMS determined to be qualified for a transition period under the upper payment limit (UPL) regulations. Could you please tell me:

- which of the 24 states were notified;
- which UPL transition periods each of the 24 states was determined to fall within; and
- how much in the way of Federal funds are estimated to flow to each of these states each year during their transition.

Response: Please see Attachment 1 for:

(i) the list of 24 States that CMS preliminarily determined may qualify for transition under the UPL regulations;
(ii) the preliminary transition period determined for each of the 24 States; and,
(iii) the estimated total computable (i.e., Federal and State share) amount of funds each State received under transition, except for states for which determinations have not been made.

Please note the following:

1. The 24 States represented a universe of States for which CMS made preliminary determinations regarding UPL transition qualification. As demonstrated in the attached chart, upon CMS review of the States' UPL calculations, some States may not or did not qualify for a transition period.
2. States for which an estimated UPL transition amount has not been identified in the attached chart have yet to provide adequate documentation to support UPL transition qualification.
3. Certain States may have qualified for more than 1 transition period under the UPL regulations based on UPL payments to different types of health care services (i.e., inpatient hospital services (IH), outpatient hospital services (OH), and nursing facility services (NF)).
4. Transition periods for 1-year and 2-year transition States have expired. Any State with 1-year or 2-year UPL transitions that has not provided adequate documentation to support their UPL transition qualification are liable for any payments in excess of their allowable UPL transition spending. CMS has identified four States with 2-year UPL transition periods (Arkansas, Kansas, Louisiana, and Missouri) that spent beyond their allowable UPL transition amount.
5. The 5-year and 8-year UPL transition periods remain active.
6. The transition amounts identified in the attached chart represent the UPL transitional spending estimates provided by States. CMS continues to monitor actual State spending to ensure no State makes payment in excess of its allowable UPL transition amount.

7. Total computable payments are identified because the bulk of these payments do not stay with the health care provider but instead are returned to the States. Thus, the states could then use these funds again to draw down additional Federal funds in other Medicaid areas of their programs.

2. In Secretary Thompson's recent press release regarding the Census Bureau's new uninsured numbers, it was noted that Secretary Thompson has approved more than 2,500 waivers and plan amendments that have expanded access to health coverage for more than 2.5 million people and expanded the range of benefits offered to 6.7 million other Americans. Specifically, Mr. Scully, from your testimony for this hearing I see that "through waivers and state plan amendments, Medicaid eligibility expanded by more than 2.27 million people between 2001 and 2003." Please break down those numbers for me so that I can get a better sense of exactly how these waivers and state plan amendments expanded coverage.

(a) Are these actual enrollment numbers, or just the projected coverage from proposals?
(b) How many of the 2.27 million people were previously uninsured?
(c) How many of the 2.27 million people were not previously covered under Medicaid or SCHIP?
(d) Are these individuals from questions (b) and (c) counted in the 2.27 million figure?
(e) How many of the 2.27 million people were covered through a state plan amendment that was actually in effect prior to CMS approving it?
(f) How many of the 2.27 million people were people who lost their jobs and their health insurance (as a result of the downturn in the economy) and as a result were able to qualify for health insurance through Medicaid?
(g) How many people were newly covered as a result of state plan amendments? Please specify the state plan amendments that have resulted in the new coverage and the date of approval or renewal and implementation of each state plan amendment.
(h) How many new people have been covered by waivers and waiver amendments? For each of the waivers that have resulted in new coverage, please specify the following:

- the number of people gaining new coverage under that waiver;
- the number of people who were covered under Medicaid, SCHIP, or a state-funded coverage program (such as a State Pharmacy Assistance Program) prior to coverage under the waiver;
- the type of waiver (i.e., section 1115 Pharmacy Plus Waiver, section 1115 HIFA waiver, other section 1115 waiver, Independence Plus waiver, section 1915(b) waiver, or section 1915(c) waiver); and
- the date of approval and implementation status of the waiver.

(i) How many people who were covered under Medicaid or SCHIP prior to coverage under the waiver have experienced reductions in benefits, new premiums, new or increased cost sharing, or other changes in coverage as a result of the waivers? Please specify the waivers that have resulted in these changes.

A: CMS estimates that 2,603,465 individuals were potentially eligible for Medicaid based upon for SPA and waiver approvals from January 2001 through December 2003. This number also includes data for the Michigan HIFA waiver approved on January 16, 2004, because the application was pending in December 2003. Of those 2.6 million potential enrollees, CMS

can track actual enrollment for 1,629,671 (63%) of those potential enrollees. The remaining 973,794 potential enrollees were covered through SPAs or waivers for which specific actual enrollment data are not available; CMS is not able to separate enrollees covered in those SPA/waiver programs from other Medicaid enrollees. In addition, CMS does not collect information on: whether these individuals were previously uninsured; if they were previously covered under Medicaid or SCHIP; or whether they qualified for Medicaid as a result of losing employment and/or employment related health insurance.

For those SPA/waiver programs for which CMS can track actual enrollment attributable to the approval of the SPA/waiver program, 37% of the potential enrollees have enrolled. If we project 100% enrollment for those SPA/waiver programs for which actual enrollment data are not available, then we would expect that 60% of the potential enrollees have enrolled. The 100% enrollment projection is based on the enrollment experience with SPA programs for which we have data (SCHIP Prenatal and Breast & Cervical Cancer Prevention and Treatment Act SPAs).

Attachment 2 presents the enrollment information requested for those programs for which we track this information. 1915(b) waiver figures are not included because 1915(b) waivers do not expand enrollment. 1915(c) waiver figures are not included because states do not separate these enrollees from other Medicaid enrollees. Separate charts are included in Attachment 2 which contain information for the Independence Plus Program and the Pharmacy Plus program. It should be noted that the Pharmacy Plus program provides expansion of coverage for prescription drugs but not a full package of Medicaid benefits.

CMS does not track information on how many people covered by Medicaid or SCHIP experienced reduction in benefits, new premiums, increases in cost-sharing, or other changes after a waiver was implemented.

3. Mr. Scully, during your responses to Member questions, you stated on several occasions that Tennessee, through its waiver, has worked successfully under a federal Medicaid spending cap. When asked about whether the Medicaid spending cap has ever been inadequate and resulted in beneficiaries losing their coverage, you stated that "it hasn't happened in Tennessee." Let me refer you to an article entitled "TennCare deficit due greatly to federal cap" that appeared in The Tennessean on February 27, 2003 (attached). According to the article, almost half of the $369 million shortfall faced by the TennCare program this year was the result of an inadequate cap on federal funds. The State Comptroller John Morgan is quoted in the article stating that the federal funding cap "has proven grossly inadequate." While acknowledging that state budget deficits contributed in part to the overall funding shortfall, Morgan stated that "our numbers were going to be bad anyway, but over half the problem we face is because we hit that cap." It is our understanding that the inadequate federal cap directly contributed to an estimated loss of coverage of about 200,000 Medicaid beneficiaries previously enrolled in the TennCare. Would you please correct or explain your statement that "it hasn't happened in Tennessee"?

A: The Federal budget neutrality caps did not directly contribute to the loss of coverage of about 200,000 Medicaid beneficiaries. There are several key things to bear in mind. The trend rates for the demonstration (including the expansion population) were agreed to by both CMS and

the State, and were not responsible for the loss of benefits. Instead, the State's delayed process of reverification of eligibility and a separate cap on non-risk plans (which CMS took action to adjust) were more direct causes of the financing and eligibility issues noted by The Tennessean.

On May 30, 2002, CMS approved the State's proposal to implement a new 5-year TennCare demonstration project with cost cutting changes, including offering a more limited benefit package to expansion eligibles (i.e. beneficiaries who were not categorically eligible for Medicaid) and reducing the eligibility level for the uninsured. The new demonstration was approved to operate from July 1, 2002 through June 2007. The approved demonstration project included budget neutrality caps based on per member per month expenditure caps agreed upon by both CMS and the State. The State had provided CMS with budget projections that indicated the State would be able to fund its demonstration project, including the expansion groups, within the budget neutrality cap.

After approval, the State implemented a process to reverify all non-Medicaid eligible beneficiaries' eligibility. As a result of this process, approximately 200,000 individuals were dropped from the TennCare rolls. However, in December, 2002, the State was ordered by a Federal judge to restore benefits to these individuals because the judge ruled that the verification process was flawed and it caused people to unfairly lose benefits.

One of the terms and conditions included in the demonstration award established a separate cap on the federal share for managed care organizations, which were operating under non-risk contracts during Tennessee's "Stabilization Plan." This cap essentially limited the Federal match, during the stabilization period, to what those non-risk plans would have been paid under risk-based capitation payments. During the first year of operation, the State determined that the non-risk managed care expenditures would be significantly more than it had projected, and requested that CMS remove this separate cap for the stabilization period. It was this budget cap that Comptroller Moran indicated was contributing to the State's fiscal crisis. On April 29, 2003, CMS informed the State that it was removing the separate stabilization period cap, after receiving assurance from the State that the demonstration would still meet the overall 5-year budget neutrality cap.

In summary, the Federal budget neutrality caps did not directly contribute to the loss of eligibility of approximately 200,000 individuals. These individuals lost eligibility during the State's reverification process.

4. Mr. Scully, during your responses to Member questions, you stated that "Medicaid is the fastest growing program in the government." According to recent Congressional Budget Office (CBO) data, that does not appear to be the case. Under its Monthly Budget Review released on October 9, 2003, CBO noted that Medicaid grew by $13 billion between fiscal year 2002 and fiscal year 2003. That comes to an increase of about nine percent. If you take out the $2.7 billion in additional federal Medicaid spending that CBO projects in 2003 to be the result of the temporary increase in the FMAP provided as fiscal relief in the tax bill, that comes down to about seven percent. Now compare that to defense spending, which increased by about *$53* billion, or 16 percent between fiscal years 2002 and 2003, as adjusted for timing shifts and

accounting changes. Other programs also increased in dollar terms faster than Medicaid (such as Social Security and Medicare) and in percentage terms (such as unemployment insurance) between 2002 and 2003. Mr. Scully, in response to this data, would you please correct or explain your statement that Medicaid is the fastest growing program in the federal government?

A: Medicaid growth was 9.0 percent in FY 2003 and has averaged 9.7 percent over the past five years. By comparison, Medicare grew by 8.2 percent in FY 2003 and has averaged 5.4 percent growth over the past five years, making Medicaid the faster growing program. In addition, Medicaid including the state share, exceeded Medicare spending for the first time in FY 2002.

5. Mr. Scully, in response to Member questions, you stated that in approving several UPL state plan amendments that benefited select states like Wisconsin and Virginia, you were convinced you did the right thing and implied that the General Accounting Office (GAO), after an investigation and discussion with you, agreed with your decision. However, in its report entitled "Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes," released on October 30, 2001, the GAO stated that "HCFA actions in implementing its revised upper payment limit regulations are troubling. At the same time that HCFA was attempting to close a glaring loophole, it allowed additional states to engage in the very schemes it was trying to slow down, at an additional cost to the federal government." The GAO also stated that such approvals are "inconsistent with CMS' stated position about its intent to curtail such schemes and continues to undermine the integrity of the financing partnership." The GAO noted that the additional cost to the federal government was an estimated $722 million. Would you please explain why the GAO was incorrect in its 2001 criticism of Administration actions with regards to controlling state UPL schemes and on what specific points the GAO eventually agreed with you?

A: I would like to note that this Administration was alert to the need to address the problems of state financing schemes from its inception. Prior to Congressional action of any kind with regard to state financing schemes, CMS recognized the abuse and proposed new regulations to curtail it. We have been very clear that we will ensure the protection of Federal funds by ensuring that States receive a Federal match only for appropriate expenditures that are also appropriately matched with actual State dollars.

It is important to understand the history of the decision-making process. The regulation published during the last Administration on January 12, 2001, specified a transition period for plans that had already received Federal approval. The treatment of *pending* plan amendments was not clearly addressed in the January 12, 2001 final rule.

For pending plan amendments, the proposed effective date is generally the first day of the calendar quarter of submission, which for the amendments in question was *prior* to the change in the UPL rule. In April 2001, we published the proposed rule, which clarified the policy of how pending applications would be treated. At the time this decision was made, we identified 11 States that had pending plans that were potentially affected by this regulation. After we had time to more thoroughly review the State plan amendments, and after the publication of the proposed

rule, CMS found that only 4 States had filed for UPL amendments that were potentially affected by the new regulation.

I arrived at CMS on May 23, 2001. At that time, I had every intention of not allowing retroactive payments to the states with pending amendments. The Health and Human Services General Counsel opined that I was prohibited from denying these payments under Bowen vs. Georgetown; the Administrative Procedures Act precludes rules such as the UPL regulation from being given retroactive effect. Therefore, I could not apply the September 5, 2001 UPL final rule to the four State plan amendments in question.

6. Mr. Scully, during your responses to Member questions regarding the Administration's Medicaid reform proposal, you stated that the mandatory populations on Medicaid would be covered exactly as they are today. I would like to ask several clarifying questions. Under the Administration's proposal, it is my understanding from your testimony that the FMAP would remain for mandatory services provided to mandatory beneficiaries. Is this correct? Would the funding cap that you described apply to any optional services provided to these mandatory beneficiaries by states including, but not limited to, prescription drugs? Would the funding cap you described apply to any mandatory services provided to optional beneficiaries covered by states including EPSDT for children as well as hospital, nursing home and physician services?

   A: Under the Medicaid modernization proposal we proposed Federal funding is provided through the State Health Care Partnership Allotment. This allotment finances both the preventive and acute care benefits, as well as community and long term care benefits. The allotment includes a 15% set aside for administration, special health initiatives and programs for special needs populations. In addition, in keeping with the Administration's commitment to ensure mandatory services for mandatory eligibles, the allotment includes an adjustment for mandatory services for mandatory populations. Federal funding for mandatory services for mandatory populations would not be subject to a cap of any kind. States currently have the option to offer pharmacy and other optional services to mandatory eligibles; pharmacy services as well as optional services for mandatory eligibles would still be optional under our modernization proposal. The federal allotment for optional services for optional populations is guaranteed based on the state's 2002 expenditures. The federal share would grow faster than the national trend rate in the early years and slower than the national trend rate in later years. Growth in enrollment, utilization, and medical inflation is already assumed in the federal baseline. Finally, for additional flexibility, states would have the ability to roll over unspent allotments from one fiscal year to the next.

7. Mr. Scully, during your responses to Member questions, you had provided what appeared to be previously undisclosed details about the Administration's Medicaid reform proposal. Would you please confirm our understanding of those details?

   (a) Rather than a fixed dollar cap, the Administration's proposal would impose a per capita cap on optional spending. The cap would be negotiated on a state-by-state basis. Is this correct? Would such per capita caps be negotiated within the context of an overall national cap?

(b) You had stated that the cap would apply for only *3-5* years and states could opt out of the cap after such a time period, rather than over a 10-year period as originally outlined. Is this correct?

(c) You stated that the per capita cap would be adjusted annually based on a specific base year's inflation rate, rather than the estimated year-by-year inflation rates assumed under the baseline. Is this correct?

A: As specified in the President's fiscal year 2004 budget, the President's Medicaid and SCHIP modernization initiative would:

Provide an estimated $3.25 billion in extra federal funding for Medicaid in fiscal year 2004, with $12.7 billion in extra funding over seven years. Federal funding for Medicaid and SCHIP would be provided in annual allotments, with one allotment for acute care and another for long-term care.

Preserve comprehensive mandatory benefits for "mandatory"groups, while giving states expanded flexibility to tailor coverage for "non-mandatory" recipients and services. The proposal would be built on the SCHIP model – under SCHIP's flexible benefits, more low-income children and families were provided health care coverage, giving a basic coverage package equivalent to what many Americans receive in the private market to a larger number of people than would be possible through traditional Medicaid rules.

Encourage coverage for whole families, not just the children in low-income family; and encourage "medical homes", so that all the members of the family are treated by the same providers, wherever appropriate.

Support increased use of home and community based services for Americans with disabilities, enabling them to be served outside of institutional settings-including older Americans needing care that can help prevent premature use of nursing home care.

The plan would also require maintenance of effort, so states continue to invest and maintain their commitment to health care.

8. Mr. Scully, during your responses to Member questions, you stated that the Administration's proposal is "purely voluntary." You stated that it is permissible "if Colorado looked at it and said, this is not a good deal for us, we don't want to do it." I disagree that states have a real choice to join in the Medicaid reform proposed by the Administration given the pressures that will exist for them to agree. First, as part of the Administration's Medicaid reform proposal, the Administration would have provided states fiscal relief only if they agreed to the federal funding cap. In other words, the Administration held fiscal relief hostage to state's acceptance of the Medicaid reform proposal. That does not seem like a "purely voluntary" choice, rather, it makes this supposed "choice" quite coercive. Thankfully, Congress provided fiscal relief to states independent of any Medicaid reforms, despite the Administration's opposition to the temporary increase in the federal Medicaid matching rate. Second, even if a state does not choose the Medicaid reform option, it could be adversely affected nonetheless. The Administration's reform proposal folds in both Medicaid and SCHIP funding. Because of this a state qualified for SCHIP redistribution could receive a small redistribution amount if it is unwilling to accept a funding cap. In other words, faced with fewer funds reallocated from other states, states that decide against joining in the Administration's reform proposal could be forced to cut eligibility for thousands of low-income

children. Given these facts could you correct or explain why you believe the Administration's Medicaid reform option is truly voluntary for states?

A: The Medicaid modernization proposal is intended to bring much needed reform to the Medicaid program – reform that goes beyond temporary state fiscal relief. We believe that states will find the flexibility of the proposal very attractive. Reforms that states have sought for years and now can only implement after going through the federal waiver process may be implemented when the state is ready, without prior federal approval. State will have the ability to design Medicaid programs that truly meet the needs of their citizens, not a one-size-fits-all program mandated by the federal government. The long-term care improvements will put consumers and their families in control of their health care. For states that do not opt-in to the modernization program, the Medicaid program will stay just the same as it is today. With regard to the amount of dollars left to be redistributed, the amount of dollars left over for redistribution to other states would depend upon the mix of states that opt for modernization and the mix of states that do not. To take but one example, if the only states that opted for modernization were states that were spending up to their entire SCHIP allotments, there would be no overall effect on the number of SCHIP dollars to be redistributed to other states. In addition, we believe that there are very few states in a position where maintaining their eligibility expansions under SCHIP is wholly dependent on accessing redistributed dollars from other states.

Attachment 1

Estimated Total UPL Transition Payments
January 22, 2004

State	Type	Transition Period	Excess Amount	Total Excess	Comments
Alabama	IH	5			May not qualify for Transition
Alabama	OH	5			May not qualify for Transition
Alabama	NF	5			May not qualify for Transition
Alaska	IH	2	$18,425,617	$36,851,234	
Arkansas	OH	2	$28,250,000	$56,500,000	
California	IH	8	$794,515,218	$3,853,398,807	
Georgia	IH	5			May not qualify for Transition
Illinois	OH	8	$202,284,046	$981,077,623	
Illinois	IH	8	$703,285,046	$3,410,932,473	
Iowa	NF	2	$74,461,795	$148,923,590	
Kansas	NF	2	$23,427,286	$46,854,572	
Louisiana	NF	2	$583,333,148	$1,166,666,296	
Michigan	OH	1			UPL calculations not complete
Michigan	OH	5			UPL calculations not complete
Michigan	NF	5	$646,361,500	$2,262,265,250	
Missouri	IH	1			
Missouri	NF	2	$216,507,212	$433,014,424	
Nebraska	NF	8	$75,004,569	$363,772,160	
New Hampshire	NF	5	$23,448,731	$82,070,559	
New Jersey	NF	2	$460,000,000	$920,000,000	
New York	NF	5	$802,814,715	$2,809,851,503	
North Carolina	IH	5	$0	$0	Did not qualify for Transition
North Carolina	OH	5	$0	$0	Did not qualify for Transition
North Dakota	NF	5	$36,660,807	$128,312,825	
Oregon	NF	5	$53,677,017	$187,869,560	
Pennsylvania	NF	8	$1,335,983,613	$6,479,520,523	
South Dakota	NF	2	$45,400,000	$90,800,000	
Tennessee	NF	2	$99,630,713	$199,261,426	
Virginia	NF	1	$477,405,016	$477,405,016	
Washington	IH	1			UPL calculations not complete
Washington	NF	5	$141,036,508	$493,627,778	
Wisconsin	NF	2	$507,434,429	$1,014,868,858	
Wisconsin	NF	8	$25,327,818	$122,839,917	
Total				$25,766,684,393	

Attachment 2

Number of Enrolled Individuals in Medicaid and SCHIP Due to Expanded Eligibility/Enrollment (January 2001-December 2003)

TYPE OF PROGRAM	ORIGINAL ESTIMATES OF POTENTIAL ELIGIBLES	ACTUAL NEW ENROLLEES
1115 – HIFA Waivers	821,750	175,149
1115 – non HIFA Waivers (FCHPG)	681,265	304,066
1115 Waivers (DEHPG)	60	25
SCHIP Prenatal SPAs	60,256	53,742
Medicaid Buy-In for Working Disabled Adults Program SPAS	56,000	56,326
BCCPTA SPAs	10,400	11,700
Total	**1,629,731**	**601,008 (37%)**
Remaining SPAs/Waivers (actual enrollment data not available)	973,794	973,794
Total	**2,603,525**	**1,574,802 (60%)**

HIFA WAIVERS

STATE	APPROVAL DATE	IMPLEMENTATION DATE	ORIGINAL ESTIMATE OF POTENTIAL ELIGIBLES	ACTUAL NEW ENROLLEES (as of 10/1/03)
ARIZONA[1]	12/12/01	Phase 1: 11/1/01 Phase 2: 1/1/03	48,250	49,065
CALIFORNIA[2]	1/25/02	N/A	275,000	0
COLORADO[3]	9/27/02	10/8/02	13,000	172
ILLINOIS[4]	9/13/02	10/1/02	300,000	608 (XIX-funded) 39,794 (XXI-funded)
MAINE[5]	9/13/02	10/10/02	11,500	15,853
MICHIGAN[6]	1/16/04	1/16/04	62,000	0
NEW JERSEY[7]	1/31/03	3/1/03	12,000	6,139
NEW MEXICO[8]	8/23/02	N/A	40,000	0
OREGON[9]	10/15/02	11/1/02	60,000	61,360 (XIX-funded) 2,158 (XXI-funded)
TOTAL			**821,750**	**175,149**

[1] Arizona amended their current 1115 demonstration to expand coverage to parents and childless adults. The Arizona HIFA amendment was approved retroactively to 11/1/01.

[2] CMS approved California's HIFA demonstration on 1/25/02, but the State has not implemented the demonstration as of 1/1/04 due to budget constraints.

[3] Colorado temporarily suspended enrollment due to budget constraints on 5/1/03. On 11/1/03 the State moved any pregnant women remaining in the program to a State only funded program.

[4] Illinois initial expansion is 29,000. The State anticipates that it will enroll 300,000 individuals when fully implemented.

[5] CMS approved a HIFA demonstration for Maine on 9/13/02 that allowed the State to provide coverage to 11,500 childless adults.

[6] Michigan HIFA was approved and implemented after 10/1/03.

[7] CMS approved a HIFA amendment to New Jersey's 1115 demonstration on 1/31/03 that provided coverage for an additional 12,000 parents that were on the State's waiting list for the NJ FamilyCare demonstration.

[8] CMS approved New Mexico's HIFA demonstration on 8/23/02, but the State has not implemented the demonstration as of 1/1/04 due to budget constraints.

[9] CMS approved a HIFA waiver for Oregon on 10/15/02. This HIFA waiver replaced the Oregon Health Plan demonstration and was named Oregon Health Plan 2. This redesign allowed for an expansion of coverage to 60,000 potential eligibles.

Attachment 2 (Continued)

OTHER NON-HIFA 1115 WAIVERS

STATE	APPROVAL DATE	IMPLEMENTATION DATE	ORIGINAL ESTIMATE OF POTENTIAL ELIGIBLES	ACTUAL NEW ENROLLEES (as of 10/1/03)
DISTRICT OF COLUMBIA	3/6/02	2/3/03[10]	1,200	1,514
MASSACHUSETTS[11]	12/4/02	1/1/04	476	0
MINNESOTA	6/13/01	6/13/01	35,589	25,808
NEW YORK[12]	6/29/01	10/1/01	619,000	257,704
UTAH[13]	2/8/02	7/1/02	25,000	19,040
TOTAL			**681,265**	**304,066**

PRENATAL SPAS STATE PROJECTED AND ACTUAL ENROLLMENT

PRENATAL	APPROVAL DATE	IMPLEMENTATION DATE	ORIGINAL ESTIMATE OF POTENTIAL ELIGIBLES	ACTUAL NEW ENROLLEES
ILLINOIS	6/11/03	11/1/03	41,000	33,452 (12/03)
MICHIGAN	4/17/03	12/1/02	5,163	4,139 (10/03)
MASSACHUSETTS	9/15/03	11/1/02	3,850	4,395 (10/03)
MINNESOTA	8/6/03	11/1/02	3,793	3,793 (estimated)
RHODE ISLAND	4/17/03	11/1/02	675	563 (10/03)
WASHINGTON	9/22/03	11/12/02	5,775	7,400 (10/03)
TOTAL			**60,256**	**53,742**

[10] Numerous changes in the District of Columbia's administrative personnel contributed to the delay in implementation of its demonstration program.

[11] CMS approved Massachusetts' Breast and Cervical Cancer Amendment to its 1115 demonstration on 12/4/02, but the State did not implement until 1/1/04 due to budget constraints.

[12] New York has estimated that not all eligibles would actually apply. The 257,704 is on target with their projected enrollment (versus eligible) rate.

[13] Utah reached a subcap of 19,000 for non-ESI enrollees on November 2003 and closed new enrollment. There is a 6,000 subcap for ESI enrollees, but enrollment in this component has been minimal (only 30 enrolled so far).

Attachment 2 (Continued)

INDEPENDENCE PLUS WAIVER PROGRAMS

STATE	APPROVAL DATES	IMPLEMEN-TATION DATES	ORIGINAL ESTIMATE OF POTENTIAL ELIGIBLES		ACTUAL ENROLLMENT (12/30/03)	ACTUAL NEW ENROLLEES
1915(c)			Total in Waiver	Total Self-Directing		
New Hampshire	1/1/03	1/1/03	570	570	180	Estimated at 15% (27)
South Carolina	3/22/03	7/1/03	1800	1800	17	7
Louisiana	4/24/03	4/24/03	13,603	250	0	0
North Carolina	12/23/03	1/1/04	335	335	0	0
1115						
Florida	5/30/03	1/1/04	3350	3350	2856	0

PHARMACY PLUS WAIVERS

STATE	APPROVAL DATE	IMPLEMEN-TATION DATE	PREVIOUSLY COVERED UNDER STATE-ONLY PROGRAM	ACTUAL NEW EN-ROLLEES (as of 12/31/2003)	TOTAL EN-ROLLEES (as of 12/31/03)
FLORIDA	8/1/2002	8/1/2002	9,000	2,694	11,694
ILLINOIS	1/28/2002	6/1/2002	51,823	316,177	368,000
MARYLAND	7/30/2002	7/30/2002	43,000	47,000	90,000
SOUTH CAROLINA	7/30/2002	1/1/2003	41,000	9,000	50,000
WISCONSIN	6/28/2002	9/1/2002	0	177,000	177,000
TOTAL			**144,823**	**551,871•**	**696,694**