Remarks of Rep. Henry A. Waxman
Chairman, House Committee on Oversight and Government Reform
"The Congressional Medicaid Agenda for 2007"
Second National Medicaid Congress
June 14, 2007

Good morning. I've been asked to speak to you about the Congressional Medicaid agenda for this year. It's fairly straightforward: First, we will do no harm to Medicaid and its 60 million beneficiaries. Second, we will reduce the number of uninsured low-income children by extending S-CHIP, and by strengthening Medicaid. And, finally, we will oversee the way in which CMS is administering Medicaid.

First, Do No Harm

The first order of business is to prevent the Bush Administration from doing harm to the program. From its very first days, the Administration has been on an ideological mission to wreck the program. They may call it "modernization," "transformation," "empowerment," and "personal responsibility," but those are all just friendly-sounding code for their wrecking mission. What this code stands for is diverting Medicaid dollars from hospitals, clinics, pharmacies, and physicians and spending them on premiums for unregulated health insurance products that have high deductibles and high co-payments. These vague words also stand for shifting federal responsibilities onto state and local governments. Having cut taxes, spent wildly, and driven the nation further into debt, the Administration has decided its budget strategy should be to reduce funding for health care for the poor.

Medicaid is much too important to allow the Administration to ruin it this way: Medicaid provides health insurance coverage to 1 in every 4 children in America; It pays for 1 in every 3 births in America and is the largest source of public funding for family planning services; It provides health coverage for 8 million Americans with disabilities and chronic illnesses such as diabetes and AIDS, many of whom are excluded from health insurance in the private market; It fills in the gaps in Medicare for over 7 million elderly and disabled Americans—1 out of every 6 Medicare beneficiaries—who are covered by both programs as "dual eligibles;" It covers 6 of every 10 nursing home residents and pays for more than 40 percent of all nursing home spending; and it is a crucial source of financial support for safety net hospitals and clinics that serve the uninsured, accounting for over 1/3 of their operating revenues.

In its budget for the coming fiscal year, the Administration proposed legislative changes that would cut federal Medicaid spending by $11.6 billion. These cuts take the form of shifting costs to states and counties through lower matching rates for administrative costs and targeted case management services.

There is no support for these ill-advised and irresponsible proposals on Capitol Hill. They will not happen.

The Administration is also trying to use regulations to make fundamental changes in Medicaid policy — changes that it knows the Congress would not approve. One regulation

would limit federal payments to government providers like public hospitals. A second would prohibit federal payments for graduate medical education (GME) costs to pay for residents at teaching hospitals. A third would limit federal payments for rehabilitation services. The last would reduce federal payments for school-based services.

According to the Administration, these regulations would reduce federal Medicaid spending by $12.7 billion over the next five years. As in the case of its legislative changes, these regulations would save federal funds not by reducing costs, but by shifting them to states, counties, and providers.

The Congress has already acted to stop two of these proposed regulations: the limitation on payments to government providers, and the prohibition against federal payments for GME costs. As a result of an amendment in the recent Supplemental Appropriations bill, the Administration is prohibited from implementing either of these proposed regulations. The moratorium expires in May 2008.

These two regulations would have had a particularly harmful impact on our nation's overburdened emergency and trauma care system — an impact the Administration seems determined to ignore. This is especially perplexing to me, because I had never understood emergency and trauma care to be an ideological or partisan issue.

Emergency care is essential for victims of heart attack, stroke, car crash, asthma, and other time-critical conditions. Our communities need functioning emergency care systems to respond to disasters, epidemics, and other mass-casualty incidents such as the recent shootings at Virginia Tech or possible outbreaks of pandemic flu.

The Administration's proposed regulations would indisputably reduce the flow of badly needed Medicaid dollars to many of our nation's emergency rooms and trauma centers. Over 140 community and teaching hospitals, including many of the leading emergency care providers in the nation, submitted public comments in opposition to the proposed regulations.

Nonetheless, despite near-universal opposition, the Administration continues to press for these changes.

At some point in the near future, the Oversight Committee will hold a hearing to explore the crisis in our emergency and trauma care system documented by the Institute of Medicine. Among the issues we will address is why the Administration is pursuing Medicaid policies that will make a bad situation worse.

S-CHIP Reauthorization

The second order of business on Congress's Medicaid agenda is the reauthorization of S-CHIP, which expires on September 30, just a few months from now.

As I don't have to explain to this audience, over the past 10 years S-CHIP and Medicaid have together reduced the number of children without health insurance. S-CHIP now covers

almost 7 million kids, Medicaid over four times that number — 29.5 million. Despite this success, 9 million children remain uninsured. Six million of those are eligible for Medicaid or S-CHIP but are not enrolled. Just to maintain current coverage in the face of health care inflation and population growth will cost the federal government a net of $8 billion over the next five years.

The Administration's FY 2008 budget proposes to increase SCHIP spending by a net of only $2.3 billion, less than a third of what is necessary to maintain current coverage. If Congress were to accept this proposal, hundreds of thousands of children would lose S-CHIP coverage over the next few years.

The Administration's S-CHIP budget proposal is not going to happen. In the Supplemental, Congress made an additional $650 million available to ensure that kids now enrolled in S-CHIP would not lose coverage in the short run.

Congress is not going to allow children to lose SCHIP coverage in the long run, either. The budget Congress adopted last month commits up to $50 billion in additional federal funding over the next five years. The only issue is how many of the 9 million uninsured children the S-CHIP reauthorization will reach.

I am hopeful that the Congress will permit states to use S-CHIP or Medicaid funds to cover immigrant children who are in this country legally. If the federal government has determined that a child is legally in the country, it should not prohibit a state from using federal funds to purchase needed health care services for that child.

I am also hopeful that Congress will give the states flexibility to decide whether or not to require documentation of citizenship by children and parents applying for Medicaid and S-CHIP.

We now have nearly one year of operating experience under the misguided "one size fits all" documentation requirement enacted by the Republican Congress and vigorously implemented by the Administration. Two points are emerging:

First, there is still no evidence that there is a problem that would justify requiring over 40 million Medicaid beneficiaries and applicants to document their U.S. citizenship. There's simply no evidence that significant numbers of illegal immigrants are actually receiving regular Medicaid benefits. Kansas and Virginia Medicaid officials each report having identified one — and only 1 — undocumented individual among the tens of thousands of beneficiaries reviewed to date.

Second, there is mounting evidence that the primary impact of this provision is on U.S. citizen children and their parents, not on illegal immigrants. Thousands of American children and parents have had their Medicaid eligibility delayed for months or denied altogether — <u>not</u> because they are <u>not</u> U.S. citizens, but because they do not have the required documentation in their possession. The Birmingham News recently reported that 5,000 Alabama residents, the large majority of whom were children, lost Medicaid coverage due to the documentation requirement. Ironically, 60 percent of those losing coverage were Black, while only 2 percent were Hispanic.

State Medicaid and S-CHIP directors are asking for the flexibility to decide whether to require documentation by U.S. citizen children and parents based on the circumstances in their state. We should give them this flexibility, so that Alabama and Kansas and Virginia and other states can decide for themselves whether the administrative and humanitarian costs of the current "one size fits all" documentation policy are in the best interests of their citizens.

Oversight

The third order of business on Congress's Medicaid agenda is oversight — ensuring accountability and transparency in the management of the program at both the federal and state level. The obvious difficulty here is that the Bush Administration fundamentally does not want or know how to make the federal government work.

We need only look at the example of FEMA. Once it was the gold standard for government. But something has gone very wrong in recent years. We saw government at its worst during the Hurricane Katrina disaster. FEMA completely failed America's citizens.

We saw it break down again at Walter Reed Hospital, in the deplorable conditions provided to our bravest Americans. And we've seen profound problems in the Iraq War, from flawed basic intelligence to a failure to supply our troops with the right armor and equipment.

I don't want government programs to be ineffective; I want them to be models of excellence.

One of the most important responsibilities for the Oversight and Government Reform Committee that I chair is to understand what's gone wrong. How did some of the best government agencies become so weak?

Last month, the Committee launched a series of hearings on making government effective again. We will be looking at the performance of a number of agencies, including the agency responsible for administering the nation's two largest health insurance programs on behalf of some 90 million Americans — CMS.

One of the issues the Committee may want to explore has to do with CMS contracting out government functions. Between 2000 and 2006, the amount of contracting by CMS rose from $422 million to $1.2 billion, an increase of 185 percent. This is nearly twice the increase in procurement contracting across all federal agencies.

Of even more concern is the fact that last year more than half of the $1.2 billion in CMS contracts were awarded without full and open competition. The amount of noncompetitive contracts awarded by CMS has grown 634 percent over the last six years. This is troublesome because competition the taxpayers by driving prices down and quality up.

This surge in government contracting is not unique to CMS. Procurement spending by federal agencies has grown rapidly over the last six years, nearly twice as fast as the rest of the

federal budget. The result is that 40 cents of every discretionary federal dollar now goes to private contractors, a record level. A report I released last year documents that the surge in contract spending has come at a steep cost to taxpayers through rising waste, fraud, abuse, and mismanagement. Whether CMS contracting is subject to these same problems remains to be seen.

On the Medicaid front, the Domestic Policy Subcommittee has already started to investigate Medicaid's coverage of dental care for children. The investigation was begun in response to the tragic and utterly inexcusable death of a Medicaid-eligible 12-year-old boy in Maryland due to a brain infection resulting from an abscessed tooth. At a hearing on this subject last month, the Subcommittee heard testimony from Mr. Dennis Smith, who is responsible for administering the Medicaid program, which last year spent $31 billion helping states purchase health care for children.

I asked Mr. Smith whether he or his agency had done a critical incident review of this child's death to determine what went wrong and why, and what changes are needed to be made to prevent this from happening to other Medicaid-eligible children. He responded that he had not done such a review, but that, quote, "the regional office had discussions with the State in terms of trying to understand what the situation was."

I also asked him whether it was acceptable to him that, even though every child enrolled in Medicaid is entitled to needed dental care, and even though the Surgeon General has documented an epidemic of tooth decay among low-income children, 2 out of every 3 Medicaid children received no dental services of any kind in 2005. His answer was, and I quote: "I would say it illustrates that there is an access problem in the Medicaid program. I would also say that those percentages, while they are still not the levels that any one of us like to see, they are higher than previously. States are showing improvement."

I would say Mr. Smith's response illustrates that there is a management problem in the Medicaid program at the federal level. It is a matter that the Committee will continue to pursue.

Concluding Thoughts

I think government can be a tremendous instrument of good. I've seen it help Americans in countless ways, from Social Security to landmark environmental laws to protecting public health.

The Medicaid program has achieved a great deal for the 60 million Americans it covers, and it has enormous potential to do even more. The challenge before all of us is to make this potential a reality.