IMPACT OF FEDERAL BUDGET PROPOSALS ON OLDER AMERICANS

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FRIDAY, MARCH 27, 1981

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:16 a.m., in room 6226, Dirksen Senate Office Building, Hon. John Heinz, chairman, presiding.

Present: Senators Heinz, Cohen, Grassley, Durenberger, and Glenn.

Also present: John C. Rother, staff director and chief counsel; Eileen Barbera, professional staff member; Ann Gropp, communications director; Nell Ryan, minority professional staff member; Robin L. Kropf, chief clerk; Helen Gross-Wallace and Nancy Mickey, assistant clerks; and Eugene R. Cummings, printing assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Senator HEINZ. Good morning.

This is the second of two hearings the committee is holding in Washington to examine the impact on the elderly of the administration's fiscal year 1982 budget proposal.

While there are a multiplicity of programs that in some measure affect the lives of the elderly, our hearings are focused on those proposals which potentially have the most direct and serious impact on older Americans.

Last week, our hearings addressed the issue of income security, including social security, food stamps, and low-income energy assistance programs. Today, we will look at the budget proposals as they affect health and human services.

Of the 26 health and human services programs which deal with community-based services and institutional care, the most important are medicare, medicaid, title XX, and the Older Americans Act.

Despite the creation of these vital programs, many older Americans are still confronted with unmet health needs because appropriate services are not available; because the necessary linkages between programs are lacking; or because they lack the financial resources to obtain the necessary care.

Every Senator is aware that there are numerous problems with the existing health and social services programs. We must insure that the current budget proposals do not exacerbate those problems or create new barriers to effective health care and needed services for older Americans.

The purpose of this hearing is to look carefully at the current budget proposals, as I said earlier, particularly the proposed cap on medicaid and the block grant proposal for services with its accompanying reduction in funding—to determine how the implementation of those proposals would affect services to older persons.

We need to explore whether the reduction of administrative requirements will enable service providers, both institutional and community-based caregivers, to use scarce resources more effectively to provide better care at more reasonable costs.

We must ask whether the consolidation of categorical programs under a few block grants will provide the flexibility to enable States to more efficiently use their resources to target services to those most in need. Or will politically popular programs be funded at the expense of the most vulnerable population who cannot effectively compete in the political arena?

Will States use this opportunity to reduce fragmentation and duplication to free up funds for additional services? We need to know that the proposed reduction in funding will not result in even fewer services and worsening of an already inadequate community-based service system.

We are also very interested in knowing what the ramifications will be of simultaneously imposing a cap on medicaid and reducing funds for services through the block grants.

These are questions and issues that seriously concern this committee in its efforts to insure that the well-being of older Americans is not threatened by the current budget proposals. And we are interested in exploring possible alternative proposals to achieve similar savings where appropriate.

Last week we heard from David Swoap, Under Secretary of the Department of Health and Human Services, regarding the administration's proposals in these areas. April 9, the committee will hear testimony from Office of Management and Budget Director David Stockman as well.

Today, we will hear from those directly involved in the implementation of these program proposals—providers of health and social services, State and local government, and the elderly consumer.

As we address these complicated issues, we look forward to hearing the views of the witnesses today.

I would like to yield now to my colleague, Senator Cohen.

STATEMENT BY SENATOR WILLIAM S. COHEN

Senator COHEN. Thank you, Mr. Chairman.

I have no formal statement to make other than to point out that I had the privilege of serving on the Committee on Aging in the House, with Senator Heinz, and both of us began over there in 1976, I believe, the first year that it was created, or 1974, actually. But in any event, Senator Heinz has indicated an interest in the issue of the elderly, and I am delighted that he is now serving as chairman of this committee.

I particularly want to commend him for instituting these hearings, because we are sensitive to the proposed reductions in budgets and how they will impact on our populations, coming from the State of Maine, which has long, cold winters, which has to pay high

cost of fuel bills with lots of poor and elderly, and as a State which is ranked as having the lowest per capita income in the United States—if you couple that with the harshness of our weather—it places a particular burden on our older people.

There are changes that can be made in our programs and there are approaches that have to be undertaken in the way of making programs currently on the books more efficient and effective.

In a few weeks, we will be holding hearings dealing with the weatherization program. Senator Heinz and I intend to join in an effort to combine certain programs such as fuel assistance with home weatherization. Because it only makes good commonsense—and dollars and cents—we are going to have help pay the fuel bills for people who cannot afford them now. We hope to reduce their consumption in the future by helping to weatherize their homes.

So I want to commend you, Mr. Chairman, for your efforts in this regard. I regret that I cannot stay long at this particular hearing because I have to attend a funeral, but I will certainly look forward to reading the record.

Senator HEINZ. Let me just say, Senator Cohen, that we in the committee are deeply indebted to you for really making a very major effort to get the committee and other committees to focus on the issue of trying to target weatherization expenditures and weatherization activities on those who have the most burdensome, highest utility bills, and it is very much accurate to say that it is due to your continuing and abiding interest in both the weatherization program and in the low-income energy assistance program that we are going to have the hearings. Because of your interest, these hearings are, I think, going to be quite meaningful and, I hope, successful.

Senator Lawton Chiles, the ranking minority member and former chairman of our committee, is unable to be with us today. He has submitted a statement for the record, and without objection it will be inserted into the record at this point.

[The statement of Senator Chiles follows:]

STATEMENT OF SENATOR LAWTON CHILES

Good morning. I want to commend our chairman, Senator Heinz, for scheduling a series of hearings on the impact of the administration's budget proposals on older Americans.

Today's hearing on health and social services for the elderly will examine budgetary matters which cause us great concern and force a reexamination of the so-called "safety net" to insure that the needy in our society continue to receive an adequate level of services.

This committee, like other committees, would like to respond to the President's challenge to balance the Federal budget. However, I believe some of the budget cuts have been too deep and I do not want us to be shortsighted in cutting back vital services which will, in the long range, require more costly solutions.

I am concerned that some of the proposals to reduce costs may not have been well thought out in terms of their effect. For instance, if a flat cap is put on medicaid expenditures, without a view toward coordinating these actions with medicare, we may find that a substantial amount of the medicaid cost "savings" will simply be transferred into the medicare program. I can foresee this happening in both hospital and nursing home expenditures.

I am equally concerned that the social service programs may not provide the needed level of service in such areas as home-health benefits or home-delivered meals thereby forcing older persons into institutional settings which in the long range are far more expensive.

The goal of our hearing today is to hear from the expert witnesses. I hope they may help us to understand how appropriate services to older persons will be assured

under the present budget proposals or that they will provide us with alternative budget saving opportunities.

Mr. Chairman, I might add that I am disappointed that a representative from the administration could not be with us today. I have questions which I would like submitted to the Department of Health and Human Services for a written response.

Thank you.

Senator HEINZ. Well, our first witnesses today are Dr. Frederick Ackerman, David C. Crowley, Thomas G. Bell, and Bill Halamandaris.

Gentlemen, let me ask Dr. Ackerman to please proceed first.

STATEMENT OF DR. FREDERICK A. ACKERMAN, CONCORD, CALIF., CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, DIVISION OF LEGISLATIVE ACTIVITIES, AMERICAN MEDICAL ASSOCIATION

Dr. ACKERMAN. Thank you, Mr. Chairman.

I am Frederick A. Ackerman, M.D., a physician in practice in Concord, Calif. I am the chairman of the AMA Council on Legislation. With me is Harry N. Peterson, director of the AMA's Division of Legislative Activities.

In the interest of time, we will abbreviate our statement we have submitted for your consideration.

Senator HEINZ. Without objection, the entire statement will be made a matter of the record.[1]

Dr. ACKERMAN. The American Medical Association is pleased to accept the committee's invitation to discuss the President's proposed health budget and its effects on the elderly, particularly the proposals to place a cap on Federal medicaid expenditures, and to group separate categorical health programs into block grants.

The medicaid program was enacted in 1965 to provide medical services to needy individuals, including our elderly citizens. Since its enactment, that program has experienced steadily rising costs. These costs have resulted from many factors—expanded numbers of beneficiaries, increased benefits, and general increases in costs of administration and services. Program costs have been further aggravated by the effects of a depressed economy and double-digit inflation, which pervades the entire economy.

Mr. Chairman, medicaid is only one of the many programs contributing to the record level of Government spending, which is recognized as a core problem in our country's economic difficulties. The American Medical Association supports the overall initiatives of the President as he seeks to restore some measure of fiscal stability and integrity to our Government budget policies. There can be little question that the American people wish to have the Government do whatever it can to stem the rapidly rising cost of living.

Where cuts are made across the board to reduce deficit spending, our association expects that some reductions in Federal health spending will also take place.

We are concerned, as you are, Mr. Chairman, and others on the committee, that the reductions in health spending should not impair the provision of necessary services to our needy elderly.

[1] See page 186.

As the medicaid program is currently structured, States may enter into agreements with the Secretary of Health and Human Services to finance health care services for public assistance recipients and certain other low-income individuals and families, including the elderly. The amount of Federal expenditures is, in effect, controlled by the States. The Federal Government is obligated to match a State's medicaid expenditures according to a percentage formula which varies from State to State. This has posed a basic dilemma for the administration.

The administration proposes to alter the present system under which States are automatically entitled to open-ended Federal medicaid matching funds by establishing a closed-end system designed to prevent Federal expenditures from going beyond a certain level, regardless of State spending. Federal expenditures would be allowed to increase by 5 percent in fiscal year 1982, and in fiscal years thereafter, the Federal ceiling would increase only with the rate of inflation as measured by the GNP deflator.

In conjunction with the proposed medicaid cap, the administration has indicated that it will seek legislation to give the States greater flexibility in administering medicaid benefits. According to the March 10 budget message, this will give States additional flexibility to target necessary services to the truly needy.

It is difficult to predict just how the States will respond should the proposed cap be enacted. We recognize that the limit on Federal medicaid expenditures might result in some decrease in overall medicaid services in a State if it does not increase its funding efforts to offset decreases in Federal medicaid payments. We hope that States may be able to effect significant enough savings in their programs to enable them to offer a medicaid program under the cap without decreasing the quality of care.

Achieving economies in the medicaid program will not be an easy task. There can be no question, however, that much can be done to help assure that medicaid achieves greater cost-effectiveness while maintaining the availability of quality care.

States should be able to maintain essential services through greater efficiencies in administration, and by elimination of fraud and abuse through vigorous enforcement of the law, and judicious cutbacks where eligibility has become overextended. Some States may have to examine priorities expressed in their benefit package and place priorities on adequate funding of basic and essential services.

We have not had an opportunity to examine any legislative provisions of the administration's medicaid cap proposal, but we can at this time offer a suggestion for consideration in developing such legislation. Because of the uncertainties involved in the ability of the States to successfully provide adequate levels of medicaid services, we suggest that a provision be included to monitor closely the effects of the cap after its enactment.

Congress might also consider establishing a special medicaid safety valve that might be triggered to assist States which, due to unusual local economic problems, suffer unusually extreme dislocations in their medicaid programs as a result of the imposition of Federal limitations. Moreover, Congress should examine whether

the specific limit of 5 percent for a 1982 increase, and the use of the GNP deflator for future increases, are appropriate as the cap.

As Congress considers the administration's medicaid proposal and as the States implement program changes, we must caution against adoption of the view that medicaid cutbacks can easily be absorbed merely through decreasing the level of reimbursement to providers of medical care. A State cannot reduce reimbursement levels and expect to maintain the current quality of care under the medicaid program.

With regard to the proposed cap on Federal expenditures, the AMA recognizes the need for such an action to gain control of the rapid growth in medicaid expenditures, where the Federal costs are tied to independent State actions.

We believe that the overriding concern at this time must be to take steps necessary to improve the Nation's economy. Unless reversed, economic hard times, factory closings, and any resulting increased unemployment would only exacerbate the problem and increase the financial burdens on medicaid. We endorse the cap concept as a part of the President's program for improving the overall economic situation.

Mr. Chairman, we intend to work closely with our State medical societies to monitor developments ahead. The medicaid program—with all its faults and limitations—must be supported with the necessary resources to furnish adequate services to our elderly citizens.

The administration has proposed a transfer of the present categorical health programs into two block grants—one for basic health, mental health and substance abuse services, and the other for preventive health services.

The present system of some 26 separately mandated and funded categorical health, programs for grants to States has resulted in excessive Federal regimentation of resources. This has resulted, in effect, in a determination of local needs through decisions made in Washington with a concomitant lessening of State responsibilities in the public health area.

We support the consolidation of present programs into block grant programs. We must raise, however, certain concerns with regard to the proposed block grant program.

Two bills have been introduced to establish two block grants in the health area—the basic health services block grant, and the preventive health services block grant. It will be important to examine not only the assignment of the programs into these two general categories, but also whether more than two blocks should be created.

One categorical program affecting older Americans to be transferred to a block grant is the program providing grants to States for the initial costs of establishing home health agencies, and for training personnel to provide them health services.

In making grants under the existing categorical programs, the Secretary of HHS must give special consideration to those areas of States that have a high percentage of the population composed of the elderly, the medically indigent, or both. The AMA has long supported home-health services and home-health agencies, and we should hope that States will give a high priority to the develop-

ment of home-health services under the proposed block grant program.

We recognize that the block grant concept could be eroded if each health interest seeks its own separate block grant. The end result could be little more than a minor variation from the present categorical grant study.

In its discussion of the block grant proposals, the administration has indicated that additional flexibility would be granted the States by permitting each State to take up to 10 percent of Federal money from one block grant and use it in the other block grant category. While we have not seen this proposal spelled out in legislation, we support the concept of permitting States limited fund transfers between the block grants.

Senator COHEN. Doctor, could I interrupt you here for a moment, because I do have to leave.

The AMA endorses putting a cap on expenditures; correct?

Dr. ACKERMAN. The medicaid expenditures.

Senator COHEN. Would the AMA endorse the concept of putting a cap on expenditures by hospitals?

Dr. ACKERMAN. The AMA opposed that concept last year, Senator.

Senator COHEN. I know.

What I want to get at, one of the reasons to the opposition, I assume, is the following:

Fuel costs have jumped dramatically in recent years. Therefore, as long as we have decontrol of oil prices and prices continue to skyrocket, that will always be an inherent irradicable expense.

Second, labor costs are going up as people try to keep pace with inflation. So, if you are going to have a cap on expenditures by hospitals, for example, you will in essence only succeed in cutting back on the quality of service that will be delivered.

Now, tell me how that is different. The argument that was raised to us, and which we generally supported, was that it would be unwise to have, in effect, a cutback on the quality of service. How is that going to be different under a cap on medicaid? What are the factors that will be distinguishing? It is easy to say we will place a cap if you will eliminate the fraud and waste—why could you not eliminate just the fraud and waste?

Senator HEINZ. The reason I wanted Senator Cohen to ask that question is that he has to leave and that will be the only question he will get to ask.

Dr. ACKERMAN. I think our reasons for opposing the cap on hospital costs issues would be the same as last year.

First of all, it involves all of our population.

It was AMA's feeling last year that it would not be in the best interests of medicaid people by putting a cap on it.

Senator COHEN. What were the rationales for it?

Mr. PETERSON. We are talking about basically different types of cap.

At the present time, the States control the Federal expenditures in the medicaid program; this is intended to place a cap on the Federal portion of the expenditure. It will not necessarily decrease the availability of services to the beneficiaries because the States will have the opportunity through guiding the funds, the entire

medicaid funds—both Federal and State—into the system to provide for greater efficiency. Perhaps they will have to examine some range of eligibility and perhaps some of the benefit package.

Senator COHEN. But you are saying that the States will achieve greater efficiencies which the hospitals could not do under existing circumstances?

Dr. ACKERMAN. The range of the cap here would go over, beyond just the hospitals.

Now, as the States implement this program, they will, of course, have greater flexibility in their expenditures than dealing with the health care delivery system. So that the ability to provide for a spreading of the cutback, there is across the entire system, not merely on one single provider. I think there is a distinction to be made there.

Senator COHEN. Thank you.

Senator HEINZ. Please proceed with your testimony, Dr. Ackerman.

Dr. ACKERMAN. Thank you, Mr. Chairman. I am just about finished.

Mr. Chairman, we support the block grant approach as a way of giving the States greater flexibility to determine their own public health priorities and addressing State needs.

The administration's proposals for a medicaid cap and for block grants for categorical programs reflect a significant shift in the relative responsibilities of the Federal and State governments toward health programs. The proposals represent the view that States are better able to determine the needs of their citizens and to target program funding to better meet local needs. The proposals also reflect the potential cost savings that can be achieved through an end to rigid, expensive, and complex Federal requirements.

The AMA, in supporting the thrust of the administration's proposals, intends to encourage State and local medical societies to continue and increase their activity in their States as advocates for proper medical care of individuals, and to encourage cost savings in programs without a reduction in quality services for those who are in need.

The administration's proposals need not lead to a diminution of medical care for the elderly and the needy. The AMA, along with State and medical societies, will seek the establishment of appropriate priorities for health care.

Mr. Chairman, we will be pleased to respond to any questions the committee may have.

Senator HEINZ. Dr. Ackerman, thank you.

[The prepared statement of Dr. Ackerman follows:]

PREPARED STATEMENT OF DR. FREDERICK A. ACKERMAN

Mr. Chairman and members of the committee; I am Frederick A. Ackerman, M.D., a physician in practice in Concord, Calif. I am the chairman of the AMA Council on Legislation. With me is Harry N. Peterson, director of AMA Division of Legislative Activities.

The American Medical Association is pleased to accept the committee's invitation to discuss the President's proposed health budget and its effect on the elderly, particularly the proposals to place a "cap" on Federal medicaid expenditures and to group separate categorical health programs into block grants.

MEDICAID CAP

The medicaid program was enacted in 1965 to provide medical services to needy individuals, including our elderly citizens. Since its enactment, that program has experienced steadily rising costs. These costs have resulted from many factors—expanded numbers of beneficiaries, increased benefits, and general increases in costs of administration and services. Program costs have been further aggravated by the effects of a depressed economy and double-digit inflation which pervades the entire economy. In 1979, some 22 million persons were eligible for medicaid, and during the last decade the costs of the program have risen over 400 percent. Expenditures in 1979 reached approximately $21.7 billion, of which some $11.8 billion were Federal funds and $9.9 billion State funds.

Mr. Chairman, medicaid is only one of the many programs contributing to the record level of Government spending, which is recognized as a core problem in our country's economic difficulties. The American Medical Association supports the overall initiatives of the President as he seeks to restore some measure of fiscal stability and integrity to our Government budget policies. There can be little question that the American people wish to have the Government do whatever it can to stem the rapidly rising cost of living. The Nation requires a commitment by Government, the private sector, and the individual household to do what each can—individually and collectively—to hold down the recent dramatic increases in the cost of living. Where cuts are made across the board to reduce deficit spending, our association expects that some reduction in Federal health spending will also take place.

We are concerned—as are you, Mr. Chairman and others on the committee—that the reductions in health spending should not impair the provision of necessary services to our needy elderly. We are pleased that the President has given assurance that the so-called "safety net" programs, those designed to protect persons in need, will be maintained. The American Medical Association has, since the beginning of the medicaid program, encouraged coverage of high quality care for all beneficiaries.

The Administration's Proposal

As the medicaid program is currently structured, States may enter into agreements with the Secretary of Health and Human Services to finance health care services for public assistance recipients and certain other low-income individuals and families, including the elderly. The amount of Federal expenditures is in effect controlled by the States. The Federal Government is obligated to match a State's medicaid expenditures according to a percentage formula which varies from State to State. This has posed a basic dilemma for the administration.

The administration proposes to alter the present system under which States are automatically entitled to open-ended Federal medicaid matching funds by establishing a closed-end system designed to prevent Federal expenditures from going beyond a certain level, regardless of State spending. The proposal would impose a ceiling, or "cap," on Federal medicaid expenditures at a level $100 million below the Office of Management and Budget current base estimate for medicaid outlays in fiscal year 1981. Federal expenditures would be allowed to increase by 5 percent in fiscal year 1982 and, in fiscal years thereafter, the Federal ceiling would increase only with the rate of inflation as measured by the GNP deflator. Under the proposal, each State would have a ceiling allocation based on its current relative share of total Federal medicaid expenditures.

This proposal has been described as an interim measure to limit costs pending the enactment of comprehensive legislation designed to more permanently resolve health care cost problems. The administration plans to introduce such legislation later this year, but details of the proposal are not available at this time.

In conjunction with the proposed medicaid cap, the administration has indicated that it will seek legislation to give the States greater flexibility in administering medicaid benefits. According to the March 10 budget message, this will give States additional flexibility to target necessary services to the truly needy. States deem such flexibility essential to their efforts to achieve desired economies to offset the cut in Federal assistance.

It is difficult to predict just how the States will respond should the proposed cap be enacted. We recognize that the limit on Federal medicaid expenditures might result in some decrease in overall medicaid services in a State if it does not increase its funding efforts to offset decreases in Federal medicaid payments. We hope that States may be able to effect significant enough savings in their programs to enable them to offer a medicaid program under the cap without decreasing the quality of care.

Achieving economies in the medicaid program will not be an easy task. There can be no question, however, that much can be done to help assure that medicaid achieves greater cost-effectiveness while maintaining the availability of quality care. States should be able to maintain essential services through greater efficiencies in administration, and by elimination of fraud and abuse through vigorous enforcement of the law and judicious cutbacks where eligibility has become overextended. Some States may have to examine the priorities expressed in their benefits package and place priorities on adequate funding of basic and essential services.

We have not had an opportunity to examine any legislative provisions of the administration's medicaid cap proposal, but we can at this time offer a suggestion for consideration in developing such legislation. Because of the uncertainties involved in the ability of the States to successfully provide adequate levels of medicaid services, we suggest that a provision be included to monitor closely the effects of the cap after its enactment. In conjunction with the Federal monitoring of the cap effect on the States, Congress might also consider establishing a special medicaid "safety valve" that might be triggered to assist States which, perhaps due to unusual local economic problems, suffer unusually extreme dislocations in their medicaid programs as a result of the imposition of Federal limitations. Moreover, Congress should examine whether the specific limit of 5 percent for a 1982 increase and the use of the GNP deflator for future increases are appropriate at the cap.

As Congress considers the administration's medicaid proposal and as the States implement program changes, we must caution against adoption of the view that medicaid cutbacks can be easily absorbed merely through decreasing the level of reimbursement to providers of medical care. In most States, reductions in provider reimbursements have already occurred over recent years. A State cannot reduce reimbursement levels and expect to maintain the current quality of care under the medicaid program.

Medicaid currently pays about 41 percent of its budget to providers of long-term institutional care such as nursing homes. Today, approximately 5 percent of those over 65 live in long-term institutions for the chronically ill or disabled. About 85 percent of nursing home residents are over 65 and 75 percent of these are over the age of 75. Of course, medicaid also finances inpatient hospital care, physician care, and prescription drugs—all of these are also services used by elderly medicaid beneficiaries. However, depending on the kind of legislation adopted by Congress to grant greater flexibility to the States for medicaid administration, and depending on how States operate in a cap environment, it is difficult to predict the impact on the elderly beneficiaries.

With regard to the proposed cap on Federal expenditures, the AMA recognizes the need for such an action to gain control of the rapid growth in medicaid expenditures, where the Federal costs are tied to independent State actions.

We believe that the overriding concern at this time must be to take steps necessary to improve the Nation's economy. Unless reversed, economic hard times, factory closings, and any resulting increased unemployment would only exacerbate the problem and increase the financial burdens on medicaid. We endorse the cap concept as a part of the President's program for improving the overall economic situation.

Mr. Chairman, we intend to work closely with our State medical societies to monitor developments ahead. The medicaid program—with all its faults and limitations—must be supported with the necessary resources to furnish adequate services to our elderly citizens.

BLOCK GRANTS

The administration has proposed a transfer of the present categorical health programs into two block grants—one for basic health, mental health, and substance abuse services, and the other for preventive health services.

The AMA supports the concept of block grants. The present system of some 26 separately mandated and funded categorical health programs for grants to States has resulted in excessive Federal regimentaion of resources. This has resulted, in effect, in a determination of local needs through decisions made in Washington with a concomitant lessening of State responsibilities in the public health area.

We support the consolidation of present programs into block grant programs. We must raise, however, certain concerns with regard to the proposed block grant program.

Two bills have been introduced to establish two block grants in the health area: the basic health services block grant, and the preventive health services block grant. It will be important to examine not only the assignment of the programs into these two general categories, but also whether more than two blocks should be created.

One categorical program affecting older Americans to be transferred to a block grant is the program providing grants to States for the initial costs of establishing home health agencies and for training personnel to provide home health services. In making grants under the existing categorical program, the Secretary of HHS must give special consideration to those areas of States that have a high percentage of the population composed of the elderly, the medically indigent, or both. The AMA has long supported home health services and home health agencies, and we should hope that States will give a high priority to the development of home health services under the proposed block grant program.

We recognize that the block grant concept could be eroded if each health interest seeks its own separate block grant. The end result could be little more than a minor variation from the present categorical grant system. However, for the block grant program to be effective, we believe that there should be a rational connection between the programs that are being subsumed into each of the block grants so that overall parameters for the States can be more clearly delineated.

In its discussion of the block grant proposals, the administration has indicated that additional flexibility would be granted the States by permitting each State to take up to 10 percent of Federal money from one block grant and use it in the other block grant category. While we have not seen this proposal spelled out in legislation, we support the concept of permitting States limited fund transfers between the block grants.

Mr. Chairman, we support the block grant approach as a way of giving the States greater flexibility to determine their own public health priorities and addressing State needs. Likewise, we believe that major economies will be available because of a major reduction in Federal administrative expenses and also in State and provider costs incurred in meeting Federal regulatory requirements.

CONCLUSION

The administration's proposals for a medicaid cap and for block grants for categorical programs reflect a significant shift in the relative responsibilities of the Federal and State governments toward health programs. The proposals represent the view that States are better able to determine the needs of their citizens and to target program funding to better meet local needs. The proposals also reflect the potential cost savings that can be achieved through an end to rigid, expensive, and complex Federal requirements.

The AMA, in supporting the thrust of the administration's proposals, intends to encourage State and local medical societies to continue and increase their activity in their States as advocates for proper medical care of individuals, and to encourage cost savings in programs without a reduction in quality services for those who are in need. The administration's proposals need not lead to a dimunition of medical care for the elderly and the needy. The AMA, along with State medical societies, will seek the establishment of appropriate priorities for health care.

Mr. Chairman, we will be pleased to respond to any questions the committee may have.

Senator HEINZ. Mr. Crowley.

STATEMENT OF DAVID C. CROWLEY, WASHINGTON, D.C., EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. CROWLEY. My name is David Crowley. I am the executive vice president of the American Association of Homes for the Aging.

I have an extensive statement that I would, with your permission, like to submit for the record.

Senator HEINZ. Without objection, your entire statement will be made a part of the record.[1]

Mr. CROWLEY. Thank you, Mr. Chairman.

I have a briefer executive summary statement that I would like to read at this time.

I would like to begin by thanking you, Mr. Chairman, and members of the committee, for taking the initiative in calling this important hearing, so that providers of services to the elderly have

[1] See page 193.

an opportunity to express what we see as a particularly negative impact that the administration's proposals will have on services to the elderly.

Our statement deals with three major areas:

First of all, we will assess the impact of the proposed medicaid budget reduction on the elderly; second, the proposal of the National Governors' Association, third, we propose a list of 25 possible alternative cost-saving items in both the medicare and medicaid programs.

I would like to point out at the outset that while the administration's proposal deals primarily with the cap on medicaid, we have approached this position from the point of view of the interaction of the two major health programs: medicaid and medicare.

The American Association of Homes for the Aging questions whether the safety net for the elderly, unemployed, and the poor can be secured without vigorous Federal support of medicaid.

Approximately one out of every five older Americans is a medicaid recipient and over one-third of medicaid expenditures during the past year were for the basic needs of these poor older persons.

Further, nearly 50 percent of daily expenditures for nursing home services are secured through the medicaid program. However, States have already sharply curtailed medicaid expenses to nursing homes, and reimbursement rates have not kept pace with the rising cost of services. It is most apparent that significant reductions in medicaid will have a substantial adverse impact on the availability of quality services. It is equally clear that a medicaid cap will require sizable reductions in the program's component and the quality of these programs.

As Congressman Stockman said last year,

> Attempting to cap the system without changing the fundamental incentives of patients and physicians ordering services will only insure that the quality of the product declines.

We strongly agree with Mr. Stockman's statement; it is an accurate critique of the very policy the administration is attempting to promote. We oppose the proposed medicaid cap.

In relation to the National Governors' Association proposal on medicaid, while we are in general agreement with much of the Governors 'proposal, there are several elements to it that we simply cannot support.

Several of these suggestions would require significant systemic changes which we feel warrant greater study. We agree that the States should have sufficient flexibility to develop medical assistance programs to best meet the needs of their resident populations.

We do not support the suggested change to permit the arbitrary adjustment of reimbursement rates based upon the availability of State resources.

We agree with the suggestion that some latitude be given to insure cost-conscious behavior, and toward that end, we recommend that multiyear waivers be granted for specific policy changes requested by the States and subject to Federal review.

We agree with their proposal to suspend PSRO review, as PSRO review in long-term care has been a punitive effort to restrict patient care to solely the medical model.

We oppose their proposal that long-term care services be capped and subject to block grants. Block grants would seriously weaken the legislative protection afforded to recipients, and increase the politicization of health care decisions among the various provider and recipient groups.

Further, a block grant with an arbitrary ceiling will do little to reorder the delivery of long-term care.

Finally, Mr. Chairman, as I mentioned, we have 25 suggestions which, taken in total, in our best estimation, could result in a proposed savings of about $2 billion. Now, it is difficult to review some of these suggestions because in some cases, particularly in terms of some changes related to the recipients themselves, we are proposing an increase in the total payment for medical deductibles and that is difficult for someone like myself and our association, which has always fought increases the elderly must bear.

However, we are conscious of medicaid expenses and, therefore, we have attempted to propose these changes from the point of view of the interaction of medicare and medicaid.

We have used about six criteria that I would just like to mention briefly in determining which of these alternatives we would propose to the committee.

These criteria are:

Least disruptive impact on the interaction of medicare and medicaid; minimal systemic changes, which should be deferred for further study, in other words, let us not make any major changes in the heat of a budget debate; minimal hardship on beneficiaries of the lowest income; maximium cost savings; assessments of the impact on older Americans generally and assessment of the impact on the member homes and the residents of our association.

With that in mind, Mr. Chairman, I would like to briefly comment on these suggested cost-saving approaches. We propose several which deal with modifying reimbursement methods for providers. They are:

No. 1, the enactment of the alternative hospital remedies limitation proposal developed by the staff of the Committee on Finance during the 96th Congress; No. 2, elimination of the nursing differential under the medicare program; No. 3, a modest tightening of the regulatory limitation on the costs of inpatient routine services for all providers under the medicaid program; No. 4, encouragement of philanthrophic support for all providers by extending the provisions of section 901 of Public Law 96–499 to nursing homes and home health; particularly we in the voluntary sector feel that the encouragement of philanthropy and providing incentives to philanthropy for home health and nursing homes is a vital way to engage the support of the community; No. 5, we would alter the requirement for hospital reimbursement to be based on full cost; No. 6, permitting greater flexibility in negotiating rates for physician services and ancillary services.

We have also suggestions for increasing the share of cost borne by program beneficiaries. We have approached this particular recommendation with a great deal of thought because we are very much concerned about making any proposal that would increase cost for the elderly. However, we have noted that there has not been an increase in the copayment required by medicaid benefici-

aries since 1972. We also approach this knowing that medicaid would, in fact, pay for the copayment and deductible for the very low-income people, and we obviously would not make this proposal if there were any change in that.

We would suggest that consideration be given to increasing the medicare part B deductible to $100 in two phases and subject the amount to cost-indexing.

We would propose it go from $60 to $75 in 1982 and then up to $100 in 1983.

We would propose increasing flexibility to establish nominal copayments and diagnoses differentials merit consideration. Also, reviewing the special copayment formulas developed for selective services.

We have suggestions which deal with reducing unnecessary utilization.

We would propose using section 1616(e) of the Social Security Act——

Senator HEINZ. May I interrupt you on that point?

On your points 8 to 9, is that with respect to medicare or medicaid?

Mr. CROWLEY. Medicare.

Senator HEINZ. These are all medicare deductions?

Mr. CROWLEY. Yes, sir.

Senator HEINZ. Thank you.

Mr. CROWLEY. Point No. 10 is, we propose using section 1616(e) of the Social Security Act to encourage States to stem the use of intermediate care facilities and expand the use of social care facilities. What we are saying there, Senator, is, we believe with enhanced services for people who do not need nursing care, with more support services and appropriate housing, we probably could reduce the increased population of the ICF.

I know this is an issue that you have shown particular interest in and worked on in the past.

No. 11, extending into long-term care.

No. 12, lessening administrative fiat with respect to utilization review.

No. 13, promoting private insurance as a vehicle to cover costs presently borne by Federal programs. We are particularly talking here about the older worker making private insurance the first dollar coverage, delaying medicare coverage until a later point, and we are particularly concerned about the recent study which revealed that perhaps less than one-half of 1 percent of long-term care is funded by private insurance.

We would propose changing the implementation date enacted by the 96th Congress. We are proposing that because we understand that the administration wants to suspend those benefits indefinitely, and we are proposing that they merely be delayed.

We would approve the health maintenance organization to include the beneficial components.

We would support accounting for eligibility for potential supplemental security interests of long-term care facilities. That point, Mr. Chairman, is particularly important.

As we understand the administration's proposal, a person would have to be at eligibility level 3 months before they are actually

recipients of medicaid benefits. This means that a person would need 4 months from the time he or she became eligible until the time he or she received benefits.

No. 16, categorical and needy classifications, that is another important suggestion.

We would propose giving the States greater leeway in developing their range of benefits subject to review. We have proposals for promoting more cost-effective providers. We would then strengthen the abilities of both the medicare and medicaid programs to pursue the most cost-conscious strategies in purchasing ancillary services and prosthetic devices.

We would make use of the leasing of services to reconcile the short-term savings and the long-term increases in program costs.

Reassessing the closing and conversion provisions for health facilities considered by the 96th Congress.

Finally, we have suggestions for improving program administration, enacting realistic penalties which would impose hardships on those who engage in fraudulent practices.

We would target administrative resources toward those homes which have the worst performance. It is ridiculous to spend the time and effort on continually surveying and certifying facilities that have established good records and reputations for services over a period of time and to allow others, those who are consistent violators of standards, to go on without penalty.

No. 25, reinforcement of the long-term care demonstrations. What we are talking about here is the channeling grants and other demonstration projects that have been initiated toward management.

Mr. Chairman, that is a summary of our testimony. I appreciate the opportunity to present it to you and I would just again like to reiterate that we are providers of long-term care, of homes in this country, and in some cases, particularly in your own State, in homes providing care since as far back as the 1800's. We are concerned about this proposal to cap and block grant medicaid and about the devastating effect it will have on the elderly and on nonprofit providers.

Senator HEINZ. Mr. Crowley, thank you.

[The prepared statement of Mr. Crowley follows:]

PREPARED STATEMENT OF DAVID C. CROWLEY

Mr. Chairman, I am David C. Crowley, executive vice president of the American Association of Homes for the Aging. Accompanying me this morning is Laurence F. Lane, director for public policy of the association.

The American Association of Homes for the Aging represents the not-for-profit providers of facility-based services to older Americans. Among our nearly 2,000 members are facilities which participate in the title XVIII (medicare) program as skilled nursing facilities and in the title XIX (medicaid) program as skilled nursing facilities and intermediate care facilities. A number of our member homes are involved in housing, health-related shelter, and community outreach services which include day care, home health, and nutrition services.

We come before this committee this morning to address the impact of the proposed budget reductions in the medicare and medicaid programs and to suggest alternative approaches which should be carefully considered by members of the committee. We can appreciate the difficult task which has been given to members of this committee to carefully carve out reductions in Federal expenditures for health services while not jeopardizing the lives and welfare of Americans who rely on these services for their basic needs. Members of our association share a responsibility to help you in this difficult task. While we would prefer to testify as we have in the

past for benefit improvements, we recognize that spending reductions will be made and we appreciate the opportunity to testify on this important matter.

This testimony is divided into three sections:

First, we will assess the impact of the proposed medicaid budget reduction upon older persons in general, and upon the older Americans served by our member homes in specific. We hope this information will assist committee members in understanding the tremendous impact which the proposed changes in medicaid will have upon the elderly.

Second, we shall set forth our views on the counterproposal drafted by the National Governors Conference. While there are portions of this proposal which we find attractive, there are provisions, especially the block granting of long-term care services to the States, which we are forced to oppose at this time.

Finally, we shall offer to the committee our assessment of a range of possible cost-saving items in the medicare and medicaid programs. We come forward with these suggestions in the spirit that an alternative to the proposed budget changes must be developed to insure continued health care protection for the indigent.

At the outset, let us emphasize that the following remarks are guided by three key principles:

Public assistance should be provided to individuals who are in the greatest need. Need has both a functional and an income definition.

Medicaid in fact constitutes a catastrophic health program for older Americans. It is an integral component of the social safety net protecting the general welfare of the elderly.

Major systemic changes in the structure of the medicare and medicaid programs should not be made in the haste of the budgetary debate. Cost-savings should be extracted from incremental program changes. Major program reforms should be deferred until a complete analysis can be completed and consideration can be given to the implementation strategy.

I. IMPACT OF THE MEDICAID REDUCTIONS

Among the most important of the proposed budget revisions recommended by President Reagan in his program for economic recovery are limits on the medicaid program. Stringent restrictions on medicaid expenditures will undermine our efforts to improve the quality of life for older persons. While supportive of our President's promised efforts to revitalize the economy, AAHA questions whether the "social safety net" for the elderly, unemployed, and poor can be secured without vigorous Federal support of medicaid. While changes must be made in both medicare and medicaid to make them more responsive to the needs of older Americans and controllable as Government expenditures, we strongly believe that the dismantling of medicaid would be a counterproductive policy. We draw this conclusion based upon the following facts:

Utilization Characteristics

During the past decade, medicaid expenditures have escalated at both the Federal and State levels. Data suggest that cost increases cannot be attributed primarily to increased utilization; rather, they are the result of increases in the number of recipients and in medical care prices. The number of recipients rose by 108 percent in the 8 years following 1972; prices rose by 74 percent and utilization by only 12 percent.

While considerable attention has been focused on the difference in utilization statistics and eligibility criteria among the States, limited attention has been given to the evolution of State programs since the beginning of vendor payment approaches. A historical view of the medical assistance program from the Kerr-Mills approach to present indicates:

(a) Significant improvement in the quality of health care services provided to indigent persons;

(b) a tendency toward standardization of basic standards for performance, staffing, civil rights, and physical plant standards for health institutions; and

(c) a regression toward the mean for standards determining eligibility for individuals. Such trends, particularly the latter, are the positive result of Federal program oversight.

Approximately one out of every five older Americans is a medicaid recipient. Over one-third of all medicaid expenditures during the past year were made to meet the needs of these poor, older persons. Another third of the expenditures went for services to the permanently disabled and blind. Of older persons eligible for medicaid, most are over the age of 75 and receive limited income support from the supplemental security income program. Most are women. Medicaid meets the coinsurance and deductible requirements of the medicare program, insuring participa-

tion by these persons in the Federal health benefit. Medicaid payment covers a significant share of their costs for nursing home services, drugs and drug sundries, eyeglasses, appliances, and other health services.

The pending cutbacks in the medicaid program may be particularly disruptive to older persons seeking long-term care services. Nearly 50 percent of daily expenditures for nursing home services are secured through the medicaid program. Such services constitute the largest health care liability for persons age 65 and over. It is estimated that 20 to 25 percent of the elderly population will spend some time in a nursing home, even though only 5 percent are residents on a given day. During the past few years, States have sharply curtailed medicaid expenditures to nursing homes. Reimbursement increases have not kept pace with the costs of such services. Shortfalls in operating revenues have been passed on to the private paying resident to subsidize care for those receiving public support. Further significant reductions in medicaid will have a great impact on the availability of quality services.

Federal Policies—Cost Increases

While the portion of medicaid expenditures allocated for nursing home services has increased during recent years, most of those increases can be traced to four significant Federal policy decisions:

(a) The imposition of stringent physical plant standards for fire safety in skilled and intermediate care facilities;

(b) significant increases in the minimum wage mandated under the Fair Labor Standards Act;

(c) policies promoting the deinstitutionalization of mental health patients from public institutions; and

(d) initiatives to upgrade both the quality of care provided to recipients and to be responsive to regulatory mandates. These Federal dictates have enhanced the responsiveness of providers to the needs of older persons, but they also forced financial commitments which will have a continued impact on the costs of services. Health Care Financing Administration data on medicaid reimbursement to nursing homes suggest that while there have been significant improvements in State payments, such per patient revenues adjusted for inflation have actually declined.

One significant spinoff of the medicaid reimbursement issue for nursing homes has been the tightening of utilization control on individuals classified as being in need of skilled nursing care. The ratio of intermediate care facility medicaid claims to skilled nursing facility claims has completely turned around. In 1973, there were six SNF claims for every four ICF claims. Skilled nursing facility claims remained static during the next 5 years, while ICF claims increased twofold. Likewise, there has been a dramatic increase in intermediate care facilities providing specialized services to the mentally retarded. ICF-MR expenditures have doubled each of the past 2 years.

Medicaid Cap

There is false economy in advocating reductions in medicaid without considering the eventual impact upon medicare. Demand for long-term care services already has created a tremendous backlog in hospitals. Medicaid reductions will further encourage providers not to serve the poor, thereby putting greater strain upon the social services system to support individuals not being assisted otherwise. Health policy should not suggest that medicare meets the needs of the elderly and medicaid does not. Both programs are complementary components of the "social safety net."

While it is difficult to project the response of the States to a specific cap on expenditures for medicaid, it is fairly clear that sizable program reductions would be required. It seems somewhat ironic that the current Director of the Office of Management and Budget responded to a proposed limitation on hospital expenditures during the past Congress by pointing out:

"Attempting to cap the system without changing the fundamental incentives of patients and physicians ordering services will only insure that the quality of the product declines."

On this particular point, we find ourselves in agreement with Mr. Stockman, and we suggest that a closed-end approach to medicaid will only translate into a deterioration of services to indigent persons. Furthermore, because the proposed approach does not carefully analyze the interactions between medicare and medicaid with respect to the provision of services to the aged and the totally and permanently disabled, there are numerous opportunities for costs to be passed back to the Federal Government, thus circumventing the cost containment thrust.

II. REACTION TO THE PROPOSAL OF THE NATIONAL GOVERNORS ASSOCIATION

While we are in general agreement with much of the Governors' proposal, there are several elements to it that we simply cannot support. Several suggestions would require significant systemic changes which we feel warrant greater study.

We agree that States should have sufficient flexibility to develop medical assistance programs to best meet the needs of their resident populations.

We do not support the suggested change to permit the arbitrary adjustments of reimbursement rates based upon the availability of State resources.

We agree with the suggestion that some latitude be given to insure cost-conscious behavior, and toward that end we recommend that multiyear waivers be granted for specific policy changes requested by the States and subject to Federal review.

We agree with their proposal to suspend PSRO review, as PSRO review in long-term care has been a punitive effort to restrict patient care to solely the medical model.

We oppose their proposal that long-term care services be capped and subject to block grants. Block grants would seriously weaken the legislative protection afforded to recipients, and increase the politicalization of health care decisions among the various provider and recipient groups. Further, a block grant with an arbitrary ceiling will do little to reorder the delivery of long-term care.

Our detailed response to the Governors' counterproposal is attached to our statement for the committee's consideration.

III. COST SAVING APPROACHES

This leads to the third section of our testimony, areas for possible cost saving. As suggested above, we believe savings can best be secured, in the short run, from incremental changes in the medicare and medicaid program. We believe a balanced strategy can equalize the impact of reductions without jeopardizing options for significant policy reforms in the delivery of health care services. Changes only in medicaid will have the greatest impact on those most in need and might lead to an exploitation of medicare to assume responsibilities beyond its program resources. The best protection for older Americans comes through a balanced approach which makes incremental changes in both medicare and medicaid. In fact, we would argue that given the catastrophic protection afforded to older persons through the interaction of medicare and medicaid, that program reductions in medicare will have the least devastating affect.

We utilize six factors in evaluating the suggested changes which we believe merit committee appraisal. Our selection criteria are:

Least disruptive impact on interaction of medicare and medicaid.

Minimize systemic changes, which should be deferred for further study.

Minimize hardship on beneficiaries of the lowest income.

Maximize cost savings.

Assess impact on older Americans.

Assess impact on AAHA member homes and residents.

Given the choice of a constricted medicaid program or a retrenchment through a number of cost control efforts, we used these criteria to evaluate the following items for plausible cost savings:

(A) Items for Modifying the Reimbursement Methods for Providers

We believe that modest cost savings can be secured through reasoned modification of a number of reimbursement methods used in the current programs. As suggested above, we believe a major weakness of the budget proposal advanced by President Reagan is its failure to address the skewing of health care expenditures toward acute care. As long as hospital reimbursement is based on a cost-plus basis, and containment is focused on all other components of the service deliver system, there will be an ever-increasing bias to use the highest cost service.

As a recent article on "Differences by Age Groups in Health Care Spending" from the Health Care Financing Review indicates, medicare and medicaid account for nearly 60 percent of resources to assist the elderly in the purchase of hospital care. The percentage of expenditures for other age groups is equally high. Upward trends in hospitalization and surgical rates for the aged also are associated with a shift in physician's medicare charges for services performed. Realistic containment of health care expenditures cannot be achieved when 60 cents of each dollar of public support is directed to an uncontrolled service. The preferential treatment for hospitals suggested in the budget message is unacceptable.

As stated above, we are supportive of the goal that medicare reimbursement approaches be reorganized to project a prospective methodology. It is hoped that such an approach would contain costs while permitting consideration of special

circumstances which merit retroactive adjustment. However, the current budget debate may be an inappropriate time for the restructuring of the medicare reimbursement system for part A providers. Short of this systemic change, we encourage consideration of the following cost saving ideas:

(1) Enactment of the alternative hospital revenues limitation proposal developed by the staff of the Committee on Finance during the 96th Congress. Such an approach develops the initial data base necessary for constructing a prospective reimbursement system.

(2) Elimination of the nursing differential under the medicare program. This reimbursement bonus primarily for hospitals was developed under questionable assumptions that care and service to older persons would require additional staffing. We believe diagnosis and patient care management are better determinants of staffing than the patient's age and we question whether hospitals have in fact staffed in a manner that justifies the differential.

(3) Tightening the regulatory limitation on the costs of inpatient routine services by lowering the tolerance limit from 112 percent of the mean to 107 percent of the mean. Such a tightening of the limits should not induce as significant a hardship as the alternative of dismantling of a program for care of the indigent. Special classifications for hospital-based services should be reconsidered. There appears to be little justification for a higher tolerance of costs for hospital-based delivery of nursing home and home health services than for all providers. A tightening of limits should be coupled with a fair process of exceptions or exemptions from the cost limitations. Current limitation waiver rules are shrouded in bureaucratic redtape.

(4) We believe there is merit in extending the provisions of section 901 of Public Law 96-499 to all health services. Section 901 clarifies the incentives for hospital philanthropy. Clearly, the community involvement, especially in long-term care services sponsored by nonprofit organizations such as visiting nurse services and religious-sponsored homes, could augment public expenditures through ambitious philanthropic campaigns. With respect to specific costs savings in the medicaid program, we see merit in modifying the reimbursement methods for providers through the consideration of the following ideas:

(5) Altering the requirement for hospital reimbursement to be based on full cost. We believe the compromise which resolved the dispute on reasonable, cost-related reimbursement for nursing homes during the previous Congress provides an acceptable model for designing flexibility in hospital reimbursement. Such an approach requires States to establish rates that, at a minimum, conform to statutory requirements and are certified to be sufficient. The Secretary is empowered to review such rates in a timely manner.

(6) We believe there is merit in the proposal by the National Governors' Association to permit greater flexibility in negotiating rates for physician services and ancillary services. Again, we believe quality for services can be safeguarded through Federal approval of reimbursement changes based upon justifications provided by States.

(B) Increasing the Share of Cost Borne by Program Beneficiaries

While we emphatically oppose use of a means test for medicare, we are mindful that the utilization of medicare benefits provides limited incentive for consumer discretion. Thus, as Karen Davis has pointed out in her writings on "lessons of Medicare and Medicaid for National Health Insurance," there is a middle-class bias in the use of medicare. She suggests, and we concur:

". . . The lesson to be learned from this experience is that uniform cost-sharing provisions will yield a pattern of benefits that systematically favors higher income persons. If properly designed, however, cost-sharing provisions could actually channel a greater proportion of benefits to those most in need both of medical care and assistance in paying for such care, this requires, however, that cost-sharing features be carefully graduated with income—rather than set at a uniform level for all persons."

It is extremely difficult to come forward with recommendations to pass the cost of services on to recipients, the magnitude of the current fiscal crisis requires consideration of such measures. We suggest these changes with the significant caveat that medicaid will continue to provide catastrophic protection for individuals most in need. The interaction of medicare and medicaid permits discussion of altering some of the medicare cost-sharing features with knowledge that the cost borne by the lowest income will be incorporated into the social safety net provided by the medicaid program.

The work of the Senate Finance Committee on its catastrophic health protection legislation took this concern into its program design. We encourage a review of the decisions reached during the 96th Congress as a general goal toward restructuring the cost to beneficiaries.

In moving in a direction which is consistent with previous congressional approaches, we believe the following ideas are modest changes which would inure cost savings:

(7) Increasing the medicare part B deductible in a two-step process from $60 to $75 in 1982 and then to $100 in 1983 and cost-indexing the amount for future years. This idea is drawn from staff recommendations of the Senate Finance Committee. The deductible has not been raised since the 1972 amendments. Costs of services have escalated significantly during that period, raising a number of beneficiaries beyond the part B threshold. The increase in the deductible could make medicare users more cost conscious. For individuals in the greatest economic need, the medicaid buy-in of medicare services protects them from the dollar increase of the deductible. Ten years ago, the average reimbursement incurred per enrollee was only $100. That has escalated to over $300 during the previous program year. A large number of beneficiaries are clustered around the threshold deductible receiving marginal coverage from the part B program but requiring extensive administrative review. Given a continuation of the cost-indexing of income maintenance strategies and a continuation of the buy-in provisions under medicaid for medicare recipients, we believe a modest adjustment of the part B deductible would not be a devastating policy course. To insure that such a reduction does not force hardship, we would prefer the continuing policy of considering expenditures during the previous 3 months for carryover calculation of the annual deductible.

(8) With respect to the medicaid program, we believe the suggested increase in flexibility to establish nominal copayments and diagnosis differentials merits consideration. States should be permitted to make a case for such cost-sharing features, provided they can justify the approach. Insuring the integrity of the Federal-State partnership in medicaid is necessary to prevent arbitrary manipulation of the cost-sharing strategies to the disadvantage of recipients.

(9) Included in the consideration of changes in the part B deductible should be a review of the special copayment formulas developed for selected services. There may be merit in restricting the proliferation of special incentives. While each of these strategies can be justified on its own merit, the cumulative effect of these special provisions is an increase in program cost to the public.

We encourage the committee to defer for further study decisions on family supplementation for medicaid services. While AAHA endorses the principle of greater family involvements to include financial support, there are a number of questions as to how such programs can be implemented. At best, such a strategy should include changes in the taxation system to provide incentives for such supports and changes in the penalty provisions of the current program to insure that efforts to encourage family support are not grounds for accusations of fraud and abuse. Restrictions of medicaid coverage under many current State plans has led to greater appeals to family and friends to meet the operating revenues necessary to provide appropriate services.

(C) Reducing Unnecessary Utilization

As we have stated to Congress in previous testimony, one of the major weaknesses of our current policy toward the elderly is our neglect to provide a realistic spectrum of living arrangements. Too often, decisions have been made which classify the elderly as either sick and in need of hospital and nursing home services or well and in need only of income supports. For a large number of the chronically impaired, the appropriate course is one which permits shelter in the least restrictive environment. Such specialized living arrangements need not be medical in scope, but can have a locus of support developed from a social support model. Few States have developed their supportive living arrangements funded by the supplement security income program to a significant level and the congregate housing services program enacted under the Housing and Community Development Act of 1979 is threatened by rescission. Thus, there are incentives either to use the more costly services funded under medicare and medicaid or to deny support to the individual.

We encourage the committee to consider the following ideas for potential cost savings:

(10) Consider increasing the level of significance given to section 1616(e) of the Social Security Act to encourage States to stem the use of intermediate care facilities while expanding the use of "social care" facilities providing protective oversight and congregate supports to persons defined at-risk and in need of specialized living arrangements. The SSI provision could be expanded with a concomitant restructuring of the intermediate care facility benefit and intermediate care/mental retardation benefit to more uniformly conform service provision among the States.

(11) We are supportive of suspending any expansion of professional standards review. PSRO review in long-term care has been a punitive effort to restrict patient

care to only the medical model. There may be merit in phasing out PSRO's as too costly an approach with few cost savings.

(12) Under the medicaid program, we see merit in lessening administrative fiat with respect to utilization review. States should be given incentives to develop sampling methodologies which target review activities to define problems. There may be a continued support role by the Federal system to combine the resources of the MMIS and SPX systems to facilitate sampling methodologies and assist in the technical development of such sophisticated techniques at the State level.

(D) Changing Benefits and Eligibility for Services

As pointed out in the Urban Institute studies on the medicaid program, while the most significant cost savings can be secured through changes in benefits and eligibility, they are also the most difficult to construct. Recognizing that axiom, we propose the following ideas for consideration by the committee:

(13) Committee attention should be directed to the relationship of private insurance to the public benefit. Neglect of this area at the Federal level has permitted a shifting of costs from the private sector to the public sector. Medicare has become the primary insurer for the disabled and aged with an abdication of responsibility by the private market. Obviously, this abuse of the public sector should be stemmed. We are supportive of approaches considered by the Finance Committee in past sessions to insure that primary coverage comes from insurance and third-party payers. A special case has been made for older workers who continue in their employment. Perhaps the time has come for Congress to phase in requirements to shift the first dollars health protection for such individuals to the private sector. A phased transition should be implemented to insure that the disadvantages of underwriting such insurance protection do not become disincentives for an employer to continue the services of an older worker.

(14) We would encourage the committee, rather than to repeal benefit expansions enacted last year in the medicare program to change the effective date for a 2-year period. Such a move permits an assessment of the merits of these expansions while stemming Federal outlays during the worst of the economic crisis.

(15) We support the suggested changes in the HMO benefit, making it more available for older persons, and we encourage the definition of an acceptable health maintenance organization to include the beneficial components of the geriatric social HMO.

(16) The committee and budget information does not indicate savings from changes in accounting for eligibility in the categorical programs. We question whether a retrospective accounting methodology as proposed might not be punitive for potential SSI recipients living in long-term care facilities. We believe only a prospective accounting system can prevent hardship from occurring.

(17) For the elderly, the medically needy category is of great importance. It constitutes the catastrophic protection which is a major component of the social safety net. Under the medicaid program, however, some States have abused the availability of Federal matching funds to expand their eligibility limits. Obviously, in a period of retrenchment, there should be a move toward standardizing the parameters of the categories and medically need classifications. Rather than increase the State discretion in this area, we believe the Federal interest is better served by phasing in standard limitations. States should be permitted to provide supports above those limits at their own expense. Such a uniform approach would be helpful in constructing a public spending floor as a component of any competitive health care model.

(18) Under the medicaid program, we believe the States could be given greater leeway to overcome the constraints of the current law mandating uniformity in benefits. States should be given flexibility to define benefit cluster which are more appropriate for defined service populations. Local governments should be given an opportunity to augment the State service packages and still receive matching support under the title XIX program. As with our previous comments on such approaches, we believe there is a need for Federal review of such program changes and a responsibility for the States to evaluate such changes.

(E) Emphasizing the Use of More Cost-effective Providers

As with the other points raised in this testimony, we strongly believe that it works to everyone's benefit to modestly tighten the screws during this period of economic crisis rather than to dismantle the current medicaid program. With that direction in mind, we suggest the following approaches:

(19) There is merit in strengthening the abilities of both the medicare and medicaid programs to pursue the most cost-conscious strategies in purchasing ancillary services and prosthetic devices. However, we caution that in developing such approaches there should be recognition of the differences in economic behavior be-

tween the marketplace and nonprofit service providers. Too often the definitions of efficiency and economy are oriented to short-range savings, neglecting to recognize the long-run cost implications. While the optimum point for the marketplace might best be defined at the intercept of marginal revenues and marginal costs, Urban Institute studies indicate that for nonprofit and governmental service providers, the optimum point is at the intercept of average revenues and average costs. To ignore that important economic distinction might be to shortchange the future potential of the provider to serve.

(20) There may be merit in reviewing the provisions of current medicare and medicaid policies with respect to leasing of services. In several provisions of the law, reference is made toward protecting the public interest in the selling of facilities engaged in health services. Limited reference is made to leasing agreement which might in the short run appear to save money but increase program costs in the long run.

(21) Likewise, there may be merit in reassessing the closing and conversion provisions for health facilities considered by the Congress during the 96th Congress. The true costs to the medicare and medicaid programs multiply when inappropriate and underutilized facilities are supported by operating indirect expenditures.

(F) Improving Program Administration

While there are modest cost savings to be secured by changes in program administration because of the prudent decisions of previous Congresses, there are areas which can still be trimmed, short of the radical surgery proposed by the administration. We call upon Congress to consider the following:

(22) Penalty fees imposed under medicare and medicaid program are limited deterrents to fraud and abuse. If Congress is serious about containing such practices, it should impose realistic penalties upon those who engage in fraudulent practices.

(23) A large share of the administrative costs of managing the medicaid program comes from the Federal sector. We are supportive of this investment, but when faced with the choice of cutting benefits to an individual or reducing the overhead fees going to the States, we opt for the latter. It is significant to note the tremendous Federal investment in information systems that has been made through the social security, supplemental security income, and medicaid programs. One of the items not accounted for in the President's budget is the loss of such investments, which have paid off improved program management and reduction in fraud and abuse.

(24) As we testified before the Congress last year, there are a number of changes that can be made in the certification and licensure area which would target administrative resources toward those homes which have the worst performance. The States should be given greater flexibility to allocate resources toward problem areas and a reduction of the makework exercises which are required in the recertification process. Medicare and medicaid certification periods could be expanded beyond the 12 months time frame. Certification surveys should focus on patient related problems and be less paperwork-oriented. Standards should accent patient care management rather than a simple accumulation of imput variables.

(25) Perhaps an appropriate step for the committee to take at this time would be a reinforcement of the long-term care demonstrations funded by the Congress during the past session. These demonstrations, and perhaps expanded ones which could develop some statewide models, are important in assessing the impact of significant policy changes. There is a significant, low cost, Federal role in providing systems development opportunities and technical assistance initiatives to States and localities to strengthen the provision of long-term care. Certainly, the Federal Government should demonstrate the significant cost savings which can be secured through the use of congregate housing and alternative facilities-based strategies to costly nursing homes.

IV. CONCLUSION

We believe these numerous options for containing escalating program costs are preferable to a wholesale change in the framework of medicare and medicaid. Our message is clear: We would prefer to see incremental changes now and a time schedule established for reviewing systemic changes following the pressures of the budgetary debate. There is a need to alter the medicare and medicaid programs and to improve our service system to meet growing human needs in a cost-efficient manner. However, to make those changes during these emotion-filled debates on economic recovery is to shortchange the American public.

Our association stands ready to assist the committee in evaluating various approaches to cost savings and to work with members of the committee in improving the responsiveness of our public programs to the needs of older persons.

Appendix I

AAHA's Reaction to the Proposal of the National Governors' Association

Members of our association applaud the initiative taken by the Governors to suggest an alternative to achieve significant budget savings in the health function. As stated above, we find ourselves in general agreement with a number of the points articulated by the Governors. At the same time, we think there are components of their plan which must be carefully evaluated before final action should be taken.

As a departure point to raise our views on the suggested counterproposal, we should reestablish the historical viewpoint of the members of our association of the medicaid partnership. We perceive medicaid as a Federal program, managed by the States rather than a State program financed by the Federal Government. While it is obvious that greater flexibility should be given to the States to develop their medical assistance program to meet the needs of their resident populations, we strongly believe that such flexibility must be within a Federal construct. The recently approved amendment for reimbursement to nursing homes under the medicaid program offers an appropriate model for program development. Section 962 of Public Law 96-499 permits the States the opportunity to establish rates sufficient to meet statutory minimums and for the Federal Government to insure in a timely fashion that such rates are adequate.

Keeping this construct in mind, we believe the proposal by the State leaders to have greater flexibility in the management of their medicaid programs is sound. A number of the points which we raise in the next section of this testimony conform to the suggestions put forth by the Governors. However, we oppose the suggested change to permit the adjustment of reimbursement rates arbitrarily based upon the availability of State resources. There is a contractual obligation by the State to meet the costs of providing services for eligible recipients. Prudent buyer approaches and prospective reimbursement strategies should insure the State the best cost purchase. If these approaches cannot contain State outlays, then there may be a serious question as to whether the State is committing sufficient resources to insure minimum health care protection.

The Governors' suggestion to alter medicare reimbursement to hospitals is a sound one. Implementing the change may require significant time; therefore, we question such a systemic change should be made a part of the emotionally charged budget debate. Clearly, we are in agreement with the State leaders that any meaningful health containment policy must address the significant skewing of resources to the acute care sector.

Medicaid hospital containment cannot be secured without companion attention to medicare. A step could be taken toward implementing the prospective reimbursement approach by implementing the suggested framework of the amendments passed by the Senate Finance Committee as parts of H.R. 934 during the past Congress. Shortrun containment on hospital expenditures could be achieved by tightening the limitations on routine inpatient services under existing regulations.

As with several other provisions in the Governors' plan, we find ourselves in agreement with the suggestion that some latitude should be given to insure cost-conscious behavior. We suggest that such latitude be given within the framework of Federal approval. Thus, we recommend that a multiyear waiver be granted for a policy-specific change requested by the State. In turn, the State would establish grounds for the suggested change and indicate a willingness to evaluate the impact of the change upon recipients. Such an approach insures some Federal review of the latitude assumed by the States and permits an evaluation which could aid in the dissemination of cost-conscious approaches among the States.

Our experience with PSRO reviews reinforces the Governors' proposal for suspending such activities. PSRO review in long-term care has been a punitive effort to restrict patient care to only the medical model. Little attention has been given to the holistic needs of residents and to the fundamental fluctuations in the health status of residents of long-term care facilities.

We concur with the benefits flexibility suggested in the Governors' plan and with the recommendations for waiver of the health maintenance organizations restrictions in medically underserved areas. Again, we believe both should be exercised within the framework of Federal supervision. Likewise, we suggest States should be permitted to extend their HMO benefit package to underwrite certain services

provided through a geriatric/social HMO approach. Demonstrations of this strategy appear promising in containing overall expenditures for long-term care services.

The major problem which we have with the Governors' proposal is the suggestion that long-term care services be capped and block granted to the States. Our primary opposition is that this is a significant systemic change should be carefully explored before enactment. Most of the research on the impact of such an approach has raised a number of problem areas that need to be carefully explored. For instance, the internal HEW policy papers written 8 years ago under the assumptions that a national health plan would be enacted suggested the following disadvantages to a formula grant to States for long-term care:

Depending on the formula for providing grants, there would be inequities among States in eligibility and levels of services provided.

If formula grants were allotted directly to States, the States would "ration" benefits through the State social services and welfare agencies.

Services financed by grants inevitably result in geographical inequities in access to services and disparities in consumer awareness of programs and eligibility requirements which influence the level of receipt of services.

A more recent assessment of the block grant idea included in the Callahan and Wallack text on "Reforming the Long-Term Care System," raised two significant policy issues in addition to the previous concerns, i.e., that such approaches (1) weaken the legislative protection afforded to recipients, and (2) increase the politicalization of health care decisions among various groups, including providers and clients, with varying power to influence policy outcomes. The author of the article, Robert Hudson of Brandeis University, suggests the following issues would be critical in the development of a block grant strategy:

Means for insuring that persons currently being served cannot be dropped from the system.

Service options now largely confined to programs being folded into the block grant system not be pressured out of existence.

Mechanisms in place that assure acceptable quality of care levels.

A range of service alternatives available so that consumers and/or case managers have reasonable choice.

Safeguards in place so that consumers are not forced into inappropriate settings financed by the Federal Government; and

Most basic of all, that the Federal Government has some meaningful way of enforcing the legislative and regulatory provisions contained in Federal legislation.

We believe these points are extremely constructive. We also believe that the States are probably incapable of providing this range of assurances, or of creating the necessary infrastructures to manage these systems. Further, a block grant with an arbitrary ceiling will do little to reorder the delivery of long-term care. It would lock in current program inequities and more probably suffocate initiatives to insure appropriate placement in the least restrictive environment.

Rather than increase community strategies, we believe such a narrowly constructed program would cause recreation of almshouses.

Thus while supportive of many of the goals specified in the Governor's proposal, we believe that some of these provisions are significant systemic changes which require further study.

Perhaps an appropriate step for the committee to take at this time would be reinforcement of the long-term care demonstrations funded by the Congress during the past session. These demonstrations, and perhaps expanded ones which could develop some statewide models, are important in assessing the impact of significant policy changes. There is a significant, low cost, Federal role in providing systems development opportunities and technical assistance initiatives to States and localities to strengthen the provision of long-term care. Certainly, the Federal Government should demonstrate the significant cost savings which can be secured through the use of congregate housing and alternative facility-based strategies to costly nursing homes.

Senator HEINZ. Dr. Bell.

STATEMENT OF THOMAS G. BELL, PH. D., WASHINGTON, D.C., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Dr. BELL. Mr. Chairman, I have a synopsis of the association's comments, which I will verbally present and submit for the record a more detailed statement.

Senator HEINZ. Without objection, your full, detailed statement will be made a part of the record.[1]

Dr. BELL. I am grateful for the opportunity to communicate to you the position of the nearly 7,500 members of the American Health Care Association on the President's budget proposals and to examine their impact on older Americans. I will confine my remarks to the administration's medicaid proposals.

The American Health Care Association today offers specific suggestions to help the administration and Congress restore the viability of the American economy by reducing the growth of the Federal budget. We recommend adoption of several statutory and regulatory amendments to give State governments sufficient flexibility and incentive to achieve substantial savings in the medicaid program without curtailing basic entitlements or services for those who need them.

First, provide the States with authority to develop cost-effective reimbursement policies for all providers similar to the recent changes in nursing home reimbursements effected by Public Law 96-499.

Second, permit States to achieve greater program savings in purchasing of health care services and medical equipment by amending the present law.

Third, encourage the States to reasonably restrict "medically needy" eligibility by withholding Federal payments for higher income recipients; and

Fourth, amend Federal laws to permit States to develop innovative cost-savings programs such as copayments and family supplementation.

We also recommend the following initiatives for achieving greater cost savings and efficiency in long-term care component of medicaid:

First, redesign federally mandated survey and certification procedures for maximum efficiency.

Second, revise regulations and eliminate those that are not cost effective or do not relate to patient care.

Third, simplify utilization review; and

Fourth, develop programs to place patients in the least costly setting that meets their health care needs.

We understand that the Department of Health and Human Services has chosen not to seek similar legislative and regulatory relief for State governments seeking to implement cost-savings initiatives in the medicaid program but has opted to provide broad waivers to the States instead.

We believe that this is a mistake because it will permit the Department to exert bureaucratic controls over State initiatives and would exclude the Congress from a role in determining which aspects of the program are to be eliminated and which are to be retained in the interests of efficiency.

I would also like to comment on the alternative health care budget savings proposals developed by the National Governors' Association.

AHCA endorses the National Governors' Association's call for reform of medicare reimbursement. We agree with the Governors

[1] See next page.

that the current reimbursement method is inflationary and inefficient. We maintain that the Federal Government could significantly reduce the growth of the Federal budget and nationwide health care costs by implementation of a well-designed prospective reimbursement system for all services funded by title XVIII.

The American Health Care Association is currently conducting a study of the potential impact of prospective reimbursement on skilled nursing facilities participating in medicare. We believe that it will expand skilled nursing services, limit the need for patients to remain in a costly hospital bed because a bed in a skilled nursing facility is not available, and reduce the cost of the individual's care and overall expense of the medicare program.

AHCA opposes the National Governors' Association's second alternative to the administration's proposal to cut medicaid funding—that is, the NGA's recommendation to cap Federal medicaid expenditures for long-term care services.

AHCA maintains that to single out long-term care as the only vehicle for achieving savings in the medicaid program would be inequitable, would not achieve the savings sought by the administration, and would inflict undue hardships on nursing home residents.

Medicaid nursing home services in most States are extremely cost effective, thanks to the use of reimbursement methods with built-in cost containment features. The growth of long-term care costs in the various State medicaid programs have resulted almost exclusively from inflation or from increased utilization induced by State policies.

In particular, the States have shifted the responsibility for the mentally ill and mentally retarded from State-run institutions outside the medicaid program to intermediate-care facilities for the mentally retarded and nursing homes that are funded by medicaid.

Were it not for this shift, 31 States would show a decrease in the proportion of medicaid in their budgets in fiscal year 1982 over fiscal year 1978. Instead, only 19 States will show such a decline. This is what is expanding medicaid costs—not normal nursing home services provided to all title XIX recipients, but the distortion created by State decisions to transfer part of their health care responsibilities to Federal expense.

Your consideration of these proposals not only will directly affect more than three-quarters of a million nursing home residents presently on public support; your consideration not only will affect the Nation's 18,000 medicaid and medicare nursing homes, almost half of which are our members, and the million constituents who work in them; your consideration will impact most significantly on the millions approaching 65 who will need and who deserve quality long-term care.

Senator HEINZ. Dr. Bell, thank you very much.

[The prepared statement of Dr. Bell follows:]

PREPARED STATEMENT OF DR. THOMAS G. BELL

The American Health Care Association (AHCA), which represents 7,500 nursing homes nationwide, supports the efforts of the administration and the Congress to restore the viability of the American economy by reducing the growth of the Federal budget. Our members, their employees, and the residents that they serve, have felt the sting of inflation. We are committed to working with the administration and the Congress to find a cure for this economic disease.

Nursing home providers, however, like the members of the Senate Special Committee on Aging, also have a duty to assess the impact of budget cutting on elderly and handicapped—our mutual constituents. The President has proposed to reduce medicaid funding by $1 billion in fiscal year 1982 and to cap Federal medicaid expenditures in future years. Nearly 50 percent of the residents of nursing homes are supported by the medicaid program nationwide. Sustained budget reductions of the magnitude proposed by the administration may have a harmful impact on the availability and quality of long-term care services for the poor, unless they are carried out in a responsible and equitable manner.

AHCA believes that any reduction of medicaid funding should adhere to the following basic principles, which are more fully developed in attachment A:

The Federal Government must not abrogate or transfer to the States its responsibility for the long-term health care needs of medicaid recipients as part of a Federal budget reduction without developing adequate assurances that those individuals will receive the services they need.

Action to reduce the growth of medicaid expenditures should be equitable. No group of beneficiaries or providers should be unfairly singled out to absorb disproportionate loss of Federal support.

The budget reductions must be accompanied simultaneously by supportive legislative and regulatory changes which allow State governments and providers greater flexibility in providing more cost-effective care and minimize adverse effects on beneficiaries.

In developing specific proposals for implementing budget savings, attention should initially be focused on regulatory reform proposals, i.e., elimination of current requirements (1) where the costs of compliance outweigh the benefits, (2) which do not relate to patient care, or (3) which restrict the State's ability to develop cost effective programs to meet their needs.

The Federal Government must seek budget savings in the medicare program which absorbs a much greater share of the Federal budget than medicare and employs less efficient reimbursement policies.

The administration's proposals, as we understand them, fail to adhere to these principles in two important areas. Medicare, particularly medicare reimbursement, an inherently inflationary mechanism, is exempted from budget savings. Also, the Department of Health and Human Services has eschewed overhaul of the statutory and regulatory obstacles to efficient management of the program by State governments in favor of a liberal blanket waiver of State initiatives.

AHCA endorses the National Governors' Association call for reform of medicare reimbursement. We agree with the Governors that the Federal Government could limit the spiraling growth of health care costs by the employment of a well-designed prospective reimbursement methodology in title XVIII. AHCA is currently conducting a study of the potential impact of the use of prospective reimbursement for skilled nursing facilities participating in medicare. As you know, medicare utilizes an inefficient and inflationary retrospective reimbursement system. We believe we can prove that a prospective system will expand skilled nursing services, reduce the need for patients to remain in a costly hospital bed because a SNF bed is not available, and limit both the cost of the individual's care and the overall expense of the medicare program.

AHCA is surprised that the administration is attempting to live up to its promise of greater State flexibility in the medicaid program by reliance on waivers, rather than by specific statutory and regulatory amendments. While the Secretary of Health and Human Services appears to be genuinely committed to more autonomy for the States, the waiver authority he envisions will counteract this freedom by reestablishing the authority of the Federal Government to veto State initiatives. Moreover, it would appear to exclude the Congress from a role determining which aspects of the program are to be eliminated and which are to be retained in the interests of efficiency.

AHCA believes that the administration and the Congress should directly address the programmatic aspects of the medicaid cuts, rather than promising the States sympathetic consideration of their initiatives. We recommend that the following proposals be adopted by the Congress to achieve savings in Federal outlays for medicaid:

Provide the States with authority to develop cost-effective reimbursement policies for all providers similar to the recent changes in nursing home reimbursement effected by Public Law 96-499.

Curtail "freedom of choice" legislation, permitting States to achieve greater program savings in purchase of health care services and medical equipment.

Encourage the States to reasonably restrict "medically needy" eligibility by withholding Federal payments for higher income recipients.

Amend Federal laws to permit States to develop innovative cost savings programs such as copayments and family supplementation.

We also recommend the following initiatives for achieving greater cost savings and efficiency in the long-term care component of medicaid:

Redesign federally mandated survey and certification procedures for maximum efficiency.

Revise regulations and eliminate those which are not cost effective or do not relate to patient care.

Simplify utilization review.

Develop programs to place patients in the least costly setting to meet their health care needs.

(Note: The above are described in more detail in attachment B.)

We believe that the above would provide maximum freedom for the States to achieve savings in the medicaid program without curtailing basic entitlements or services.

AHCA opposes the National Governors' Association's (NGA) alternative proposal to restrict Federal title XIX expenditures for long-term care services. The NGA bases its initiative on the inaccurate assumption that nursing home services are the most rapidly growing component of medicaid costs.

Data of the Department of Health and Human Services contradict the NGA assertion that nursing home services are the most rapidly rising component of medicaid costs and indicate that the growth is attributable to treatment of the mentally ill and retarded in intermediate care facilities for the mentally retarded (ICF-MR). The data indicate that in 31 States the estimated percentage of the medicaid budget consumed by nursing home services (other than ICF-MR) will decline during the period from fiscal year 1978 to fiscal year 1982. However, if ICF-MR services are included only 19 States decrease the percentage of the budget which goes to long-term care services. Moreover, the estimated nationwide percentage of medicaid expenditures going for nursing home services will decline slightly (2.8 percent) during the same period if ICF-MR is excluded but will increase 1.7 percent if ICF-MR is included. The States are largely responsible for this increase as a result of their policies to "deinstitutionalize" State supported mental institutions and to place these individuals in ICF-MR's and nursing homes funded by medicaid.

Studies have indicated that growth of nursing home expenditures are also due primarily to increased utilization and general inflation. Nursing home services are one of the few services covered by medicaid which can attest to the increased utilization as having a significant impact on the growth of expenditures. The elderly population in need of these services has been increasing and is projected to expand in future years.

AHCA maintains the medicaid nursing home care is very cost effective. It should be noted that States have successfully employed prospective reimbursement systems for nursing homes for several years in order to contain costs. Medicaid reimbursement to nursing homes is unique, in that historically, States have a considerable amount of flexibility and latitude in developing payment methodologies for nursing home services. Since the inception of the program, States have had the great flexibility to develop efficient nursing home reimbursement methodologies.

As a result of this flexibility, in 1977 States began developing and implementing prospective reimbursement systems with built-in cost containment mechanisms and incentives, such as cost center limits and ceilings on payment rates. Currently, 38 States employ prospective reimbursement; 48 States establish various ceilings on costs; 24 States impose overall rate limits; 33 States have cost center ceilings; and 34 States offer incentives for efficient providers.

These systems have been successfully employed to contain nursing homes' costs and typically result in payments to providers that are lower than their costs of serving needy medicaid patients. As a result of these systems with their cost containment mechanisms, payments to nursing homes have been restrained. It should also be noted that a recent amendment to the medicaid law provides States additional flexibility and latitude in establishing prospective reimbursement systems and determining payments to nursing homes.

Medicaid nursing home cost increases have been limited to increases attributable to inflation, greater utilization, and costly State regulations. These costs have grown approximately 15 percent per year in recent years largely because of inflation. The NGA maintains, however, that the State governments could convert a block grant for the long-term care portion of the medicaid program, capped at 7 percent in fiscal year 1982, into a more comprehensive system of services, including noninstitutional care.

To apply a cap and block grant solely on long-term care would be to single out one group of beneficiaries to bear the burden of reduced Federal support which is contrary to the administration's objective of equitable sacrifice. In addition, to the extent that nursing home services are not provided and noninstitutional services are not available, recipients will be forced to remain in more costly hospitals which will increase expenditures in that area.

[Attachment A]

IMPLICATIONS OF THE BUDGET REDUCTIONS ON LONG-TERM CARE PROGRAMS

NEEDS OF BENEFICIARIES

AHCA believes that it would be tragic for the Federal Government to abrogate or to transfer to the States its responsibility for the long-term health care needs of medicaid recipients as part of a Federal budget reduction, without developing adequate assurances that these individuals will receive the services they need.

Nursing homes are the principal institutions for delivery of long-term care for the elderly and handicapped. Home health and support services are an alternative to institutional care but these programs are haphazardly funded by the Federal Government and are unavailable in many parts of the country. Medicaid and to a much lesser degree, medicare, are the principal Federal funding mechanisms for care inside a nursing home. Federal support of home health and support services is less extensive and less concentrated, involving titles XVIII, XIX, and XX.

We advocate the development in the community of a mix of facility and home-based services that will permit delivery of care in the most appropriate setting. We are concerned, however, that some States will leap into lower cost home health programs and withdraw funding for care in long-term care facilities to the detriment of medicaid recipients of institutional care, if Federal funds are cut back and States are given discretion to do so. Perhaps 10 percent of all residents in nursing homes could be cared for in a community-based setting if appropriate services were available. Many residents in nursing homes, particularly those covered by medicaid do not have homes or living relations that would permit them to take advantage of home health care programs. An increasing number of residents supported by medicaid are the "frail elderly" who are severely debilitated and could not function outside an institutional setting, except through massive expenditures for care.

The Federal Government established the patterns of long-term care delivery by its categorical requirements in both titles XVIII and XIX. If the patterns of delivery are to be restructured, the States must be given maximum flexibility to assess needs and package delivery systems, but the Federal Government has a responsibility to insure that current recipients are not disenfranchised and that long-term care services are available to entitlement recipients who need them.

REQUIREMENTS OF PROVIDERS

Both the Federal and State governments have a stake in maintaining the viability of health care providers when they cut back on medicaid funding. Hospitals, physicians, nursing homes, home health agencies—all provide necessary services to the community.

Modern nursing homes are largely the product of a public demand, generated by the creation of titles XVIII and title XIX. Nearly 50 percent of all long-term care facility residents are funded by medicaid. Another 4 percent are funded by medicare. Nursing home construction, life and fire safety devices, staffing, and administration are mandated by Federal or supplementary State regulations.

Unlike hospitals, nursing homes are primarily (80 percent) for-profit corporations. They are labor intensive businesses with a median size of 100 beds and employing over 100 staff members as an average. General inflation and federally mandated requirements such as minimum wage increases and compliance with life safety codes have greatly increased the cost of maintaining a nursing home.

Despite the increases in expenses, the cost of nursing home services (i.e., nursing care, social programs, room and board) have been held to a reasonable level in recent years. The expansion of nursing home costs in the medicaid program is a result of increased utilization resulting from a growth of the elderly population needing long-term care, eligibility criteria adopted by the States and a shift of expenditures for the care of the mentally ill and retarded from State programs to medicaid, as well as the proliferation of excessive Government regulations unrelated to patient care. Despite these increases, most State medicaid plans have stringent controls on the per-patient charges for medicaid nursing home services through the use of prospective reimbursement methods with built-in cost containment features,

plus incentives for efficiency. A provision in the recently enacted 1980 Omnibus Reconciliation Act (Public Law 96-499) was specifically designed to increase State flexibility for developing cost-effective medicaid nursing home rates.

Drastic reduction in medicaid reimbursement to nursing homes will have the effect of lowering the quality of care or restricting bed availability for medicaid patients, unless the administrative and regulatory requirements required by the Federal Government are simplified and streamlined. Providers can furnish care at lower costs if they are given freedom, within reasonable limits, to produce cost savings. Expansion of prospective systems to all State medicaid programs would further reduce program costs, particularly if providers are permitted to keep part of the cost savings as an incentive for efficiency.

THE MEDICARE-MEDICAID CONNECTION

The Reagan administration has targeted medicaid for reduction of Federal outlays, but has exempted medicare as part of the social safety net. Federal medicare outlays are projected at over $40 billion in fiscal year 1982; medicaid outlays at $18.2 billion. AHCA agrees that medicare benefits are an essential component of the well-being of our senior citizens. We also point out that medicaid coverage for long-term care services, particularly for those recipients without families or other means of support, is an equally valuable component of the social safety net.

AHCA does not believe that current medicare reimbursement or regulatory policies are efficient vehicles for the delivery of care to beneficiaries needing acute or long-term care. Medicare's retrospective "reasonable-cost" reimbursement policies are inflationary and do not impose either incentives or disincentives for cost-effective delivery of care.

Title XVIII policies have had a pernicious effect on long-term care. Nursing home operations have dropped out of medicare in droves because of excessive administrative requirements, low utilization created by arbitrary Federal policy, and retrospective denial of reimbursement. Medicare policies have also had a harmful effect on the medicaid program. Several States have adopted medicare principles of reimbursement with little opportunities for cost savings by the Government other than ruthless denial of charges for service rendered and concomitant provider uncertainty and resentment.

AHCA implores the administration and the Congress not to uncritically reject medicaid and endorse medicare. Medicaid long-term care reimbursement and regulatory policies are more cost-effective than their medicare counterparts. Adoption of the former for all institutional providers participating in either title XVIII or XIX programs would drastically reduce Federal health care expenditures without affecting benefits for recipients.

[Attachment B]

SPECIFIC BUDGET REDUCTION RECOMMENDATIONS

DEVELOPMENT OF COST EFFECTIVE PROVIDER REIMBURSEMENT POLICIES

AHCA believes that the recent changes in nursing home reimbursement effected by Public Law 96-499 can serve as a model for removal of impediments for States to develop cost effective reimbursement methodologies. Section 962 of Public Law 96-499 often referred to as the "Boren Amendment," provides that States must reimburse nursing homes based on rates that are adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care in accordance with mandated requirements and standards. Within this broad statutory requirement, States have the flexibility to develop their own methodology for establishing rates based on the unique needs within and characteristic of the State. In fact, the principal purpose of the amendment was to provide States additional flexibility in determining reimbursement to nursing homes.

Although States have been given considerable flexibility and latitude, the amendment also requires that States provide assurances to the Federal Government that the rates are adequate and satisfy the statutory requirement. Thus, the States have obtained sufficient flexibility while the Federal Government has retained appropriate authority to insure that its minimum requirements are met. This approach to reimbursement for nursing homes could serve as a model for other providers and other aspects of the program as well as fitting within the overall framework of the medicaid program AHCA recommends—retain medicaid as an entitlement program but permit maximum State flexibility in determining eligibility, services, and reimbursement.

Medicaid reimbursement to nursing homes is unique in that even prior to the additional flexibility provided by the "Boren Amendment," States had a considerable amount of flexibility in developing reimbursement methodologies for nursing homes. For several years, States have used this flexibility to control the per patient day costs of nursing home services though the employment of prospective reimbursement plans with built-in cost containment mechanisms, such as cost center limits and ceilings on payment rates. AHCA earnestly believes that as a result of these systems with their cost containment mechanisms and the unrealistically low reimbursement rates which preceded these systems, payments to nursing homes are not excessive and contain "very little fat" controllable by a facility. To assume that payment rates to nursing homes could be significantly reduced without having a detrimental impact on quality of care would be a tragic mistake.

CURTAILMENT OF FREEDOM OF CHOICE

Under the existing freedom of choice statutory provision and implementing regulations, the only services which are amenable to volume purchasing are eyeglasses, hearing aids, prescribed drugs and durable medical equipment. Last year, a provision was introduced (and subsequently dropped) in the omnibus reconciliation bill limiting freedom of choice for beneficiaries obtaining services and supplies under medicaid. The intent of this provision was to enable States to achieve greater savings through bulk purchase of services. The States were to be limited in this only to the extent that the restrictions on freedom of choice were cost-effective, assured reasonable access to services, and avoided substantially adverse effect on access to teaching hospitals.

AHCA supports curtailment of freedom of choice to permit State governments the opportunity to negotiate competitive prices for provider services and vendor goods, provided there are safeguards to prevent the use of this provision to exclude participation by providers or vendors for any other reason than noncompetitive prices.

GREATER STATE COST SAVINGS FLEXIBILITY

Federal laws should be amended to permit States to develop innovative cost-savings program.

Several States have sought authority to introduce cost-savings measures in the medicaid program. Last year the Alabama congressional delegation introduced legislation permitting family supplementation, copayments and greater authority to crack down on program abusers. Massachusetts is currently exploring a negotiated rate purchase system with groups of providers.

The administration has promised to develop a comprehensive health care reform package which would reduce the growth of health care costs. While work on that initiative goes on, States should be permitted maximum flexibility to develop cost-effective systems by the elimination of Federal legislative and regulatory restrictions.

RESTRICTING ELIGIBILITY

One approach to reducing medicaid expenditures is to address the issue of increasing utilization by imposing stricter limits on eligibility for benefits. Eligibility could be tightened up in an effort to insure that only the "truly needy" are receiving benefits.

For example, the income standard to qualify as a "medically needy" recipient could be reduced. The medically needy are generally people whose incomes are too high to receive cash assistance (e.g., SSI, AFDC) but who cannot afford to pay their medical bills. The amount of their incurred medical expenses must equal or exceed the amount of income they have above the State income level. Each State with a medically needy program (over half the States) sets income levels for determining eligibility of the medically needy. The level at which these income standards are set could be reduced so that only the "truly needy" are covered.

Another approach, which has been proposed by the Congressional Budget Office, is to eliminate from coverage as "categorically needy" individuals who only receive optional State supplements. The categorically needy are generally individuals who are eligible for medicaid because they can meet the income requirements for cash assistance, regardless of the extent of their medical bills. However, 34 States also have elected to include in the categorically needy group persons whose income disqualifies them for Federal SSI payments but who receive State supplements. That is, these individuals do not receive Federal cash assistance, but receive State supplements and are entitled to medicaid benefits as the categorically needy group. The Congressional Budget Office has estimated that a savings of $320 million could be realized in the first year if these individuals no longer receive medicaid benefits

as categorically needy. The 5-year savings was estimated to be almost $2 billion. It was further estimated that elimination of this coverage would eliminate or reduce medicaid benefits for about 600,000 persons. However, the "truly needy" would continue to receive benefits because those individuals livings in States with coverage for the medically needy could continue to receive benefits if they had sufficient medical expenses.

SURVEY AND CERTIFICATION REFORM

A poll of AHCA members last year revealed that long-term care facilities are surveyed an average of 10 times each year. Each survey involved approximately three government inspectors and takes the full time of three to five facility staff members. We believe that the survey process is an expensive administrative process.

Immediate changes could save program administration costs, free facility staff for patient care activities; and reduce expenditures for unneeded correction plans. Such changes include:

Combining all the federally mandated surveys into one. We see no reason why an inspection of care team, certification team, professional standards review organization team and health planning team (for appropriateness review) all must review essentially the same components of long-term care facilities.

Extend provider agreements. Facilities performing well could be reviewed every 2 years rather than annually if provider agreements could be made for 24 months. This way, survey teams could concentrate their efforts of facilities having numerous deficiencies.

Revise the survey report form. Currently, inspectors survey 520 separate items in skilled nursing facilities. We suggest that this form be cut back to only statutorily required and other elements critical to the provision of health care.

Improve survey training so that all inspectors know the standards and can recommend cost effective corrections. Misinterpretation and surveyor private interpretation of rules account for large expenditures, eventually billed to the medicaid program. One AHCA facility replaced five doors five times because each successive inspector had a different idea of fire door requirements.

REVISE REGULATIONS AND ELIMINATE THOSE WHICH ARE NOT COST EFFECTIVE OR DO NOT RELATE TO PATIENT CARE

The skilled and intermediate care facility conditions of participation contain numerous provisions that are either not cost effective and/or not related to patient care. These rules relate to committee meetings, recordkeeping requirements, and other activities. The interpretive guidelines accompanying the nursing home standards frequently impose additional requirements. For example, regulations requiring "timely visits" by consultants are translated in the guidelines to 5 hours per week. We suggest that the conditions of participation and guidelines be reviewed and rewritten in an outcome oriented, rather than process oriented fashion. This regulation reform would result in more efficient use of nursing home staff.

Some examples of rules we believe should be reviewed include:

Frequency of physician visit: Regulations mandate that physicians must visit patients every 30 or 60 days, whether or not the patients' conditions warrant a physician visit. We suggest rules be revised to require visits based on patient need, an allowance of nurse practitioner and physician assistance visits (under general physician supervision) in lieu of physician visits. This change would reduce physician medicaid costs, not facility costs.

Committees: The pharmaceutical, infection control, and utilization review committees, each necessitating numerous professional's attendance, could be eliminated if their functions could be accomplished more efficiently.

Consultants: Highly qualified consultants are required in skilled facilities whether or not department performance shows a need for consultants. These include: medical records administrators, social workers, dieticians, advisory dentists, activity consultants.

Patients' rights: Interpretive guidelines far exceed the regulations. For example, guidelines require that patients who are wearing safety devices be observed every 30 minutes and that observation must be documented.

Since Federal nursing home rules apply to facilities with both medicare and medicaid patients, the potential savings realized would apply to both the medicare and medicaid programs. We believe that these measures would effectively control the growth of long-term health care costs (but not necessarily lead to immediate cost savings).

A second step-in regulation reform must be directed at the State level. The Federal Government portion of medicaid payment must cover State as well as

Federal rules. These State standards often far exceed Federal rules, especially in the areas of staff qualification, numbers of staff, and reporting requirements.

Two approaches could be directed at curbing the growth of health care costs as a result of State rules:

Disallow costs related to State requirements from the Federal medicaid match. In this option, the Federal Government would not pay for State-imposed standards beyond Federal requirements.

If Federal payment for State standards is continued, require States, as a condition of being part of the medicaid program, to establish mechanisms to review the cost and necessity of their rules. These mechanisms could be similar to those mandated on the Federal level by Executive Order 12291 (regulation reform), the Regulatory Flexibility Act (for small entities), and the Paperwork Reduction Act.

SIMPLIFIED UTILIZATION REVIEW

Utilization review in long-term care facilities, the system of assuring that each medicare and medicaid patient needs the services being given, is an expensive and burdensome medicaid requirement. We believe it is not worth the medicaid dollars now spent. Typically, it involves three activities: (1) Each attending physician must visit medicaid patients either monthly or bimonthly in order to certify the need for continued care; (2) facilities hold monthly meetings with administrative and nursing staff and three private physicians in attendance to review physician certification and continued need for care; (3) at least annually, an inspection of care team visits each facility to inspect the record of each public pay patient. (These visits often involve several weeks of daily facility attendance with three or more health professionals. This survey is paid in full by the Federal Government.)

This process could be greatly simplified and made less costly to the medicaid program if:

Greater attention was given to patients entering the long-term care system and less attention to those already placed in facilities. A good assessment prior to admission could reduce unnecessary placements.

Patients with little discharge potential were reviewed less frequently than is now required. If discharge is not expected for at least 6 months, review should not be necessary for 6 months.

Patients with no discharge potential were not reviewed. In some instances, especially in the case of the terminally or progressively ill, utilization review is only a paper exercise.

Mail, telephone, and other expedient review procedures replaced physician visits, meetings, and onsite review. The Iowa Professional Standards Review Organization has found these procedures to be extremely cost efficient.

Physician assistants and nurse practitioners (as well as physicians) could certify the need for care.

Combine the three review activities into a single, binding review process.

CONSIDER SHIFTING PLACEMENT OF PATIENTS FROM MORE COSTLY TO LESS COSTLY HEALTH CARE SETTING

Nursing home medicaid expenditures must not be viewed in a vacuum. The provision of long-term care is actually performed along a continuum, in various locations—from services rendered in the home to services provided in acute care hospitals. These services may be paid for by the medicaid program, by State funds, through the Veterans Administration, by medicare, or by other Federal programs. We believe that services should be delivered in the most cost-effective setting that meets the patient's needs. We suggest that funds expended through medicaid be viewed in relation to the overall government dollars spent in providing long-term care. Reduction of medicaid nursing home disbursements will have the effect of raising Federal long-term care costs in other programs, usually at a higher level of expenditure.

The community long-term care facility is the most cost-effective source of health care for individuals in need of the services provided in these facilities. We wish to bring to your attention:

When the Veterans Administration places a veteran in a community nursing home, the cost of that care is less than over half of what it would cost in a long-term care Veterans Administration facility. Still, the VA is planning on converting or building 32 nursing home facilities in the near future.

State mental institutions cost two to four times as much to care for a patient as would a community long-term care facility. Some chronically mentally ill patients currently in State institutions could be adequately cared for in general community nursing homes. Others could be cared for if community long-term facilities were

permitted to specialize in the care of the chronically mentally ill. However, present law excludes medicaid reimbursement for certain age groups when such specialization exists.

Likewise, State institutions for the mentally retarded are far more costly than most long-term care facilities. Current rules require that facilities for the mentally retarded all have similar program standards, whether or not all patients could benefit from such programs. If program requirements were based on the patient needs and potential rather than blanket standards, cost savings would be realized.

Some hospitals are gradually becoming long-term care facilities because community nursing home placement for patients is not available. Large numbers of patients are receiving acute care (at acute care prices) when they need long-term care (at approximately a quarter of the cost). During 1980, the American Association of Professional Standard Review Organizations conducted a 1-day survey of patients awaiting nursing home placement. The 101 PSRO's reported a total of 17,783 patients awaiting placement on one single day. A reason for this "back-up" is resistance of long-term care providers to participate in the medicare program because of numerous problems inherent in this program.

We believe that the hospital backup problem will continue and that its toll on medicare and medicaid programs will escalate. A reason is that many States are trying to control (or cap) their long-term care expenditures by prohibiting the building of long-term care facilities and the addition of beds. We see this as a shortsighted solution to a complex problem.

Senator HEINZ. Bill Halamandaris.

STATEMENT OF BILL HALAMANDARIS, WASHINGTON, D.C., EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

Mr. HALAMANDARIS. Thank you, Mr. Chairman.

Mr. Chairman, this statement represents the view of four national home care organizations: Council of Home Health Agencies and Community Health Services of the National League for Nursing; Home Health Services and Staffing Association; National Home Caring Council; and National Association of Home Health Agencies.

We are pleased to have this opportunity to express our opinion on the implications of President Reagan's budget recommendations—particularly the proposed medicaid cutback—on older Americans. Against a backdrop of spiraling Government spending and double-digit inflation, we welcome this chance to help formulate strategies which do not perpetuate increasing demands for the Federal dollar.

Obviously, we support activities aimed at controlling Federal expenditures. However, unless policy revision accompanies spending decisions, we feel that this exercise will be doomed to failure. Indeed, unless there is a careful reappraisal of current long-term care policies under title XIX and accompanying legislative/administrative reforms, we believe that the proposed cap on Federal financial participation in the medicaid program will merely aggravate the inefficiencies inherent in the system.

For this reason, we recommend the enactment of legislation which would stimulate more appropriate and cost-effective use of long-term care resources in the medicaid program. Specific recommendations include:

Eliminating financial incentives for the use of institutional rather than noninstitutional services.

Authorizing comprehensive "homemaker-home-health aide" services under titles XVIII and XIX; and

Exploring alternative methods of reimbursement to encourage more efficient service delivery.

Let me elaborate on each of these issues separately.

Financial incentives for institutional services—as this committee is no doubt aware, medicaid eligibility criteria in most States provide powerful incentives for institutional placement. Even those States which do not require pauperization prior to medicaid eligibility, require evidence of such outstanding medical expenses that, in general, individual recipients do not have the means to maintain themselves independently in the community.

This "institutional bias" is compounded by the fact that public expenditure for social services and community housing arrangements—which can often make the difference in helping a person to live independently—have been limited to date. The result is that, except in New York, few funds have been spent on home care under medicaid.

At this point, in the interest of time, I will abridge my statement and move to page 5.

Senator HEINZ. Without objection, your entire statement will be made a part of the record.[1]

Mr. HALAMANDARIS. I would like to focus specifically on alternative provider reimbursement methods.

There has been some discussion about that today by other speakers. We do believe this is a central area in limiting cost and providing the right incentives.

Current methods of provider reimbursement under titles XVIII and XIX offer little incentive for service efficiency. Generally, home-health providers are reimbursed on the basis of reasonable costs, as determined retrospectively by the fiscal intermediary. This approach has spawned costly retroactive denials, which are not uniformly applied from one intermediary to another, and delayed payment in some instances, creating serious cash-flow problems.

We feel that new approaches to provider reimbursement should be explored in an attempt to stimulate more efficient delivery of home-health care.

I will add at this point that since this testimony was written, we have become aware that the development of these mechanisms is in process. We have had an opportunity to review some of these things and, although they are in a draft stage, I am of the opinion that they could be effective in curtailing costs and providing the right kinds of incentives.

Other issues: The recommendations which we propose to this committee would impose needed, incremental modifications on the existing system. We believe this to be more expedient, more equitable, and less costly than other proposals with which we are familiar, including a long-term care cap. From our perspective, without any Federal incentives for home-based care, a long-term care cap would generate unfair competition for scarce resources between institutional and noninstitutional providers—competition in which noninstitutional providers would fare poorly.

Block grants: Before closing, it would be remiss if I did not reflect our concern over the proposed cutback and consolidation of

[1] See next page.

social service and health programs in block grants to State and local governments.

The title XX program, one of the many programs targeted for consolidation, has been operating under a similar block grant approach for over 5 years, and its history is far from encouraging. Other block grant programs have demonstrated similar problems. Based on these experiences, we predict that the following problems will emerge under a block grant approach:

Diminution of quality control and accountability; in the absence of Federal quality control—standard-setting and monitoring—mechanisms, fiscally contrained State and local government will skimp on their oversight responsibilities. Faced with difficult and complex resource allocation decisions, they may not, in fact, carry out the intended goals of the U.S. Congress and Federal administrative departments. Accountability for the expenditure of public funds will be diminished.

State and local bureaucratization; although Federal administrative slots will be reduced, it is realistic to assume that an equal number, if not more, will be needed at the State and local levels.

Unfair competition for scarce resources; when groups are forced to compete for scarce resources, decisions will be made politically and on the basis of what is available. Services without a highly vocal or politicized constituency will lose out in the foray. The most vulnerable would have the least chance of receiving services.

In sum, while we believe that State and local governments are capable of meeting the challenge which block grants present, we recommend a stronger Federal role in standard-setting, monitoring, and focusing the services to be provided, as well as providing resources with which States and localities may purchase needed technical assistance and consultation.

In conclusion, Mr. Chairman, we have attempted to bring before you today, a series of constructive recommendations for working within the President's proposed budget to insure that older Americans receive the most effective health and social services which we as a society can provide. We believe that the gross imbalance in this Nation's allocation of long-term care resources—as reflected in the fact that nursing home services have accounted for over 90 percent of all public long-term care expenditures—need to be redressed.

We pledge our support in working with you to accomplish needed changes in the long-term care system.

Thank you for this opportunity to appear before you today.

Senator HEINZ. Thank you very much, Mr. Halamandaris.

[The prepared statement of Mr. Halamandaris follows:]

PREPARED STATEMENT OF BILL HALAMANDARIS

Mr. Chairman, this statement represents the view of four national home care organizations: Council of Home Health Agencies and Community Health Services of the National League for Nursing; Home Health Services and Staffing Association; National HomeCaring Council; and the National Association of Home Health Agencies.

We are pleased to have this opportunity to express our opinion on the implications of President Reagan's budget recommendations—particularly the proposed medicaid cutback—on older Americans. Against a backdrop of spiraling Government spending and double-digit inflation, we welcome this chance to help formulate strategies which do not perpetuate increasing demands for the Federal dollar.

Obviously, we support activities aimed at controlling Federal expenditures. However, unless policy revision accompanies spending decisions, we feel that this exercise will be doomed to failure. Indeed, unless there is a careful reappraisal of current long-term care policies under title XIX and accompanying legislative/administrative reform, we believe that the proposed cap on Federal financial participation in the medicaid program will merely aggravate the inefficiencies inherent in the system. For this reason, we recommend the enactment of legislation which would stimulate more appropriate and cost-effective use of long-term care resources in the medicaid program. Specific recommendations include:

Eliminating financial incentives for the use of institutional rather than noninstitutional services.

Authorizing comprehensive "homemaker-home-health aide" services under titles XVIII and XIX.

Exploring alternative methods of reimbursement to encourage more efficient service delivery.

Let me elaborate on each of these issues separately.

FINANCIAL INCENTIVES FOR INSTITUTIONAL SERVICES

As this committee is no doubt aware, medicaid eligibility criteria in most States provide powerful incentives for institutional placement. Even those States which do not require pauperization prior to medicaid eligibility require evidence of such outstanding medical expense that, in general, individual recipients do not have the means to maintain themselves independently in the community. This "institutional bias" is compounded by the fact that public expenditure for social services and community housing arrangements—which can often make the differences in helping a person to live independently—have been limited to date. The result is that, except in New York, few funds have been spent on home care under medicaid.

About 3.5 million noninstitutionalized older Americans are "functionally dependent." These people are increasing by 100,000 each year. By the year 2030, an estimated 7 million persons will fall into this category. One-third of these functionally dependent people are homebound and bedfast.

It is estimated that if current patterns are unchanged, the number of nursing home beds will increase by 50 percent in the next 20 years. Recent studies indicate that between 10 and 40 percent of those older persons currently residing in nursing homes could be transferred out if appropriate supportive services were available in the community. Such findings—coupled with copious research documenting that homebased care can be less costly and disruptive than institutional care—provide us with solid ground on which to challenge eligibility policies which foster unnecessary nursing home placements. Whether or not present nursing home residents are moved back to the community, ways must be found to change the utilization patterns and prevent such inappropriate placements from continuing.

In December 1979, Congressmen Waxman and Pepper introduced legislation [1] which would have authorized the D/HHS Secretary to make Federal payments for home care at a rate higher than payments for other services under title XIX. Such financial incentives would provide the needed support for fiscally constrained States and localities to alter their mix of long-term care services, thereby allowing chronically ill or impaired older persons the option of maintaining themselves in the community with adequate home-based services. Moreover, we feel that these incentives would curtail the current practice of some State medicaid departments in setting reimbursement rates for home-health agencies at unrealistically low levels, a practice which has had the unfortunate consequence of essentially eliminating home care as a service to medicaid recipients in these States.

We therefore urge that the 97th Congress enact legislation to increase the financial matching rate for home-health services under title XIX.

COMPREHENSIVE HOMEMAKER-HOME HEALTH AIDE SERVICES

The limited availability of social service backup has been a major barrier to the increased use of home-health services in this Nation. When an older person is in a nursing home or other institution, the provision of such "environmental" tasks as meal preparation, light housekeeping, laundry, and the like, is taken for granted. Such environmental services must be available in a comprehensive fashion with personal care services in order for that person to maintain him or herself in the community.

Unfortunately, the current situation in this country is far from comprehensive. In some cases, individuals are able to receive environmentally focused "homemaker"

[1] H.R. 6194, "The Medicaid Community Care Act of 1980."

services under title XX of the Social Security Act or title III of the Older Americans Act. However, such services are in limited supply because of close-ended Federal grants. Furthermore, the fragmentation and confusion caused by having two separate workers in one home—the home-health aide and the homemaker—are costly and counterproductive. We urge that comprehensive "homemaker-home-health aide" services be authorized under title XVIII (and, by proxy, title XIX) to insure that older persons receive the environmental assistance they require to maintain themselves in a noninstitutional setting.

ALTERNATIVE PROVIDER REIMBURSEMENT METHODS

Current methods of provider reimbursement under titles XVIII and XIX offer little incentive for service efficiency. Generally, home-health providers are reimbursed on the basis of reasonable costs, as determined retrospectively by the fiscal intermediary. This approach has spawned costly retroactive denials, which are not uniformly applied from one intermediary to another, and delayed payment in some instances, creating serious cash-flow problems.

We feel that new approaches to provider reimbursement should be explored in an attempt to stimulate some efficient delivery of home-health care.

OTHER ISSUES

The recommendations which we propose to this committee would impose needed, incremental modifications on the existing system. We believe this to be more expedient, more equitable, and less costly than other proposals with which we are familiar, including a long-term care cap. From our perspective, without any Federal incentives for home-based care, a long-term care cap would generate unfair competition for scarce resources between institutional and noninstitutional providers—competition in which noninstitutional providers would fare poorly.

BLOCK GRANTS

Before closing, it would be remiss if I did not reflect our concern over the proposed cutback and consolidation of social service and health programs in block grants to State and local governments. The title XX program, one of the many programs targeted for consolidation, has been operating under a similar block grant approach for over 5 years, and its history is far from encouraging. Other block grant programs have demonstrated similar problems. Based on these experiences, we predict that the following problems will emerge under a block grant approach:

Diminution of quality control and accountability.—In the absence of Federal quality control (standard-setting and monitoring) mechanisms, fiscally constrained State and local governments will skimp on their oversight responsibilities. Faced with difficult and complex resource allocation decisions, they may not, in fact, carry out the intended goals of the U.S. Congress and Federal administrative departments. Accountability for the expenditure of public funds will be diminished.

State and local bureaucratization.—Although Federal administrative slots will be reduced, it is realistic to assume that an equal number, if not more, will be needed at the State and local levels.

Unfair competition for scarce resources.—When groups are forced to compete for scarce resources, decisions will be made politically and on the basis of what is available. Services without a highly vocal or politicized constituency will lose out in the foray. The most vulnerable would have the least chance of receiving services.

In sum, while we believe that State and local governments are capable of meeting the challenge which block grants present, we recommend a stronger Federal role in standard-setting, monitoring, and focusing the services to be provided, as well as providing resources with which States and localities may purchase needed technical assistance and consultation.

CONCLUSION

Mr. Chairman, we have attempted to bring before you today a series of constructive recommendations for working within the President's proposed budget to insure that older Americans receive the most effective health and social services which we as a society can provide. We believe that the gross imbalance in this Nation's allocation of long-term care resources—over 90 percent of all public long-term care expenditures [2] —needs to be redressed.

We pledge our support in working with you to accomplish needed changes in the long-term care system.

Thank you for this opportunity to appear before you today.

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[2] Congressional Budget Office, "Long-term Care for the Elderly and Disabled," 1977.

Senator HEINZ. Let me ask this:

Dr. Bell, I was a little unclear in your presentation whether you were strongly opposed or moderately opposed or you did not oppose the medicaid cap.

Dr. BELL. I was successful in my presentation.

Senator HEINZ. Yes; I thought you were.

So that I know what your position is, would you care to state it more clearly?

Dr. BELL. Well, first, we believe that nursing home care is currently the best buy you have in health care and we believe if the cap is to be imposed, there has to be some assurance that there is adequate provision for funds to be available to take care of the current caseload and the projected caseload of nursing homes. I would be less than candid, Mr. Chairman, and members of the committee, if I said that I do not think it is fair to make the nursing home the scapegoat for budget problems in the medicaid program.

If we are going to have cuts, then there have to be related cuts in what is expected that nursing homes should provide, but let us not go back to the situation where we expect a provider of services to provide one thing and we are willing to provide something else.

The second thing is that in relation to this, I really believe that it would be possible to accomplish the savings, the dollar savings which the administration seeks to achieve through the caps, through the implementation of other regulatory changes, some of which I enumerated in my testimony.

Senator HEINZ. Now, one of the changes that was proposed by the National Governors' Association; that is to say, capping only long-term care under medicaid has drawn, as I understood it, fire from you and from Mr. Crowley; I do not think you commented on it specifically, Mr. Halamandaris, or Dr. Ackerman.

May I have your comments on whether you—what you think the National Governors' Association proposes is equitable?

Dr. ACKERMAN. I think we would be opposed to that.

Senator HEINZ. You think you would be opposed to that?

Dr. ACKERMAN. I think we support the cap across the board.

Senator HEINZ. But not capping just the components of medicaid?

Dr. ACKERMAN. No.

Senator HEINZ. Mr. Halamandaris.

Mr. HALAMANDARIS. I think I mentioned quickly in passing that we thought it was unrealistic. We do not believe in general that the answer to our problems will be in capping programs or even in redesigning the mechanisms for redistributing Federal funds. In order to achieve long-term savings, given the exploding needs that we have in this area, the programs will have to be redesigned and the areas have to be redesigned as well as the overlap between governments.

Senator HEINZ. Now, many people have said that one of the reasons that you cannot justify a cap on medicaid expenditures is that the way the program operates with the large number of federally mandated restrictions, that many of those restrictions, some of which have been mentioned by some of you, are counter-

productive; as some of you have mentioned, there is an incentive for inappropriate institutionalization; there is not sufficient patient outcare; there is very little, as we all know. I think Mr. Halamandaris said New York is the only State that was doing anything with home-health care of any significant amount under the medicaid program. Others say that too frequently, medicaid recipients are hospitalized when they could be treated on an outpatient basis.

To give you a tough question, why, if all this is true, is not the right conceptual approach to say we are going to give medicaid less money but we are going to give the States a good deal more freedom from the Federal strictures and let us not get into the argument of whether it is through waivers or regulatory changes for the moment.

What is wrong with that principle?

Dr. BELL. Mr. Chairman, may I attempt to respond?

Senator HEINZ. Yes, Dr. Bell.

Dr. BELL. I was asked a question by Secretary Weinberger when he was the Secretary of HEW, "What are you doing to contain costs?" That was the question put to me. I responded, "What are you doing to reduce the cost of Government regulations?" His response, very quickly, and I believe honestly, was: "Nothing."

We believe the public wants better nursing home care.

Our costs are the market basket for food and clothing which you or anyone else in this room or anyone else pays for.

Now, if you can assure us that those are not going to increase, we could say, sure, we will go along with the cap. But 60 percent of our costs are for labor. What are you going to do about minimum wages? What do you want to do about the wages of aides in nursing homes that essentially are at the minimum wage? We cannot pull any magic out of the box, but we can deal with the realities of life in the United States today as probably the best health care managers you have got of any service that is being provided to you. That has to be my response.

We are providing a personal service to the residents in our facilities 80 percent of whom are widowed women. We believe that we now are the most efficient health care managers you have. You were very perceptive, Mr. Chairman, in making the observation with regard to the political attractiveness of cutting funds to the medicaid program.

We are dealing with the poorest of the poor, those who have no voice in public policy. That is what we have in nursing homes.

I get criticized sometimes because I say the problem that most of our beneficiaries or residents have is that they lived too long and people immediately seize upon that and say, I would do away with them.

All I am trying to emphasize is that they have lived so long that all of their resources are gone. I am sorry to be so long in my response, but I think those things have to be entered into the record, because we are trying to provide quality service but we cannot do it without adequate funds.

Senator HEINZ. Any further comments on my question?

Dr. Ackerman.

Dr. ACKERMAN. Only that we basically agree with you as outlined in our testimony, the concept of the cap.

Senator HEINZ. That I noticed in your testimony.

Dr. ACKERMAN. Allowing some flexibility for those areas that experience unusual problems.

Senator HEINZ. What we have from the panel is one person, one representative in favor of the cap, two opposed, and the fourth—well, we will see how it works out.

Dr. BELL. That is correct.

Mr. CROWLEY. Mr. Chairman, to answer your question, I would like to make this comment:

When I first read and looked at the administration's proposals in terms of the cap on medicaid, I thought that they showed a clear lack of understanding of the interrelations, interaction between Government programs and I was hoping that was the case; because that would be simple enough.

However, I am convinced that they do understand the interrelationship, and yet, in the interest of economic pressures, still want to pursue this particular approach.

The concern that we try to delineate in our testimony, and that comes through, I hope, is that while there can be flexibilities for the State and there can be effective cost reductions, it cannot be done by the simplistic notion that putting a lid on expenditures alone is going to effect that change.

There are just too many interrelationships.

Dr. Bell pointed out that, as a result of initiatives in mental health, increasing numbers of people have left mental institutions. Many of those people are now in nursing homes. Those kinds of interactions, Senator, do not lend themselves to simplistic answers.

Senator HEINZ. Let us talk about interaction.

One interaction that was proposed last year—it was not accepted as part of the reconciliation bill—was the elimination of the freedom-of-choice provisions under medicaid. What was provided, what was proposed instead was a change for a prudent purchaser rules and activities. Let me ask those who want to comment what you would project to be the impact of eliminating the freedom-of-choice rules under medicaid; how that would impact physician participation?

Let me address that first to Dr. Ackerman.

Dr. ACKERMAN. I think it would affect physician participation adversely, Senator. The AMA was opposed to this concept when it was discussed last year. We have had some personal experiences in California with this particular problem, some 10 or 12 years with prepaid health plans, and it did not work out well. I think it is our position that the present multiple option choice is in the best interest of the people.

Senator HEINZ. Do each of you feel the same way?

Mr. Crowley, do you?

Mr. CROWLEY. I think that it would make it—the physicians would.

Senator HEINZ. Mr. Halamandaris.

Mr. HALAMANDARIS. Yes, sir; particularly when in our case the consumer has very little to say about the service that they are acquiring.

Senator HEINZ. Dr. Bell.

Dr. BELL. I think we are in favor of the proposal, Mr. Chairman.

Senator HEINZ. My time has expired.

Let me recognize Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman.

My questions deal with more general approaches and maybe are more philosophical than some of the specifics you dealt with. I have a question to ask Mr. Halamandaris on whether or not, in regard to home-health care, you personally see a linkage or connection between homeownership and how it relates to senior citizens. Basically, that people who have been in their homes a long time, one of the crisis periods in their lives is when they want to leave.

Homeownership and the concept of home-health care.

Mr. HALAMANDARIS. Yes, sir; I do see a very direct connection, and one of the large problems we have with the current system in the way it is structured is that it forces the decision of selling that home in many cases, and going to an institution, and once that is done, to pay for the cost of institutionalization or whatever else; there is no way that you can return that patient to the community. So they are locked in.

I think there is a direct correlation, yes, sir.

Senator GRASSLEY. So then you would see the concept of home-health care and the maintenance of people in a home that they have owned for a long time directly related, not just to home-health care, but in a more general sense of noninstitutionalized?

Mr. HALAMANDARIS. Yes, sir; I do think that is the case, and, really, what I have been trying to say here today, is what we are after is a better relationship of all of these programs, so the appropriate level of service can be found in each case, so that they can reinforce each other, and in the long term, service can be provided more economically.

Senator GRASSLEY. OK. Then I wanted to ask Mr. Crowley whether or not you are opposed to the concept of block grants per se.

Mr. CROWLEY. Well, our association does not have a blanket position on block grants per se. In the particular case of health services and medicaid, we are opposed to a block grant.

Senator GRASSLEY. OK. But it is not against the concept of block grants?

Mr. CROWLEY. No, sir.

Senator GRASSLEY. Following up on that, then, since you would support what I would refer to as categorical approach, as opposed to block grants approach, do you feel that there ought to be then, as is generally connected with categorical grants, a great deal of policymaking within Washington as opposed to the block grants approach which leaves great discretion to local and State governments?

Mr. CROWLEY. I think that the time has come, as we have lived with categorical programs for several years, decades, now, for realization that there is perhaps too much regulation and direction from the Federal level.

What we tried to point out in our testimony is that while maintaining a categorical identity, there can be more flexibility at the local level; there should be some basic Federal minimum standard for quality and level of services. But beyond that, the States should be provided more flexibility now.

So that the relationship between the States and Federal becomes much more——

Senator GRASSLEY. Again, in a philosophical vein, then, you feel that there should be more discretion left to the local and State community even within the concept of a specific narrow categorical program?

Mr. CROWLEY. Yes, we do.

Senator GRASSLEY. The reason I guess I push on this is, last week, we had some evidence of people who testified, who kind of felt like while the only solution to these problems must come from Washington, that somehow we in Washington had the only resources and the expertise and compassion and all; they were really expressing very little confidence in State and local officials and you do not share that view?

Mr. CROWLEY. We have to be realistic about how quickly the States could pick up and administer the heavy burden that would be placed upon them; what kind of skills and infrastructure they have.

Before I came to Washington, I worked in State government in Ohio, and I have fond regards for people in State government and their capabilities.

However, there have to be realistic notions about what the States are ready, willing, and able to accept and implement; and I do not think that has been thought through in the administration's proposals.

Senator GRASSLEY. Mr. Chairman, did you raise the question about amending current laws and regulations to stop the use of blanket waivers?

Senator HEINZ. No; that was commented on by a number of the witnesses, but I did not address that question.

Senator GRASSLEY. Could I zero in on that as the last question? Because I thought maybe you addressed that point, and I would like to specifically address it to Dr. Bell, to explain why you favor amending current laws to the use of blanket waivers in order to give the States the flexibility to achieve savings in the medicaid program.

Dr. BELL. We believe that waivers are arbitrary and that they are subject to bureaucratic whim. We believe it would be better for the Congress to be specific in determining the scope of State authority by amending restrictive legislation which would be supplemented by complementary changes in regulations by the Department of Health and Human Services.

The States would then know exactly their range of options.

Senator GRASSLEY. Mr. Chairman, I do not have any other questions.

Senator HEINZ. Very good. Thank you, Senator Grassley.

I want to recognize Senator Durenberger, but before I do, I want to point out that we are delighted that he is here, because he also serves as the chairman of the Health Subcommittee of the Senate Finance Committee.

STATEMENT BY SENATOR DAVID DURENBERGER

Senator DURENBERGER. Of course, I am a member of that committee and this committee, which gives us both the opportunity to spend a lot of time learning about health care in this country.

As I listened to the questions, I sit here very frustrated about the fact that I do not think we are getting any answers or we cannot get any answers either from you, or from us up here, or from this administration, about where we are going, where we are really headed in this country, and that is very frustrating, because I would like to sit here and ask you a question about your feeling on the Federal Government taking over the financing of health care for those who do not have their own resources; in other words, medicaid into medicare, have it administered basically at the State and local level; have it administered in a competitive health environment for various kinds of institutional and noninstitutional delivery systems, competing on the basis of quality and price for service, but that we here have the basic responsibility to make sure that people have equal access to those services and are not eliminated because of lack of financial resources, but I could ask you that question and you could say you are either for it or against it; and I do not know how relevant it is in what we are trying to get done this year, which is to operate within a basically $2 billion reduction in the subsidization of health care, the regulation of health care in America.

So let me just ask you each a couple of questions.

First, on the—if we are looking to the States for some direction, whether we trust them or not, the issue of capping or blocking, rather, long-term care, I think each of you in one way or another has addressed that one, but I am trying to find out if there is any consensus on where the problem lies in blocking long-term care.

Is it in the testimony of one of you, the competition between care for the aged versus the community care thrust for the mentally ill and the retarded? Is it competition, as we really have in my statement, and some areas between proprietary and nonprofit, which is influenced by the regulatory process within my State?

Is it the competition that one of you testified to between institutional delivery systems and noninstitutional delivery systems; or is it just the fact that you might have less money?

Mr. HALAMANDARIS. May I try that?

I think you have asked a fundamental question, Senator Durenberger. I will try to give you an answer in 20 words or less.

I do not have great difficulty with the block grant concept. There are problems there, but those problems can be minimized with effective controls. The gut problem, I think, is that we are not dealing with a static population. We are making projections and caps based on existing circumstances and existing costs and what that has done is set up the kind of competition you are taking about.

What we should be dealing with is some projection of our expected needs and some way to most effectively array the services to meet that need. I think that is the inherent problem.

Mr. CROWLEY. I would like to supplement that.

I think the question of the increasing population is important. Because whether we are talking about the elderly who need insti-

tutional care, or home-health care, or who are some way sick or frail, or dependent, or mentally retarded, we are talking about competition among groups of people who are in no way able to compete. It is not as though we are talking about competition of providers. We are talking about forcing groups of people who are already disadvantaged to struggle with each other in addition to the other elements they have to struggle against.

In our case, nonprofit homes have been around for several hundred years. I think that there will be an element of community response, if in fact there are cutbacks in Federal funding, but community response will not be able to match the resources of the Federal Government in caring for this group of people who need care. Therefore, from our point of view, it is not a provider issue; it is an issue of the groups of people who will be forced to compete with each other for services.

Dr. ACKERMAN. Senator, we did not address the specific issue in our testimony on block grants for long-term care. We did address the issue that it is our understanding now there are basically two blocks; one for basic health and one for preventive health; and we have some concerns of whether the issue would be best addressed with two block grants.

Perhaps there should be others, but we do support the block grants.

Dr. BELL. I find it difficult to distinguish between a cap and a block grant. That is the difficulty. I support what Mr. Crowley and Mr. Halamandaris said.

We have two specific States now that have placed a cap—Mississippi and Kentucky are proposing to limit to 80 percent of the beds in a nursing home that may be occupied by medicaid patients.

Why?

Any philosophical discussion? Any issue of that nature being raised?

No; it strictly deals with the capacity of that State to purchase the care.

Senator DURENBERGER. I do not know how we are being timed.

Senator HEINZ. I do not either, because our lights blew a fuse and the electrician is on the way. Why do you not go for one more question, and then I will recognize Senator Glenn.

Senator DURENBERGER. Maybe this was asked while I was in and out of the room; but the subject is the medicaid-medicare connection; has that question been asked?

Dr. BELL. Not really, Senator.

Senator DURENBERGER. Are any of you strongly opposed to our exploring that connection and, if so, is there some way that, on behalf of the poor and the aged in this country, there is some way that we could get a message to the President of the United States that his safety net might have some holes in it if he totally neglects the relationships between medicaid and medicare?

Mr. CROWLEY. If the safety net were a net that I had to jump into from a third story of a building, I think I would take my chances with the fire.

Our testimony enumerates several issues of interaction between medicaid and medicare. Our association would strongly support your efforts to pursue that interreaction, and we have several

suggestions that we think could effect cost savings on the medicaid side which would hopefully prevent the need for the cap.

Dr. BELL. I think one of the ways to provide fiscal relief to the States is for the Government of the United States to provide that benefit which it promised to the senior citizens; namely, 100 days of skilled nursing care under medicare.

If the patients that are now being taken care of by the States under medicaid, if skilled nursing services were to have those benefits paid by the medicare program, a benefit which was promised to the aged of this country, there could be significant fiscal relief to the States.

Senator DURENBERGER. Anyone else have any comments?

If not, I thank you very much for your testimony, which was terrific, and for your responses to my questions.

Senator HEINZ. Senator Glenn—who very much admires the comments of Mr. Crowley. You have used it on other occasions?

STATEMENT BY SENATOR JOHN GLENN

Senator GLENN. I might steal it to indicate our concerns, very serious concerns. I do not mean to make light of it.

Let me say that the reason why there are no more Democrats here this morning than there are is because we are meeting right now on this very subject in caucus in the Capitol. We are trying to decide where we are going to go and what recommendations to the budget resolution to have on the floor. I dropped out and I will have to get back.

The newspaper account of what is going on in the budget operation now on the floor of the Senate perhaps gives some misconceptions to you gentlemen and to the public in general. What is going on is a formulation of recommendations to the committee. They are that—recommendations. They are not firmly locked in by law; they are indications of where we think we should go, but they do not firmly bind those committees to the specific figures that you sometimes see in the newspaper. So if you see things being cut up or down to a level that you do not want, do not despair too much; they are indicators and they express the will of the Senate, of course, but changes can still be made.

I think it is important that the Senate Special Committee on Aging is conducting these hearings. I compliment the chairman on calling the hearings, because there is a great deal of concern that older Americans will be particularly hurt by cuts in Federal programs and proposed changes in the social security system.

To me, the programs that we are talking about here are the ones that are the most sacred from budget cuts because they affect people who are beyond their normal working years.

The people who are living on social security, or other minimum retirement incomes, do not have the same flexibility of adapting to our current economic situation as those of us in our more productive years. Over and over again, we have all heard from senior citizens that inflation is the No. 1 problem they are facing.

Let me say this: I think if there is to be change, then one of the most important things is that we give time to adapt to whatever that change is going to be. That is where we can get in a real bind, it seems to me. Many of these programs became Federal programs

because the States had not acted to take up what was a real tremendous need of our citizens. To just suddenly now say, well, the Federal Government is spending too much, so we now have to give this back to the States and they will somehow take care of this, that just is not likely to happen.

If we cut these programs, the States are not going to suddenly say, oh, my goodness; there is a big need here; we will increase our taxes and take care of these needs. These programs became Federal programs for people who cannot adapt in our society simply because the States did not do anything in the beginning.

I have not seen any States come forward, any Governors come here and say, yes, I think it is a good thing; I am upping the taxes in my State to take care of the people less able to take care of themselves in our society.

Senator HEINZ. The National Governors' Association is going to be testifying in the next panel. We will find out what they have to say.

Senator GLENN. I think it is the timing of how we do this, how we phase out Federal support for what programs, and give the States time to adapt. It would have to be several years. Give States time to adapt. To me, it is critically important because we are likely to do irreparable harm to many millions of people in this country.

Having said that, I think it is clearly the mandate of the Congress and the administration to stabilize the Nation's economy, and I agree with President Reagan completely that Federal spending must be brought under control, but not through a wholesale dismantling of programs which grew out of the needs of the citizens of this country.

I will continue to support programs which will protect people, such as many older Americans, who have placed their faith in our Government, and who cannot now defend themselves.

Now, how do we provide for long-term care needs of our elderly population? The programs that we are discussing today—medicaid, title XX social services, and the Older Americans Act—are all important in meeting these needs.

I am concerned that the proposed medicaid cap will adversely affect the availability of high-quality nursing home care. And I am concerned that reductions in medicaid and social services will cause a decline in the availability of home- and community-based health and social service programs—services that make it possible for many older Americans to remain independent.

There are many important questions to be discussed and I am sorry I could not be here for all the session this morning.

I will read your testimony, will go over the record and, Mr. Chairman, I would hope that we would still be able—Mr. Chairman, can we still submit questions?

Senator HEINZ. Yes; by all means.

Senator GLENN. I would hope that after we go over the transcript that you gentlemen could respond to written questions so that they could be part of the record as we consider this very vital problem.

Thank you.

Senator HEINZ. Thank you, Senator Glenn.

I, too, am going to submit questions for our group, but there a couple of important questions I would like to address.

In particular, I would like to address one to Dr. Ackerman, with the possible results of the implication of this cap, which would be the lowering of imposition rates to physicians.

We already have a relatively low rate of physician participation under medicaid. I understand that approximately 40 percent of physicians do not participate in medicaid. Given the fact that reimbursement rates are already low under physician participation, that they are relatively much more generous, at least certainly much larger in dollar amounts when it comes to hospitalization for acute-care purposes, what impact do you think the cap might have on the already low imposition of rates on physicians?

Do you think it would be lowered further and, if so, do you think more physicians might drop out, or do you think it is unlikely that the physician rates would be reduced further?

Dr. ACKERMAN. Senator, physicians, since the outset of the program, have been receiving fees which are lower than usual fees. I use that term in the sense that physicians have been subsidizing the medicaid program since its onset.

In California, since inception of the program, we have had a 2½-percent increase in 1969, and just 2 years ago, an increase that varied from 7 to 20 percent depending on your specialty. So we have been doing this, subsidizing the program, and I would assume that physicians will continue to participate in the program, we could also make the case that perhaps by increasing fees to providers, you could save the program money.

Let me give you an example of that.

One of the common sources of care for the medicaid patients is the emergency room of the hospital.

The patient, if he went across the street to the doctor's office, might have trouble getting an appointment because they are going to pay only $8 or $9 for that office visit.

The patient will take the same complaint across the street to the emergency room; the State will be billed $42, and the hospital will get the whole $42. I think there is a good point to be made, that by increasing fees to physicians you could actually save this program money. But I do want to stress that physicians have participated in this program from the onset, have subsidized it from the onset, and certainly are concerned about the care of the elderly and the needy.

Senator HEINZ. Any other comments on that?

No?

Very well.

Let me ask Mr. Halamandaris a question on block grants.

I assume that many of the home health agencies you represent attempt to coordinate home-base services under title XX, medicaid, medicare, Older Americans Act, title III; how successful are the home-health providers in coordinating these efforts; and also, what is the expense both to the providers and the patients, associated with the coordination of services under these programs?

Mr. HALAMANDARIS. Senator, there are a number of agencies that I am aware of that try to coordinate their activities under these very titles. It is difficult, if not almost impossible, to do that.

You find agencies that are caught between the cracks. There are excellent examples in vogue right now relating to the medicare cost report for home health agencies and the basis by which overhead is allocated.

As a consequence, we have a range of other programs that are now the subject of renegotiation. Obviously, these things are difficult. So agencies are faced with the ground rules that have changed. That is a continual problem and the cost—I cannot give you a dollar amount—but I know it is enormous in terms of time and effort.

The real cost, however, is to the program; because what happens in most cases is that people have a need they try to meet—and they cannot meet it with the entitlement of one program. Since they are generally talking about the same people, they slide them back and forth from one program to another. They go off the title XVIII and go on to title XIX and other funding sources, title XX, what have you. So there is a shell game that is being played in some cases that is unnecessary.

Senator HEINZ. Very well.

One last question and I will yield to Senator Grassley.

Mr. Crowley, you indicated in your testimony that PSRO review and long-term care has been a punitive effort to restrict patient care to solely the medical model.

Can you clarify to the committee what the experience of your facilities has been with the PSRO program and is there any evidence that PSRO medical care evaluations have improved the quality of care for institutional long-term patients?

Mr. CROWLEY. I do not have any evidence in that respect, Senator, that it has improved the care. Our guess is, because there is such a heavy emphasis on the medical needs of the person that, in fact, the whole person gets overlooked.

Our concern is that in long-term care, health is obviously a big factor, but it is not the only factor, contrary to a person's reasons for being in a hospital with a medical condition of acute consequences at that time.

With the chronic older person, there are whole life aspects as to why there needs to be placement.

The PSRO review is concentrated on health issues and overlooks the other aspects of the person.

Our concern is that while it may be adequate for medical review, PSRO review is so shortsighted that it misses the whole person. Therefore, decisions are made not necessarily in the best interests of the recipients. That is the extent of this comment and why we are concerned about PSRO review.

Senator HEINZ. Senator Glenn.

Senator GLENN. I have no further questions.

Senator HEINZ. Gentlemen, I will submit a number of questions to you and other members may also do so.

We thank you for your being here. You have made a valuable contribution, and we appreciate your testimony.

Let me ask that, first, Senator Glenn, who is now down at the witness table, be recognized to introduce a special guest of his.

Senator GLENN. Thank you, Mr. Chairman, and I do appreciate this consideration.

I just want to be here to take part in introducing Dr. Stanley Broadnax to the committee. He is from Cincinnati, Ohio, and I will not read over all of his credentials, but he is particularly well qualified to testify on these matters today.

He is commissioner of health of Cincinnati. He directs the largest health department in the State of Ohio. He is the project director for a network of 12 community-based health centers that have both Federal and local sponsorship and he is also project director of the municipal health services program which facilitates needed primary health programs sponsored by municipalities.

He has advanced degrees in public health. He is assistant professor of medicine at Cincinnati and is here today to represent the U.S. Conference of City Health Officers, of which he is on the board of trustees.

So I think his credentials, his background, make him particularly well qualified; and I am glad to take part in introducing him to the committee today.

Thank you very much.

Senator HEINZ. Senator Glenn, thank you.

Let me ask that Mr. Broadnax make his statement first and then we will have Mr. Curtis, and then Mr. Callahan.

STATEMENT OF DR. STANLEY E. BROADNAX, COMMISSIONER OF HEALTH, CINCINNATI, OHIO, REPRESENTING THE U.S. CONFERENCE OF CITY HEALTH OFFICERS

Dr. BROADNAX. Thank you, Senator.

Mr. Chairman and other distinguished Members of the Senate, on behalf of the hundreds of members of the U.S. Conference of City Health Officers and Conference of Mayors, I want to express their collective appreciation for being allowed to share with you our collective opinion on the block grants and our concern regarding the impacts of the proposed medicaid cap.

In the long term, this has potential for significantly damaging the structure of the Nation's health care delivery system, especially as it relates to the poor and the elderly and the potential to cause deterioration of the health status of the poor and the elderly.

It is important to note that both the city health officers and the Conference of Mayors have gone on record as endorsing and encouraging well-founded and well-planned efforts to curtail health care costs. However, we have serious concerns that the medicaid cap, as outlined to occur in the near future, does not allow adequate time for planning in order to make the wise and prudent decision that must be made in order to avoid radical and devastating changes to the Nation's health care delivery system or change in the health care status of the poor and the elderly.

I am here to give a critical analysis of the impact of the cap.

My position on this issue, as a professional health administrator, a physician specializing in internal medicine, and as a businessman, is consistent with my many colleagues and in the cities represented by both of our organizations.

First, let me reiterate that we support the goal of making the medicaid program more cost effective. We welcome the opportunity to help; we offer our services and experience to assist in planning, development, implementation of cost-savings measures.

We urge a cautious, well-planned approach to making changes in this medicaid program. This issue is a matter of life or death and, for many of our citizens, it may mean a life not worth living.

I would first like to address the block grants.

Consolidation of over 40 health and human resources programs into a single block grant is a trouble approach to cost containment. City health officers have heartily supported the concept but find many problems related to the proposed program.

The Conference of Mayors and City Health Officers seek a block grant that groups logical programs, offers realistic funding, includes mandatory passthrough to local governments and allocates funds in a judicious manner.

Let me just address one of those programs.

As far as health programs, health programs need to be separated from human service programs in any block grant scheme. At a minimum, a health program block grant should distinguish preventive and curative services.

With respect to funding, a level of funding that provides 75 to 80 percent of the current dollars is not sufficient. Local and State governments are already finding it difficult to maintain core service levels currently.

Inflation teams with cuts and would cause the elimination of services nowhere else available including the private sector. Moreover, as States and local governments will be required to reorder their administrative systems, at the outset of this block grant conversion, considerable funds will be necessary for this task.

On the topic of passthrough, local government must be guaranteed a receipt of a certain percentage of funds in order to adequately provide for the public health services to the medically needy. Decisions must be made regarding the distribution of funds.

We propose targeting basic services on a formula comparable to that developed by the health incentive grant 12143D program. This formula was designed and approved by city, county, and State health officers under the guidance of the Center for Disease Control.

With respect to the medicaid cap, our examination will cover three basic issues. I will be speaking on the budget cuts versus the national health expenditures, an increase in that expenditure; the drastic change in the health care delivery system and deterioration of health care status of the elderly. Budget savings—the medicaid cap will not result in cost savings to the public. It will shift the cost of health care to States, counties, and municipal governments.

In many large and urban areas, especially in the Northeast, North Central, governments are confronted with escalating costs, shrinking tax base, and high unemployment. In these same areas, the population are aging ones with fixed incomes, eroded by inflation. Many local governments will be unable to absorb this shift of financial responsibility. Consequently, there will be a need to deny eligibility and services to thousands of the poor and the elderly.

What will happen with this decreased or eliminated medicaid benefits to millions of the poor, we will not be—they will not be served in the private sector. They will seek care in expensive hospitals for routine episodic care. The public hospital, upon whom enormous caseloads will probably be dumped, are forced to subsi-

dize the care; both private and public funds will be forced to subsidize the care. It will be distributed to all first- and third-party payers by increasing hospital charges. This will lead to higher insurance premiums, paid by all of us.

The net result is the national health care expenditure will be dramatically increased when compared to the potential of saving of the Federal budget.

We can pay now or pay more later because the cost will be passed to all Americans through the higher charges to cover the cost.

Let us discuss momentarily the impact on the health care delivery system. Let us look at the private industry.

There is already considerable reluctance by many private providers to accept medicaid patients because of the low patient-mountainous paperwork, and delay of payments.

In one large city, we found in a telephone survey, that 80 percent of the local physicians did not accept medicaid patients. Private physicians, pharmacists, and other health providers who would want to serve our patients but cannot afford to; would begin to close their doors to the medicaid patients and to those who are no longer eligible.

Cash-flow problems have increased and would be increased to these same providers which would cause them to eliminate and close their doors.

Again, the cost would be passed through to all citizens; community health centers have delivered early detection, early prevention programs which have basically kept our senior citizens and the poor population healthy. These centers depend upon medicaid payments in order to function. A cut would decrease their ability to provide these preventive, education, and early detection programs, and what we would see is a deterioration of health status of the elderly and the poor; they would then need to go to hospitals and other expensive forms of care, in-hospital or in-nursing home care would increase; the overall health expenditure would increase.

The door to this would also close. The nursing home industry has been talked about.

But the important thing I want to emphasize, the national health expenditure overall will increase with this momentary decrease in the Federal budget, the impact on the health status of the poor could be devastating.

I would like to offer just a few alternative proposals which would achieve similar reductions in expenditures.

For example, medicaid cost containment programs might unify and streamline billing and payment procedures for medicaid and medicare programs; restrictions on provider participants whose services are excessive, unreasonable, and cost-excessive; imposition of nominal, income-sensitive copayments and deductibles; excessive and duplicative reporting requirements of federally supported health services should be reviewed as a means of reducing health costs.

I would certainly appreciate the opportunity to express our concerns. The city health officers and the Conference of Mayors certainly back, as I mentioned; cost containment would help, but we should be very clear, our steps should be very difficult, well

planned, and I think at this particular time, there has not been enough time to plan.

We are willing to help; we are willing to cooperate, and we certainly hope that our Congress will act in the best interests of our elderly.

Thank you.

Senator HEINZ. Thank you, Dr. Broadnax.

[The prepared statement of Dr. Broadnax follows:]

PREPARED STATEMENT OF DR. STANLEY E. BROADNAX

I. INTRODUCTION—CONCERNS

On behalf of the hundreds of members of the U.S. Conference of City Health Officers and the hundreds of members of the U.S. Conference of Mayors, I express their collective concern around the potential damage to the structure of this Nation's public health system and the health status of the poor, the elderly, the young, and the disabled.

II. CURTAILING COST: ALLOWANCE OF ADEQUATE TIME FOR PLANNING

Both organizations have gone on record as endorsing well-founded and well-planned efforts to curtail health care cost. We further commend the intent of Congress, the administration, and Secretary Schweiker to control cost. However, for the medicaid cap as outlined to occur in the near future does not allow adequate time for planning in order to make the wise and prudent decision that must be made in order to avoid radical changes in the health care delivery and health status of the poor and the elderly.

III. WE OFFER OUR ASSISTANCE

I am here to give a critical analysis of the ramifications and dynamics from my unique perspective of being a public health administrator, a physician specializing in internal medicine, and as a businessman.

My position on this issue is consistent with my many colleagues whose cities are represented by both organizations. We support the goal of making the medicaid program more cost-effective. We welcome the opportunity to help; we offer our services and expertise to assist in the planning and development and implementation of the proposed measure. However, we urge a cautious, well-planned approach to make changes in this medicaid and other health programs which are a matter of "life or death or a life not worth living" for millions of America's poor and elderly.

IV. MEDICAID CAP

Our examination and analysis of this issue shall be in three major categories:

(A) Impact: Decrease budget savings versus increasing of the national health care expenditure.

(B) Impact: Drastic changes in the health care delivery system.

(C) Impact: Deterioration of health care status of the poor and the elderly.

A. Budget Savings and National Health Care Expenditures

The medicaid cap will not result in cost savings to the public. It will shift the cost of health care to the States, county, and municipal governments. In many large urban areas, especially in the Northeast, North Central, and Midwest, governments are confronted with escalating cost, shrinking population, shrinking tax base and high unemployment. In these same areas, the populations are aging ones with fixed incomes eroded by inflation. Many local governments will be unable to absorb this shift in financial responsibility. There will be a need to deny eligibility and services to thousands of the poor and the elderly.

With the decreased or eliminated medicaid benefits, millions of the poor and elderly will not be served by the private health care industry; they will be seeking care at expensive hospitals for routine, episodic care. The troubled public hospitals upon whom enormous new caseloads will be "dumped" will be affected. If the hospitals (private and public) are forced to subsidize this cost, it will be distributed to all other first and third party payors by increased hospital charges. This will lead to higher insurance premiums paid by all of us.

The net result is the national health care expenditure will dramatically increase when compared to the potential savings to the Federal budget.

B. Impact on the Health Delivery System

The medicaid program was designed to decrease the financial barrier to health care for many of this country's poor and elderly. It offered life preserving medical assistance to the truly needy.

More than 18 out of 23 million people eligible for medicaid are dependent children, or aged, blind, or disabled adults. For the low-income elderly, medicaid is necessary to supplement limited coverage under medicare. Over 40 percent of all medicaid expenditures are for the elderly. Forty-five percent of all medicaid eligible individuals are children.

Reductions in the services covered by medicaid and the amount of reimbursement would have serious impacts on the delivery system for the poor. Let's look at the private industry, community health centers and nursing homes:

(1) Private industry.—There has already been reluctance by many of these private providers to accept medicaid patients because of the low payments for services, mountainous paperwork, and delay of payments. In one large city in 1980, a telephone survey indicated that 80 percent of the local physicians did not accept medicaid.

Private physicians, pharmacists, and other health providers would close their door to medicaid patients and to those who are no longer eligible.

Cash-flow problems, which would increase with the medicaid cap, already are causing closing and reductions of services in pharmacies and community clinics. Many of these people will go to hospitals which will ultimately cost the entire national health care system (public and private) more dollars.

(2) Community health centers.—Care for the elderly in ambulatory care facilities particularly the Bureau of Community Health Services (BCHS) clinics provide preventive, early detection and educational measures. These have kept many of the elderly from more expensive institutionalized care, thus assisting in curtailing the increases in national health care expenditures. These BCHS centers are increasingly dependent on the medicaid payments (inadequate as these payments may be). Any significant loss of medicaid payments to these ambulatory facilities will result in reduction of services to all; but particularly the elderly and the young. This will result in an increase in the inappropriate use of hospital emergency services in all hospitals again. This is a more costly form of care than is provided in ambulatory clinics and is not comparable in quality because of its crisis orientation and lack of comprehensiveness.

In a report by the University of Chicago Center for the Study of Welfare Policy, it was noted that 41 percent of all medicaid funds are spent on the 6 percent of recipients who are institutionalized, primarily aged or disabled people in nursing homes. If medicaid expenditures are reduced and the elderly person's access to preventive and ongoing health services is limited, the percent of persons institutionalized or in nursing homes will increase.

We have 12 Bureau of Community Health Services centers in Cincinnati. Like many other cities, we have been working closely with: (1) Regional and central officials of Health and Human Services, and (2) the Robert Wood Johnson Foundation through its municipal health services program, and (3) HCFA, to provide quality services more efficiently, cost-effectively, maximizing productivity and maximizing program-generated revenue. The ultimate beneficiaries have been outpatients and the national health care system.

(3) Nursing homes.—Over 75 percent of medicaid payments for the elderly provide nursing home services. Urban nursing homes have a large majority of their patients dependent on medicaid funds. If a reduction in funds occurs, the preventive and rehabilitative services traditionally are abandoned first. The result will be the development of diseases more costly to treat than the cost of preventive measures. The patients will need hospitalization instead of nursing home care. The hospitals will pass the cost on to the private sector by increased hospital costs.

Occupational therapy, physical therapy, and nutritional services will be reduced in scope and quality which will result in minimal nursing and medical services for these patients. Quality of life will be reduced and essentially "warehousing" of the elderly in an institution will result.

C. Impact on Health Status of the Poor

The previous discussion says that with the decreased medicaid funds there will be fewer services geared toward prevention, early detection, and education. The health status of the poor will deteriorate. They will develop diseases which are more costly to treat than the preventive measures. They will also be receiving this treatment in more costly treatment centers.

The net result will be a deterioration of the general health status of the poor and it will cost the Nation more health dollars through cost in the private sector passed on to the general population.

V. ALTERNATIVE PROPOSALS WHICH WOULD ACHIEVE SIMILAR REDUCTIONS IN EXPENDITURE

A. Medicaid Cost Containment Program

(1) Unifying and streamlining billing and payment procedures for medicaid and medicare programs.

(2) Restrictions on provider participants whose services are excessive, unreasonable, and cost excessive.

(3) Imposition of nominal, income-sensitive copayments and deductibles. The latter would not place an excessive barrier to health services but would reduce the abuse often occurring with free service.

(4) Excessive and duplicative reporting requirements of federally supportive health services should be reviewed as a means of reducing health costs.

B. State/Local Government Cooperation To Implement

(1) Prospective reimbursement.

(2) Restrictions on provider participants whose costs are excessive.

(3) Elimination of statutory barriers to the development of HMO's and other capitation based programs.

SUMMARY

Thank you for this opportunity to express our concerns. The poor and the elderly are the group at highest medical risk with the most barriers to access (financial, distance, etc.) and whose collective health status is most sensitive to changes,.

The medicaid cap needs more planning and more specifics around its impact and implementation. Failure to do so could result in a higher national expenditure for health services by the general population and a deteriorating health status of the poor.

We look forward to working jointly with you to address the issue of curtailing health care cost.

Senator HEINZ. Mr. Curtis, we are glad to have you here representing the National Governors' Association. You are the associate staff director for health policy.

STATEMENT OF RICHARD E. CURTIS, WASHINGTON, D.C., ASSOCIATE STAFF DIRECTOR FOR HEALTH POLICY, NATIONAL GOVERNORS' ASSOCIATION

Mr. CURTIS. Thank you, Mr. Chairman.

Before commenting on the medicaid cap specifically, I think I should indicate that the Governors share the President's concern over the state of our economy, and agree that firm action must be taken to bring the economy back on track, including making reductions in Federal expenditures.

Governors are prepared to accept budget cuts in this context, but cannot support a nationwide cap of 5 percent on Federal medicaid funding as proposed by the administration because this undoubtedly would shift significant Federal costs to many States that already are unable to afford their medicaid programs.

This, in turn, would undoubtedly result in a number of undesirable consequences, including limitations on the availability of needed care. The NGA believes that we have developed a responsible alternative mechanism to achieve the desired savings.

As you know, many States' budgets have been affected severely by medicaid costs, which constitute a much larger proportion of State budgets than of the Federal budget.

The recession has caused reductions in State revenues, medicaid caseloads have risen sharply in some States, and medical care costs have risen dramatically nationwide.

About three out of five States are facing significant difficulties in funding the program, and many are finding that despite cutbacks in medicaid, the programs' continuing cost increases are forcing reductions in other important State responsibilities; for example, State education funds.

The States desperately need greater flexibility to reduce medicaid costs and we have developed specific recommendations in this regard.

We believe that in order to responsibly reduce medicaid costs, we must focus on those aspects of the program that constitute the cost problem. The largest and most rapidly growing portion of medicaid expenditures is institutional care. If we are to reduce medicaid cost increases, we must effectively deal with the 75 percent of program expenditures that go to nursing homes and hospitals.

Even if given additional flexibility, State medicaid programs have only a limited ability to influence hospital costs that currently are rising at 18 percent a year. This is true particularly when no revisions are planned for the far larger medicare program's inflationary cost-based reimbursement policies. The State and local share of medicaid constitute only about 4 percent of national expenditures on hospital care, while Federal medicare and medicaid costs constitute 30 percent. Furthermore—and this is very important, medicare expenditures are relatively evenly distributed across hospitals while medicaid tends to be concentrated on hospitals that serve large numbers of the poor.

If we try to reduce substantially medicaid reimbursements only, we are going to most adversely affect those hospitals that are already faced with tight fiscal situations. In this context, we are asking that the Federal Government shoulder its fair share of the responsibility for reducing Federal costs and replace inflationary medicare cost-based hospital reimbursement policies with prospective policies that do not encourage or subsidize waste.

Let me emphasize that the Governors strongly believe that Congress must seek cost reductions in the Federal medicare program, as well as the State/Federal medicaid program.

Our recommendations explicitly recognize that medicaid's role in long-term care is totally different from its role in medical care. In its latter role, medicaid buys into a large and complex medical care delivery system, constitutes only about 10 percent of that market and, therefore, has only limited leverage over costs.

Unexpected fluctuations in the use rates for medical care, large increases in local medical care costs, and caseload increases due to economic downturns result in substantial program expenditure increases that are beyond the control of a State.

Our recommendations propose that States be allowed to establish more cost-effective financing structures, to establish reimbursement policies that encourage efficiency and discourage waste, and to selectively purchase services from efficient providers.

States desperately need and will use aggressively such additional latitude to reduce costs, and our action will produce significant Federal, as well as State, budgetary savings.

Nevertheless, some States will experience substantial medical care cost increases for aforementioned reasons that are beyond the control of States.

We therefore think that across-the-board 5-percent cap on the rate of increase in medicaid that would be applied to all States is just plain not the right direction to go.

In the long-term care sector, however, medicaid is the major purchaser of care. While the population's need for such care is growing, at least wild fluctuations in functionally impaired caseloads do not occur due to economic downturns. Perhaps the most important distinction between medicaid's role in medical care financing and in long-term care is that medicaid policies have a profound influence on character and dimensions of the long-term care delivery system.

The medicaid program is the major purchaser of long-term care services, accounting for about one-half of total nursing home expenditures nationally. Nursing home costs are the most rapidly growing component of medicaid costs, accounting for more than 40 percent of total expenditures. A growing elderly population and other demographic factors point toward a continuing increase in the need for long-term care.

Federal medicaid policies are biased strongly toward institutional care, and there is a virtually universal agreement that more humane policies, encouraging care in the home or other noninstitutional setting, whenever possible and appropriate, should be adopted. However, there is understandable reluctance on the part of Federal policymakers to provide Federal funding for such alternatives on an open-ended basis because of the potential cost implications.

As you know, Mr. Chairman, between 50 and 80 percent of the care received by the functionally impaired elderly now is provided by family or friends. No one knows what the impact would be on Federal costs if we opened up the program to alternative care under the current structure.

In that context, a close-ended long-term care grant that is indexed appropriately for inflation and for the increasing need for long-term care could both contain Federal expenditures and give the States the latitude to develop a comprehensive system of services that emphasize the use of the least restrictive and most humane settings appropriate to individual needs.

We have developed tentative cost projections that would indicate that indeed we can appropriately index for growth in inflation and population, over time, and at the same time, reduce the rate of increase in Federal expenditures. The rate of increase will be greater than 5 percent a year, Mr. Chairman, but it is going to be less than it would otherwise be under current policies.

Even though Federal funds flowing to the States would increase less rapidly than historical increases for medicaid nursing home costs, we think that the Congress should consider seriously this major reform in Federal financing policies for long-term care.

In summary, the Governors agree that escalating Federal and State expenditures on medicaid must be contained. But we must assure that we do not sacrifice the provision of needed care to the poor, the elderly, and the disabled.

If we are careful and creative, we can pursue these seemingly incompatible objectives simultaneously. We believe that our recom-

mendations constitute a responsible way to achieve our common objectives.

Senator HEINZ. Thank you very much.

Mr. Callahan.

STATEMENT OF JAMES J. CALLAHAN, JR., WEST NEWTON, MASS., DIRECTOR, LEVINSON POLICY INSTITUTE, BRANDEIS UNIVERSITY

Mr. CALLAHAN. My name is James J. Callahan, of West Newton, Mass. I am delighted to appear before this distinguished committee.

I am the director of the Levinson Policy Institute at Brandeis University, and deputy director of the health policy consortium, also at Brandeis University.

I produce and host a weekly television program on channel 7 in Boston, dealing with the elderly, and for 2 years I was the secretary of the Department of Elder Affairs for the Commonwealth of Massachusetts.

I will summarize my prepared statement [1] by highlighting a few important points, many of which you have already heard today.

Point No. 1, is that the rising costs of health care hurt the elderly. They hurt the elderly, one, because programs get cut back, like we were discussing this morning; and two, because, despite medicare and medicaid, older people pay a substantial portion of their expenses out of their own pockets—29 percent in 1977, and even in the area of nursing homes, elderly people pay 50 percent of the cost of their care because their social security benefits, pensions, and other income is applied to the cost of that care.

According to the Department of Labor, low-income couples spend 13 percent of their budget on medical care. There is no question costs need to be controlled.

Point No. 2, is that the rising public cost of care for the elderly is not due to more elderly persons using the program. Between 1972 and 1978, the percentage of people over 65 increased 14.9 percent. Medicaid recipients increased 10.8 percent, less than population growth.

The percent of elderly using medicaid dropped from 16.3 percent of all elderly, to 15.7 percent. Despite that, costs went up 249 percent. This occurred for a couple of reasons:

No. 1, the ICF program that had been funded under public assistance, was moved to medicaid; No. 2, States used the medicaid program to support their deinstitutionalization programs; and No. 3, medicare really opted out of nursing home care in the early 1970's by restricting definitions. So part of the reason for the increase in costs is due to Government policymaking.

Point No. 4. A 5-percent cap in 1982, if you assume a growth of 11 to 12 percent in inflation on a medicaid base of $22 billion, will mean that somewhere between $481 to $555 million less will be available for elderly recipients. Seventy-five percent of that will have to come out of nursing home care because, as Willie Sutton said, you rob banks because that is where the money is. In medicaid, institutional care is where the expenditures are. This translates out to 12 to 15 million fewer patient days per year.

[1] See page 238.

Surprisingly, $50 million would be cut from hospitals under medicaid. I say "surprisingly," because the elderly are supposed to be covered for hospitalization under medicare. Additionally, $50 million would be cut from prescriptions, that is about 2½ fewer prescriptions for every older person on medicaid.

What would be the results of these cuts? States would cut both eligibility and services; costs would be shifted to older people. Lower quality would result in nursing homes. These are all things that you have heard, and there would be greater use of the medicare program.

Point No. 5, is on the block grants reduction.

Block grants affect four areas that impact the elderly in a major way: Primary health-care centers, mental health services, title XX, and energy assistance.

I do not know in numbers what the impact would be on primary health care centers except that is a delivery source that serves not only the medicaid patient but also that older person who gets bumped off of medicaid by increases in their social security. Dr. Broadnax has already noted the problems faced by health centers.

Mental health services—only 4 percent of the elderly are now served. There have been objectives to increase this percent. That would be difficult under a reduced block grant. In respect to fuel assistance, cuts in New York alone mean that 85,000 to 145,000 elderly households would be cut.

In respect to title XX, 21 percent of all title XX expenditures are for SSI recipients, and of this, 38 percent are for the elderly.

Using $2.7 billion as the figure available for title XX, that would mean $215 million goes to the elderly; a 25-percent cut would be a drop of $54 million.

Where is that spent? Most of that money is spent for homemaker services and for chore services; that is where the cuts would be. New York State would lose 3,500 people on their home-care programs. On one hand, Government cuts back on medicaid to reduce nursing home costs, yet at the same time, cuts back on title XX for needed in-home services. This means there are no escape hatches for the elderly, and they will bear the burden.

Point No. 6, is that a block grant with less money is being proposed. The elderly will compete with day care clients, mentally ill, alcoholics, and other groups. We know that under title XX the elderly have not fared as well as this committee would like to see them.

What should be done?

For medicaid, you have heard many of the recommendations about cost controls, about getting a handle on medicare, which drives the system, about abolishing retrospective cost reimbursements, about use of prudent buyer approaches, and also about new forms of service delivery. At Brandeis, we are doing work on a demonstration to see if an organization can be created called a social health maintenance organization that will enroll older people, have the acute and long-term care services managed under one structure.

Regarding the block grant, be sure that no change in the delivery services will occur when combined with the cuts. Only the blood will flow. I have a friend who is president of a bank holding

company and he said that when they are making money, all the bankers love one another; and when we they are losing money, it is a fight.

My recommendation, which is probably unfeasible in this atmosphere, is to have block grants that provide States with more money as incentives to change and then over time by a reduced inflation factor, squeeze the inefficiencies from the system. Incentives, as well as sanctions, are required for real change.

In respect to a separate block grant for community care, I think that may be desirable, but I would not include the institutional program with the community-care program. For one reason, in 1977, the inflation alone on the nursing home bill was $600 million. That was more than was spent for all the in-home care under medicaid, medicare, and title XX. I fear that if the institutions are combined with the community care, that the economic requirements of the institution will just drive out other dollars for community programs.

Point No. 7, medicare, medicaid, and title XX are interrelated. You have heard that over and over again. And one has to look at the effects of these interrelationships.

Finally, I would suggest that we all worry about the redistributive effects of these caps on older people. Older people pay their bills; older people are not deadbeats. They will take from something else to pay their bills. On one of my TV programs, I had two older persons who were part of medicare's beneficiary aid program at Massachusetts General Hospital. I asked them when you go to the bedside of a medicare patient and talk to him or her about medicare benefits, what is the first question they ask? Both of those people answered in unison: "Will medicare pay the bill?"

I think that is the kind of thing we have to keep in mind, the effect on older people, the fear they have that their bills will not be paid and that they are going to be dependent on someone else.

Thank you very much, Senator.

Senator HEINZ. Thank you very much, Mr. Callahan.

[The prepared statement of Mr. Callahan follows:]

PREPARED STATEMENT OF JAMES J. CALLAHAN, JR.

Mr. Chairman and members of the committee, I am honored to have been invited before the Special Committee on Aging—a committee with an unexcelled record for looking after the well-being of the elderly in this country. Your present concern with the impact on the elderly of a medicaid cap and block grants is just one more example of your distinguished record.

For the past 2½ years, I have been director of the Levinson Policy Institute and deputy director of the University Health Policy Consortium, composed of staff and faculty from Boston University, Brandeis University, and MIT, located at the Florence Heller School, Brandeis University, Waltham, Mass. These two units conduct research and policy analysis on issues of financing and service delivery in the areas of health, nursing home care, home health services, social welfare, and related fields. Both the general population, the elderly and disabled have been of concern to us.

In addition, I am producer/host of a weekly TV program in Boston dealing with elder issues (Senior Circuit) broadcast on WNAC-TV (CBS). This helps keep me in contact with older people and to find out what is of concern to them. From 1977 to 1979, I was secretary of the Department of Elder Affairs for the Commonwealth of Massachusetts.

MEDICAID CAP

The medicaid cap proposal, as I understand it, is to reduce Federal expenditures in fiscal year 1981 by $100 million and allow a 5 percent increase for fiscal year 1982. For 1983 and beyond, spending increases would be tied into some cost of living measure.

There is no question that the rising costs of medical care is a concern to all Americans and a particular threat to older Americans. This distinguished committee stated it very well in its 1977 survey of developments in aging when it stated:

"Health care costs particularly the costs of institutional nursing care, continue to rise at a pace faster than the general increases in the cost of living. This trend has a major impact on our Nation's elderly population. Efforts to reduce rises in health care costs of all forms will be beneficial to all older Americans. The Committee on Aging, therefore, supports efforts to limit hospital and other health care cost rises with adequate protections for older Americans." [1]

Rising health care costs threaten older persons in two ways:

(1) They result in cuts in Government programs, such as medicaid, which then force older people back on their own resources to pay for needed care.

(2) They increase the cost of those health services which older people typically purchase out-of-pocket or which they are forced to purchase out-of-pocket because of cutbacks that may occur.

It is important to remember that despite the availability of medicare and medicaid, older people finance a substantial portion of their own care—and thus are directly victimized by rising costs. In 1977, persons over 65 paid 19 percent of their health care costs, approximately $12.5 billion from their own pockets.[2] Even in the area of nursing home care, the cost culprit in medicaid, older people finance 52 percent of their own care out of pocket.

Table I, which is based on the Department of Labor budget for a retired couple, presumed to be in good health, shows a range of from 13.9 percent for the lowest income to 6.7 percent for the highest income spent on medical care—and this is for a population that back in 1965 was to be relieved of the burden of health expenses. These health care expenses compete with the rising costs of food, housing and energy in the elders budget. This highlights the vulnerability of poor elderly to additional costs that may be shifted onto them.

TABLE I.—BUDGET LEVEL AND MEDICAL EXPENSE, ELDERLY COUPLES

Number of elderly couples	Budget level (autumn 1978)	Budget amount	Amount spent on medical care	Percent spend on medical care
1,082,000	Lower	$5,514	$765	13.9
2,213,000	Intermediate	7,846	769	9.8
3,656,000	Higher	11,596	774	6.7

Table II is instructive both for understanding what has been going on with medicaid and for estimating the impact of the cap.

TABLE II.—PERSONS, MEDICAID RECIPIENTS, AND VENDOR PAYMENTS (65 AND OVER), 1972–78

	Persons 65+ (in thousands)	Medicaid recipients 65+ (in thousands)	Recipients as a percent of total	Medicaid vendor payments (in millions)
1972	20,949	3,417	16.3	$1,925
1973	21,300	3,549	16.7	3,235
1974	21,815	3,805	17.4	3,691
1975	22,420	3,699	16.5	4,649
1976	22,954	3,808	16.6	5,192
1977	23,513	3,619	15.4	5,826
1978	24,064	3,786	15.7	6,727
Change, 1972–78	3,115	369		4,802

[1] "Developments in Aging: 1977," report of the Special Committee on Aging, U.S. Senate, report No. 95–771, p. 82.

[2] Charles R. Fisher, "Difference by Age Groups in Health Care Spending," Health Care Financing Review, spring 1980.

TABLE II.—PERSONS, MEDICAID RECIPIENTS, AND VENDOR PAYMENTS (65 AND OVER), 1972–78—Continued

	Persons 65+ (in thousands)	Medicaid recipients 65+ (in thousands)	Recipients as a percent of total	Medicaid vendor payments (in millions)
Percent	14.9	10.8		249
Change, 1975–78	1,644	87		$2,078
Percent	7.3	2.3		44.7

Sources: U.S. Bureau of the Census, Statistical Abstract of the United States, 1973, 1974, 1975, 1979 editions. U.S. Bureau of the Census Current Population Reports, p. 25, No. 870. Charles R. Fisher, "Differences by Age Groups in Health re Spending," Health Care Financing Review, spring 1980

Between 1972 and 1978, the elderly population grew from 20,949,000 to 24,064,000, a change of 3,115,000 or 14.9 percent. The number of older people receiving medicaid during that period grew only 10.8 percent—a figure less than population growth. Recipients of medicaid as a percent of all elderly decreased from 16.3 to 15.7 percent. The cost of care on the other hand, grew a dramatic 249 percent. Many complex reasons are put forward to explain this kind of cost growth—inflation, intensification of service, greater utilization, aging of the aging population, and so forth. Three things are clear, however: Rising costs are not the result of older people rushing to embrace the medicaid program; the number of older persons using medicaid is not keeping pace with the growth of the older population; nonetheless, a significant number of older people, 15 to 16 percent, are dependent on medicaid. The slower growth of elderly medicaid recipients may be the result of income maintenance cost of living increase putting them over the medicaid eligibility limit—a problem that this committee identified some years ago.[3]

Before I go on, there is one further comment on table II. The increase in expenditures of 249 percent is real but could be misleading: It was in 1972 that the intermediate care facility (ICF) program was moved from public assistance to medicaid. Some of these costs were already being picked up, in part, by the Federal Government. Expenditures were $743 million in 1972, of which I estimate 67.2 percent or $499 million was for the elderly.[4] This would increase 1972 costs to $2.4 billion and reduce the increase to $4.3 billion or 177.5 percent. This is another indication that the rising costs are not due to elderly persons themselves. The shift to ICF's was of benefit to States. It is well known that many residents of State institutions were moved to ICF's where their care would be reimbursed by medicaid. State and county mental hospitals had 559,000 residents in 1955. By 1975, this number had dropped to 193,000. If there had been no change in trends between 1955 and 1974, it is estimated State and county mental institutions would have been housing 825,000 residents. Many of these individuals now live in nursing homes supported by medicaid.

Medicaid a multipurpose program which differs among States and serves many populations—children, families, elders. How States will distribute reductions across categories is not known but we'll assume that the elders' share will remain the same.

A cap, in a time of inflation, means one thing—less money to do this year what was done last year. A $100-million decrease in 1981, if enacted in the last quarter of the year, is the equivalent of a $400-million cut on and annual basis. The reason for this is that operating programs have been spending at a higher level all year and now must reduce expenditures to recoup the $100 million annual cut within one fiscal quarter. A 5-percent increase in 1982, when costs may be expected to increase by 11 to 12 percent, would be a cut of $1.3 to $1.5 billion using $22 billion for 1981 as a base. Medicaid expenditures for the elderly account for about 37 percent of all medicaid expenditures. That means that the elderly will absorb $481 to $555 million of the cuts. A $555 million cut would be distributed across services in the manner shown in table III.

[3] "Medicare and Medicaid," op. cit. pp. 56, 57.

[4] Calculated by applying 1975 figure on percent of ICF costs accounted for by persons 65 and over (67.2) to 1972 total ICF expenditures of $743 million. Source: Data on the medicaid program, Institute for Medicaid Management, DHEW, 1978, p. 64.

TABLE III.—ESTIMATED DISTRIBUTION OF $555 MILLION REDUCTION IN MEDICAID FOR PERSONS 65 AND OVER, BY TYPE OF SERVICE [1]

Type of service	Percent distribution	Amount (in millions)
Inpatient hospital	8.8	$49
Skilled nursing	37.6	209
ICF	36.5	203
Physician service	3.9	22
Dental care	.7	4
Prescribed drugs	9.0	50
Other	3.6	19
Total	100.0	555

[1] Based om 1975 distribution, Data on medical program, op. ct., p 60.

The major impact of the cuts would be not only on persons in institutions but also on those using hospital and prescription drugs. Older persons would either go without drugs or pay for them privately, thus reducing further their limited incomes. Lower income elders would be most seriously affected as higher income persons are able to afford medi-gap policies that cover some drugs.

Large numbers of older people will be affected. Using $555 million as the expected cut and 72 percent as the proportion going to nursing home care, 12 to 13 million fewer days of care would be paid for by medicaid (at $30 per day). This translates out to about 30,000 to 35,000 patients. Both hospitals and drugs would be reduced by about $50 million. At $200 per day this would mean 250,000 fewer hospital days paid for by medicaid. Assuming $5 per prescription, there would be 10 million fewer prescriptions an average of 2.5 percent less for every older person on medicaid. Who will pay? The most probable outcome is that many elders will go without needed care or attempt to pay from their limited budgets.

The hospital-nursing home area is of most concern. Most hospital patients are covered by medicare so that the medicaid expenditures represent deductibles, coinsurance, and coverage when medicare benefits are exhausted. Hospitals would fear being "stuck" with a tough patient and may refuse or try to redirect that patient to a public hospital. Public and certain inner-city hospitals, however, will be affected also by the cuts. A colleague of mine, Alan Sager, has been studying closure of urban hopitals.[5] He has noted that American's elderly are disproportionately concentrated in rural areas and in large cities. The medicaid cap is likely to increase the financial problems now experienced by many hospitals in both areas, as fewer persons are declared eligible for medicaid, and as reimbursement for patients who remain eligible continues to drop further below actual cost.

As in the past, the smaller, less expensive, and less specialized hospitals are likely to suffer the greater financial distress. These are the ones which are the least costly providers of care. More of them are apt to close. Older patients seeking hospital care will therefore increasingly be forced to rely on the more expensive, high-technology hospital. Should medicare and medicaid implement prudent buyer polices, these would be difficult to carry out because fewer inexpensive hospitals will be available to the elderly. Moreover, the expensive hospitals which are available may not be appropriate to caring for the chronic problems from which many older patients suffer. The medicaid cap therefore is likely to reinforce our present drift toward more expensive hospital care for few patients—and often the wrong types of care at that.

Nursing homes (SNF, ICF) account for about 74 percent of medicaid expenditures for the elderly. Means of reducing this are limited. Nursing home residents are very old and have no option for community placement. They apply all their income from pensions and social security to the cost of their care, save $25 to $30 personal care allowance, which reduces opportunities for further cost sharing. With the aging of the aged, pressure will continue for nursing home care. Reimbursement to many homes is not high and with inflation will necessarily need to rise to some extent.

Nursing homes will be more reluctant than ever to take medicaid patients, if reimbursements are frozen or reduced. Those that can opt out by attracting private patients will do so. Those that can't live without medicaid will accept lower rates and provide lower quality care. Hospital patients will tend to back up. Nursing

[5] Alan Sager, "Urban Hospital Closings: Solution or Signal," in Citizen and Health, Barry Checkoway ed., London: Pergammon, 1981.

homes may discharge patients more frequently to hospitals where care and services will be reimbursed by medicare, which will increase the total Federal share of costs, not reduce it. This is a more likely danger where State medicaid program pays to hold a patient's bed for a set number of days while the person is in the hospital. The "answer" to the nursing home problem, if there is one, is to create the supervised housing with needed services that will maintain older people outside of institutions.

Institutions and providers have a will to survive. If there is less money available from medicaid they will look elsewhere. They will also look differently at who comes to their door. If you arrive with a Blue Cross card in your hand you'll be welcomed with open arms. If you're old and on medicaid, you'll find the gate much tougher to pass through. Differently funded patients will have different bounties on their head.

The cap promises little that is good for the poor elderly. You can expect: A lower percent of elders using medicaid, higher out-of-pocket costs for their health care, differential treatment by providers and attempts to load costs on the medicare ledger.

The problems facing medicaid are not new, nor are ideas for solving them. The 1970 Task Force on Medicaid predicted the escalating cost problem and recommended changes in the delivery system to control costs.[6] The report, "Medicare and Medicaid," to the Senate Committee on Finance, documented the escalating cost problem back in 1970 and made a number of useful recommendations.[7] New suggestions continue to be put forth. Colleagues of mine at Brandeis have proposed different methods of a prudent buyer approach to reimbursement under public programs.[8 9] We are working also on a demonstration called the social/health maintenance organization which would combine both acute and long-term care services in one organization which will enroll older persons and be reimbursed on a prepaid capitation basis.[10] Fundamental reimbursement and organizational changes are needed to get costs under control. The use of arbitrary caps will merely redistribute the costs generated by the system and the least able to bear this redistribution are the poor elderly.

Let us be aware of one important fact about older people—older people pay their bills. The laxness of the younger generation is often compared to the integrity of the older generation. Without passing judgment on youth, I do agree with the second part of that statement. Older people are not "deadbeats." They buy too much medigap coverage because they are *afraid* that they won't be able to pay their bills. On one of my recent TV programs, I interviewed two older persons who were part of medicare's beneficiary aide program at Massachusetts General Hospital. Their job is to advise medicare patients of their benefits. I asked them what was the No. 1 question medicare patients had for them. They answered immediately and in unison—"Will medicare pay the bill?" We have examples in Massachusetts of elderly who would pay their oil bills even after an escrow account had been established under the energy program. This just reinforces the need to protect older people from costs being shifted on to them.

SOCIAL SERVICE BLOCK GRANTS

The administration proposes to establish four block grants which would combine a large number of programs and give States greater flexibility. Along with this increased flexibility would be an approximate 25-percent reduction in dollars. These block grants do not include Older Americans Act programs which are targeted in fiscal year 1982 to be cut by $34 million below the fiscal year 1981 appropriation. The elderly will be most seriously affected by block grants involving primary health care centers, mental health services, title XX, and energy assistance.

The positive element in a block grant is the opportunity for flexibility and for reduced administrative costs it offers the States. The liability is that Federal objectives of meeting the needs of certain groups cannot be guaranteed. An excellent discussion of this has been published by a colleague at the Heller School.[11] Removing Federal designation of those to be served, in part, removes a certain amount of protection from them. Combining dozens of programs into a block grant will create

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[6] Report of the Task Force on Medicaid and Related Programs, DHEW, June 29, 1970.

[7] "Medicare and Medicaid," report of the staff to the Committee on Finance, U. S. Senate, Feb. 9, 1970.

[8] Stuart H. Altman and Stanley S. Wallack, "Making Hard Choices in the 97th Congress—Opting for a Prudent Buyer Approach," Medical Care, January 1981, vol. XIX, No. 1.

[9] Marcia Mabee, "The Prudent Buyer Concept: Review and Evaluation of its Use in the Health Care Industry," discussion paper DP-30, University Health Policy Consortium, Brandeis University, December 1980.

[10] Larry M. Diamond and David E. Berman, "The Social/Health Maintenance Organization," in James J. Callahan and Stanley S. Wallack, Reforming the Long-Term Care System (Lexington, Mass." Lexington Books) 1981.

[11] Robert B. Hudson, "Restructuring Federal-State Relation in Long-Term Care: The Block Grant Alternative," in Callahan and Wallack, op. cit.

tremendous competition among the various constituencies. There is no guarantee that the elderly will benefit. This committee has documented that the needs of elderly SSI recipients are not being met adequately by title XX services.[12]

The data on elderly participation in these programs is not as good as that for medicaid. I don't have a figure for elders' use of primary health care centers, but know many elderly live in the urban areas where these are located. I would assume that they are used both by medicaid recipients and those low-income elders not eligible for medicaid people who have been bumped over the eligibility level by cost-of-living increases. Cutbacks might force medicaid eligibles to higher cost hospitals and might eliminate a primary source of care altogether for the low-income group. This could result in higher medicare costs if lack of primary care leads to some acute crisis.

It has been documented that only about 4 percent of the elderly use mental health centers.[13] With less funds mental health needs of older people will continue to be unmet.

Title XX does have some information on the number of SSI aged recipients served.[14] The number of income eligible aged and their expenditures were not available. Thirteen percent of all aged SSI recipients, about 292,903, are served by title XX. They account for 38 percent of all title XX expenditures for SSI recipients. All SSI recipients however, account for only 21 percent of all title XX expenditures. The SSI elderly therefore, account for about 8 percent of title XX expenditures. Title XX outlays are capped at $2.7 billion. Eight percent is about $215 million and a 25-percent cut to this figure amounts to $54 million less for the elderly. This would have to be taken from homemaker and chore services where the largest expenditures occur. These are two of the most important services for maintaining people at home and out of institutions. New York State estimates that up to 3,588 older people will lose home care services and 87,000 will be cut from other programs.

Most of the $54 million reduction would have to be absorbed by two of the services most important for maintaining people at home and not in institutions. Here is where the medicaid cap and title XX link up. The medicaid cap will affect, most directly, institutional services for the elderly. The title XX reduction will affect most directly the noninstitutional services required by those striving to stay out of institutions. What is the result—more troubles for older persons and those who care for them.

We know how inadequately funded block grants work. Title XX has been level funded at $2.7 billion for a few years. States have cut back on eligibles and services. Between 1976 and 1978, 14 States decreased maximum eligibility levels. Others applied certain nonincome criteria to limit services.[15]

Energy assistance is the final area of concern. In 1981, it amounted to $1,850 million. It is being combined with about $55 million energy assistance program and reduced to $1,400 million for 1982. There is no need for me to expand on the problems of energy before this committee which has studied it in great detail. Senator Domenici has stated: "We must not put our senior citizen in a position of having to choose between heating their homes or eating." [16] I might add between cooling and eating after the heat wave difficulties of last year.

As a former State administrator for about 10 years, I believe there are many advantages to block grant approaches. Such an approach, however, cannot be successful when it's combined with drastic dollar cuts. A study of title XX conducted at the Heller School showed that States that were below their title XX cap did some good planning as to how they would spend additional funds. States that claimed at or above their caps did little planning or reorganization and used title XX solely as a revenue source.[17]

Businessmen know that it takes money to make money. Front-end investments are needed for long-term gains. A block grant that provided some incentive dollars up front and a reduced inflation factor in the future would have a chance of wringing efficiencies from the system without producing serious political and human consequences.

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[12] "Developments in Aging: 1978," op. cit., pp. 173-174.

[13] "Developments in Aging: 1978," report of the Special Committee on Aging, U.S. Senate, report No. 96-55, p. 58.

[14] "SSI Recipients of Title XX Services," July-September 1977, Research and Statistics Note, Dec. 17, 1980, U.S. Department of Health and Human Services.

[15] Eileen C. Wolff, "Title Technical Rates," Child Welfare League, Hecht Institute for State Child Welfare Planning, June 1978.

[16] "Developments in Aging: 1977," op. cit., p. 49.

[17] Jack Hansen, "A Study of State Government Decisionmaking in the Allocation of Title XX Funds," unpublished dissertation, Florence Heller Graduate School, Branders University, Waltham, Mass., 1980.

One suggestion that has been offered recently is the idea of a block grant or a separate title (XXI) for long-term care. The idea is to combine ICF, home health, homemaker, meals, and so forth, from existing programs. This has merit as long as SNF or ICF expenditures are not included. The institutional costs will eat up the resources for community programs. In 1977, the increases alone in nursing home expenditures due to inflation were more than all public dollars spent on home health care under medicare and medicaid.[18] There should be two titles, one for long-term institutional care and one for community-based care if we take this route.

Throughout this testimony I have pointed out the relationships among medicare, medicaid, title XX, and related programs. This is important to keep in mind for what is done in one area may impact on another. Medicare expenditures, for example, have been rising at a greater rate than medicaid (88.5 percent and 63 percent increases respectively, between 1975 and 1979).[19] A medicaid cap may accelerate this. Reduction in title XX community based services conflict with attempts to reduce institutional costs under medicaid. Cutbacks in energy assistance may have health consequences and so forth.

Older citizens should not have to live in fear of anything—medical expenses, crime, cold weather, rejection. Both the rhetoric of cuts and their actuality can produce this fear. But, I am certain that this committee won't abandon our older citizens. Rather, they will examine each and every proposal put forward for cutbacks and reductions to insure that our elders are protected.

Senator HEINZ. Let me observe that I think we have a very expert panel of witnesses, all of whom have grassroots of some of the practical problems that we have in any of the changes of our health care system.

I think your testimony has been particularly incisive indeed. There are a variety of questions. Let me ask one of Mr. Curtis.

Mr. Curtis, since medicaid is usually a secondary benefit for the elderly—medicare is the primary benefit—would removing the freedom-of-choice provision, as some have proposed under medicaid, have to be linked to the same limitations under medicare?

Mr. CURTIS. That is an interesting issue.

I am not sure if we have given that adequate thought. I think that the Federal Government, if it is willing to go along with some of our prudent purchaser proposals, may want to adopt appropriate medicaid policies for hospitals participating in medicare. Although a State may have said to an institution in general, you are not to participate in the medicaid program, there probably should be an exceptions policy for the situations you describe.

Although we have not explicitly addressed that, I do not think the Governors would want to force patients to change institutions.

Senator HEINZ. Let me ask you about a possible scenario under what I understand to be the thrust of the National Governors' proposal.

If a seriously ill medicare patient who is not in contract with the State for medicaid, enters the hospital and stays for 100 days, on the 61st day that patient has to pay $51 a day through the 90th day.

Now, because of that expense and the low income, she becomes medicaid-eligible. The hospital is not contracted with medicaid.

What does the National Governors' Association propose to do to handle that kind of situation?

Mr. CURTIS. As a staffer, you can imagine I am uncomfortable responding to such issues on an off-the-cuff basis. But it seems to

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[18] James J. Callahan, Jr., "Delivery of Services to Persons with Long-Term Care Needs," in Policy Direction of Long-Term Care, Frank Farrow and Judy Meltzer, eds. (Chicago, Ill.: University of Chicago Press), forthcoming September 1981.

[19] Robert M. Gibson, "National Health Expenditures, 1979," in Health Care Financing Review, summer 1980.

me that the cost to the State would be the same whether or not it is a high-cost hospital.

Senator HEINZ. But it is not contracted to the medicaid provider?

Mr. CURTIS. I think that is really a technical issue that we could work out. It seems to me that we could arrange for contracting exclusively for the purposes of supplementing medicare benefits. I do not see why that would not be possible.

Senator HEINZ. Now, the National Governors' Association opposes the Reagan administration overall cap but you support the cap on part of medicaid, long-term care.

How do you reconcile that?

Mr. CURTIS. Well, for fiscal year 1982, we have said if the Federal Government feels that it has to assure substantial savings, in a concrete way, and feels that in order to do that, they have to limit some part of the program to an absolute level, it is most appropriate to apply a limit to the long-term care component. As I pointed out in the testimony, in this part of the program we do not experience wild fluctuations from year to year that are not at all predictable as we do in the medical care financing component of the program. Therefore, a 1-year limitation on the order of magnitude of 7 percent, while it would be very, very difficult for States to live with, would be more acceptable than an across-the-board 5 percent limitation.

Now, beyond fiscal year 1982——

Senator HEINZ. Let us dwell on fiscal 1982 for a minute. It may be more acceptable to Governors.

Is it going to be more acceptable to the elderly?

Mr. CURTIS. My sense is—and I think the sense of the Governors is—that our proposal would be far less devastating for the elderly and other recipients in most cases, in most States, than would an across-the-board 5-percent increase. As the previous testimony indicated, there has not been a large increase in the volume of nursing home care.

Senator HEINZ. I understand that, but let us just try and look at the alternatives. Somebody could come back—not in my proposal, I want to make it clear—but somebody could come back and say, what you really want to cap is not long-term care; what you want to cap is everything else, because there is inappropriate use of hospitals, and the wrong kind of providers are being used too often; first of all, the people cannot get a doctor, so they either stand in line in the emergency room or somebody hospitalizes them just for the benefit of outpatient care. Maybe it should be argued that one possible way to force changes in the system, whether it is waivers or other mechanisms, might be to implement a cap. Because of a variety of very strange decisions made by States over the years on reimbursement rates, that is really the part of the system that is inefficient—that provides the wrong kind of care to the wrong person at the wrong time. Why is that not really in theory a better proposal than the National Governors' Association proposal which goes against——

Mr. CURTIS. Because that view implicitly presumes that States need an incentive of a cap to reduce expenditures in the program.

We feel very strongly that States cannot afford the current medicaid program and, if given additional flexibility, will pursue exact-

ly those kinds of changes. Nevertheless, even if given that flexibility, there can be changes in the economy, changes in the use of medical care generally, and changes in hospital admission rates like those that occurred in Maryland last year that are totally beyond the States' control and would result in hospital care costs far that exceed 5 percent.

Senator HEINZ. Let me ask you one question—and this might be a slightly unfair question, because you may not have been consulted in advance before the position was taken—but, the National Governors' Association came to town 1½ months ago and they said, well, we really support what President Reagan is doing, and there may be a few things in there that will make life tough for us, but we really support him.

Now, the National Governors' Association, represented by you, is saying, well, we support him, but not where money that the State has to pay is involved. But yet the National Governors' Association seems to be very supportive of all those things that cause money to flow through the States.

Now, is not that having your cake and eating it, too?

Mr. CURTIS. Well, I guess——

Senator HEINZ. A simple yes or no will suffice.

Mr. CURTIS. The Governors are not opposing substantial reductions in a number of other areas that will have severe implications for States. We feel, and the Governors have passed a resolution to this effect, that medicaid should be a Federal responsibility and that really underlines the difference between our position on the budget reductions generally, and our position on medicaid. The Governors, when they were in town for the meeting that you are referring to, did adopt these positions with respect to medicaid. This is not something that they did independently of their support for the President's proposal generally.

Senator HEINZ. Dr. Broadnax, first of all, let me thank you for your testimony. I noted your concern, particularly where the health block grants were concerned. First of all, community health centers might or might not be able to survive successfully under the medicaid cap and, second, I think there was implication they might or might not have a difficult time getting appropriated under the block grants; is that correct?

Dr. BROADNAX. That is correct.

Senator HEINZ. By the way the block grant is structured, community health centers are one of several programmatic elements, including migrant health, home health services, maternal and child health, mental health, and substantive uses. Why do you suppose they would have particular difficulty in asserting successfully their claim on their fair share of a block grant resource?

Dr. BROADNAX. I think that is a multifaceted question. Mr. Callahan alluded to it earlier; but I think block grants which lump a lot of programs, will lead to a lot of infighting——

Senator HEINZ. It does down here, too, by the way.

Dr. BROADNAX. The community health center movement, which is a relatively new concept, which has been shown to be, one, more comprehensive and, two, more cost-effective than, say, your private physician who would have his office, no lab, X-ray, social service onsite, and more cost-effective than a hospital. One, we do not have

as big a lobby and, two, as I mentioned, we are a young movement in community health centers.

I think in most urban areas, where we have seen community health centers, there has been a marked improvement in the health status for mortality rates, for example. Many of those community health centers in large urban areas, with that money coming to the States, then get enmeshed in all the other programs and the political infighting at the State level, where there is a cry for equitable distribution possibly just based on population as opposed to being based just on needs.

So we are at a disadvantage so much as we are a young movement. We are small and may get lost in the maze when that money comes to the State, especially if they are lumped, as proposed.

What we are advocating from the city health officer standpoint is that one, health be separated from social services. That would help us. So that we could only compete for the health dollars.

Senator HEINZ. In terms of the health service block grants, is it not pretty much nonsocial service elements?

Dr. BROADNAX. No; the elements in primary health care are——

Senator HEINZ. No; I meant in the health service block grants, as proposed.

Dr. BROADNAX. Right. We want to make—to insure that there are specific guidelines attached to that, to insure that the money indeed comes to those programs.

Senator HEINZ. Well, let me be the devil's advocate for a moment. I might note that defeats the purpose of the block grants, the purpose of the block grants being to try and get a better delivery system of these health-care services. Everybody who is in the system now is understandably concerned about the survival of each and every one of their elements, including the community health centers. But is there not the opportunity, at least in theory, to consolidate the delivery so that maternal and child health, home-health services, sudden infant deaths or mental health services and community health services work together more than they now do?

Why can we not work toward a greater integration and consolidation of the delivery systems?

Now, I ask that of you because you are right on the firing line.

Dr. BROADNAX. That is right.

Senator HEINZ. If anybody is going to make it happen, you are going to make it happen.

Dr. BROADNAX. That is right.

Senator HEINZ. Can it happen or is there just insurmountable differences?

Dr. BROADNAX. It can happen. In fact, in Cincinnati, we have a unique situation where we operate 12 community health centers that have a number of funding sources; the Bureau of Community Health Services, Robert Woodson Foundation, infant child programs, all administered by the Cincinnati Health Department doing just what you are proposing; we have been a pilot project of HHS to look at how that integration can take place.

However, we are unique and that is not the case in many counties. Many of those programs are dispersed to various agencies. There is not the interlinking cross-referral to cut down on that.

That is what we are recommending, to build in better coordination and communication between those programs.

However, the interesting piece that should be recognized, we have been asked, as a city, to integrate all of that; however, all of those agencies require the same reporting, mechanisms, each of those agencies will require different reports on the same data which increases our administrative cost; so as we attempt to better coordinate the regulations that are attached to each of those separate programs, drives up our cost, which means that we have less money to give to the service.

Senator HEINZ. Is that not one of the principal arguments for the block grants?

Dr. BROADNAX. That is the principal argument for the block grants but we want to make sure that health is separated out from other kinds of programs and that there is some definite guidelines at this particular point. I am not clear that those specific guidelines are worked out and what we are saying is, that needs to be a very judicious and prudent process before we just throw a block grant to the States.

Senator HEINZ. That is a very well-taken point, and I think perhaps the way you could be most helpful to us—and we are limited on time today, so I will not ask all of this—for you to do all of this now, give us your specific suggestions on what you think should and should not be in each of the various block grant proposals and any other thoughts you have on how to go through this transitional period a little bit more successfully. It would be very much appreciated; because that clearly has to be the problem with any block grant proposal.

In theory, they are fine. But there are many, many difficulties in getting from the narrow categoricals that we have to the flexibility and opportunities proposed in the block grants.

Many people talk about the billiard ball effect, which is, on any day you just kind of close the pockets, these categorical pockets around the billiard table, and you put all the billiard balls out there in the middle of the table and you happen to put them out there on the day that the table is tilted by political forces in one direction, either toward one thing or away from the other; all the balls run off the table, and some very vital services are left high and dry.

Dr. BROADNAX. Senator, we welcome that opportunity. I am so happy that you asked.

Thank you very much.

Senator HEINZ. I am glad I did not ask you to speak about it, because I have a feeling that you would have a good deal to say and we would be here until 3 o'clock this afternoon.

Dr. BROADNAX. I could tell you about it.

Senator HEINZ. We are looking forward to it.

Dr. BROADNAX. All right.

Senator HEINZ. Mr. Callahan, you have an outstanding background here. You had the opportunity not only to be able to step back as a member of a very fine university staff, Levison Policy Institute of Brandeis University, but also have been in there as a State medicaid director.

I would like to ask you to respond to this question.

Many of the flexibility recommendations that have been proposed are already available to the States through the waiver process and through the State plan process.

What are the deterrents that seem to prevent States from acting more aggressively in this area.

Mr. CALLAHAN. It takes a long time to get a waiver. It is a difficult process. I have been away from the waiver process for a while, but I know that back in 1972, we attempted a home-care program in Worcester, Mass., and by the time the waiver came through, I had been out of that job for over 1 year. So I think that the waiver process is just a very difficult process. Waivers would tend to get evaluated on a very narrow basis. It is more of a jurisdictional decision on waivers rather than a management decision. So I think that that is one of the limitations.

They have to be very specific. They can produce resistance by others—other forces in the State because you are waiving part of the State plan that may not be in the interest of providers or some consumer groups. I think that the main reason is they are difficult to put together and obtain.

Senator HEINZ. So as many other people have suggested, you would like to see flexibility in the form of overall regulations or changes in the law?

Mr. CALLAHAN. I think that is necessary. Legislation is what gives the mandate to the States and the legitimization to do things.

You asked earlier about freedom of choice. Freedom of choice is extremely important and when medicaid began it did change patterns of care. People who were being forced into clinics did not have to go to the clinics any more; people being used, as in teaching material in hospitals, could opt out. We are now at a point now where freedom of choice has been used, not so much by the recipients to obtain a range of services, but by providers to prevent the State from taking prudent action to affect the delivery system.

I think there has to be an understanding of the differences in freedom of choice—we want people to be in the mainstream, so any freedom of choice has to be that they are in the mainstream. They may be free to join an HMO and then they are locked in for 1 year or they may be free to sign up with a particular provider.

On the other hand, you want to be able to affect the delivery system and not have providers use freedom of choice as the excuse for not having bulk purchasing of drugs, bulk purchasing of laboratory tests, and so forth. There is a retail and wholesale business in the medical care industry; you want freedom of choice at the retail level, but you may want a little bit less at the wholesale level, so that you have a more effective system. These kinds of things have to be distinguished.

Senator HEINZ. You know, that really brings us to something Senator Durenberger was driving at earlier, which is just the entire way we structure our health care system.

There is no reward for a prudent choice, assuming you have a free choice structured into our system. There is no reward for a health care provider being particularly efficient. There is no system that provides for meaningful competition both in terms of quality or in terms of cost among providers and, on behalf of health care consumers, the way we reimburse health maintenance

organizations being the exception to the rule, along with other prepaid health plans. Our system simply does not permit people to make meaningful choices.

Mr. CALLAHAN. Senator, there are other factors that need to be looked at; that is, the impact that the court have on health policy. There is a good deal of health policy made by courts through their decisions on reasonable costs. It would be worth looking at some of the court decisions and some of the decisions of the Provider Reimbursement Review Board. As you read these, you get no feeling of concern with health care. They are all around reimbursement, issues, that is, whether or not income tax is a reimbursable cost; whether or not a trip was a reimbursable cost. You are looking at something that has nothing to do with health care. Cost reimbursement is really an important place to get a handle on the problem rather than scaring older people and they are scared. They read the newspapers. What is going to happen to my social security? It is not going to go up any more because the elderly are rich. What is going to happen to me when I am on medicare? They will not pay the bill.

I think the message is that the game of rising health costs is over. The question is: How do we begin to wrench that system into something that is reasonable without wrenching the people who are being served?

Senator HEINZ. I think we all agree on one thing: Regardless of what Congress finally settles on by way of trying to reduce the increase in the Federal budget of health care costs, anything we do is going to be very cosmetic; it will not deal this year, or next, with the real underlying factors that have to do with the appropriate health care services, meaning full consumer choice, a system that actually has incentives to control its cost. Until we deal with those underlying issues, everything we do, even though we may say it is in the name of curtailing health care costs, will in fact not curtail health care costs. Because until those systematic changes are made, such as in Senator Durenberger's Health Incentive Act, and legislation that I have introduced, all we are going to do, with few exceptions, is to shift around who is paying for these costs. I wish I could be more optimistic about it.

I tend to believe that there will be some very identifiable costs shifting from medicaid to medicare under this proposal. I think there will be still more going to indemnity, Blue Cross, Blue Shield types. There is nothing here that really reduces health care costs.

Well, if you have got a melon and you just slice it up three ways, you say I am going to slice it up differently; it is still the same melon.

Mr. CALLAHAN. It is even worse than that.

When I was in medicaid, I formulated Callahan's law.

Senator HEINZ. I hope it is better than the Callahan Tunnel. That was a very dark hole in the ground.

Mr. CALLAHAN. The law is—anything that is done to control medicaid costs will increase them. You put in utilization review and the patients get out a day earlier, but they end up in nursing homes. Medicaid is like a big monster that you try to blow up, but it absorbs the bomb's energy and gets bigger.

Senator HEINZ. I cannot resist asking this question—particularly after that last comment on Callahan's law—for which those of you who did not hear it, is that anything aimed at controlling the cost of medicare or medicaid, tends to increase its cost.

Did you support President Carter's hospital cost containment proposal?

Mr. CALLAHAN. Yes; I supported it.

Senator HEINZ. I could be very cruel and heartless and ask the next question of Dr. Broadnax.

Did you?

Dr. BROADNAX. Portions of it, yes, I did.

Senator HEINZ. A qualified yes and a partial no.

Mr. Curtis?

Mr. CURTIS. Yes.

Senator HEINZ. Well, I am tempted—I am tempted but I think that is a little inconsistent with the position that you have taken today.

I do not understand how you could support a cap on hospital costs and, by the way, most of the people that I have talked to said there is a very simple way we will deal with that cap on hospital costs; we will just eliminate our least profitable services, and guess what those services tend to be? The services that affect the poor and the elderly.

Mr. CALLAHAN. But there has been experience in Massachusetts with limiting hospital charges which has reduced the rate of inflation.

Senator HEINZ. But that is again Callahan's law. Either the law has to have a caveat, or a loophole, or——

Mr. CALLAHAN. I will work on the loophole, but I was talking of medicaid, not the total health system to which these others apply.

Senator HEINZ. It is an all-encompassing law with a hole in the middle.

Mr. CALLAHAN. It is called a tunnel.

Dr. BROADNAX. I would like to make one comment.

I think whether you are talking about hospital cost containment or containment with medicaid or other reimbursable programs, it is the concept of the program and how the services are delivered, what services are offered in what geographical area.

I think the concept of health planning agencies was good; there are some problems with it; but I think those are the kinds of things, other than just putting on caps; we have to actually look at the content and the meat of what is going on inside of the institution, whether it be a hospital, medicaid program, medicare program, a community health center.

Senator HEINZ. Mr. Curtis, we are saving the best, in a sense, for last. I think you know what question I am going to ask.

The National Governors' Association is proposing capping long-term care under medicaid; that is, this year.

Last year, they supported capping hospital costs.

Which do you support?

Mr. CURTIS. We are supporting capping hospital costs this year and in medicaid as well as in medicare.

The point is that medicaid is a very, very small purchaser, only 10 percent of the market; and if you try to cap medicaid alone,

including a hospital factor, it will not work. Hospitals will in many cases say, fine, we will not participate in your program. You have to go beyond medicaid.

The Governors supported the Carter program because it would not isolate payers as this program does. We are suggesting, look at medicaid along with medicare. If you are looking for truly ironic inconsistent positions, I would suggest that you go beyond the positions of the three sitting at this table.

Congressman Stockman was a very adamant opponent of capping hospital costs.

Senator HEINZ. I am well aware and his quote was read to us by somebody who testified earlier. He will be testifying before us in about a week or so and I cannot resist the opportunity, when it presents itself, to ask him the question that I think you were framing.

Gentlemen, thank you very much. I appreciate your being here.

Our next witnesses are Carmela Lacayo and Laurie Shields.

Mrs. Lacayo, would you please begin?

STATEMENT OF CARMELA G. LACAYO, LOS ANGELES, CALIF., PRESIDENT/EXECUTIVE DIRECTOR, ASOCIACION NACIONAL PRO PERSONAS MAYORES

Ms. LACAYO. Thank you, Senator.

I would like to thank you for inviting us and I would like to thank you, and your staff, Senator, for making sure that the minority perspective and perhaps the citizens' perspective, are heard in the hearings you have conducted, as well as the technical perspectives that have been well placed before this committee this morning.

I come to you this morning more from a grassroots perspective than from a technical perspective. I hope the committee will take into account that I am speaking to you as a minority person from a minority perspective.

My prepared testimony[1] is submitted for the record. I will summarize the testimony, because it is short and, I hope, sweet. I will read much of it.

We begin by saying that we respectfully take issue with the administration's promise that its proposals will not harm the truly needy, of whom the elderly comprise a large part. Of course, a medicaid cap will force the States to raise eligibility requirements for medicaid. If one out of every five elderly in the United States depends on medicaid, certainly the ratio in the poor and near-poor Hispanic elderly community will be even higher. Of course, a 25-percent reduction in health care moneys will affect the Hispanic elderly. I will address a little later the ways in which they will be affected. First, let me focus on what, to my people, is a very serious turn of events.

Historically, the minorities and the poor have turned to the Federal Government because the States were unable or unwilling to address their needs. The Congress became a last resort.

Some progress has been made in bringing minorities into the mainstream of American life and in giving the poor some level of dignity—this we recognize.

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[1] See page 255.

At this point, however, we are forced to ask whether this momentum for progress for our country's poorest citizens is at an end. Evidence has been placed before this Congress that when Federal dollars go to the States without strings, as in the Revenue Sharing Act of 1972, I quote from the House Subcommittee on Civil and Constitutional Rights in their hearings on "The Civil Rights Aspects of General Revenue Sharing":

> There is clear and strong evidence that widespread discrimination against minorities exists in programs funded by general revenue sharing.

Of course, the block-grant legislation will have appropriate references to title VI of the Civil Rights Act. But in the past, this language was powerless to force the States to recognize, for example, the health rights of nonresidents. The States consistently refused to recognize the rights of migrant workers.

Congress responded with the migrant health program, which we now learn is to be block granted along with 16 other health programs. These programs are to be administered at the discretion of the States who refused to serve the migrant in the first place. This is just one example that fuels our fears.

Why should we expect a Governor, be he a Democrat or Republican, Conservative or Liberal, not to reward the constituents who elected him with a bigger piece of the health pie, when the administration that proposes the block grants clearly tries to do the same thing by supposedly saving elderly programs from the block grant sting because they are, in the words of the Heritage Foundation, a conservative constituency.

Under Secretary David Swoap, in his testimony before this committee, described the values of the block grant proposal in the following way, and I quote:

> By eliminating many burdensome Federal administrative requirements, standards, and the like, the block grant will permit more efficient State and local administration.

We are, to be sure, in favor of more efficient local administration. But "burdensome requirements, standards, and the like"? We ask this committee, "What requirements? What standards?" Those that guarantee that all the needy will be served, regardless of where they live and the color of their skin?

We cannot be assured of equal services when the proposal offered by the administration speaks in such vague terms as "many burdensome requirements." History has taught minorities that loose legislation can sink the ship of equality.

Finally, in regard to the block grant philosophy, we find it very difficult to understand why the Congress, historically the great defender of the rights of the poor and the minorities, seems to stand mute before this paradox. While the President publicly declares the defense of the truly needy, his proposals give the sovereign States the power to define just who is, in fact, truly needy, especially in regard to health and human services. Are we to understand that the political pressures of 1981 will force the honorable men and women of this body to wash their hands of their sacred responsibility for the sake of the budget?

Now, I will turn to some specifics of the administration's proposal.

Social services block grant—older persons would also be faced with the prospect of sharp cutbacks under the proposed social services block grant programs—including title XX social services, rehabilitation services, senior opportunities and services, SOS, and others—into a single block grant with only 75 percent of the existing funds for all these programs.

This translates into a $1.2 billion cutback, from $5 billion for the 12 programs in fiscal year 1981, to approximately $3.8 billion.

Many of these services do not affect the elderly directly, but several do, and the overall reduction would adversely affect low-income aged minorities. Older persons represent, for example, a significant proportion of title XX recipients.

We are concerned about the sharp cutback in funding for necessary services. This represents a double-barreled negative impact, because inflation is driving up the cost of service programs. The total real reduction is probably well above 25 percent when inflation is factored into this equation. The net impact is that block grants with less funds for services mean less resources for the elderly—no matter how you cut the funding pie.

With respect to medicare, the Asociacion Nacional is deeply concerned about the administration's proposals to repeal the recently enacted measures to: (1) Remove the 100-visit limitation on reimbursable home health visits under medicare, and (2) make occupational therapy a qualifying primary service for home health benefits.

These provisions were approved last year, with strong bipartisan congressional support, to make home health services more readily available to older persons.

Today, many older Americans are placed in institutions at a much higher public cost because alternative care is not available. We believe that it makes much more sense to encourage elderly persons to live in their homes where most of them would want to be, instead of being prematurely or unnecessarily institutionalized.

We recognize that some persons have no realistic option but to be placed in a nursing home. But large numbers of elderly persons are inappropriately placed in nursing homes. Some experts estimate that 20 to 40 percent of all nursing home residents should receive other forms of care.

Our policies should encourage—and not discourage—older Americans to live independently in a family or home setting. This is particularly important for Spanish-speaking persons, because most services are provided through informal support systems, such as the family.

Older Hispanics have repeatedly emphasized to the Asociacion Nacional that they would prefer to live independently in their homes if at all possible. We strongly support policies to implement this objective, such as providing for unlimited reimbursement for home health services under medicare, instead of imposing a 100-visit limitation.

In addition, we want to reaffirm our support for making occupational therapy a qualifying primary service for home health benefits. This measure would be especially helpful for stroke victims; and we urge that it be retained.

Many elderly persons with health problems can live independently in their homes with appropriate care. The vast majority of these individuals would prefer to live at home with their families and be near their friends and neighbors. And they can do so if essential home health care and other appropriate services are available.

Other medicare provisions—the Asociacion Nacional also opposes the administration's recommendation to repeal the measure to provide full medicare reimbursement for pneumococcal vaccine and its administration. About 54,000 older Americans die annually from pneumococcal strains of pneumonia. Low-income elderly persons would be most adversely affected by this proposal because they may not be able to afford the vaccine.

One of the major problems with our health care system today is that it is crisis oriented. Soundly conceived and well-timed preventive measures, though, can be cost effective for older persons as well as our Nation. We have long maintained that preventive measures must be built into our health care system. Otherwise, many low-income Spanish-speaking persons will not receive the care they need until their disease or illness reaches the crisis stage. At that point, it often is too late.

We further oppose the administration's proposal to permit States to purchase medicare part B coverage—primarily physician services—for medicaid recipients only once a year. States can now buy in at any time. This measure would impose greater restrictions that would work to the disadvantage of older Hispanics and other aged minorities who simply do not have the resources to pay $9.60 a month for part B supplementary medical insurance. Beginning in July, this premium charge will rise to $11.

Minorities have a lower participation rate in part B because the existing premium charge can be a major obstacle for persons struggling on limited incomes.

Figures are not available concerning the participation rate for Spanish-speaking persons. However, less than 92 percent of all nonwhites were enrolled in part B in July 1979, compared to 96 percent for Anglos. Our Asociacion opposes efforts to make it more difficult for low-income minorities to obtain part B coverage.

These are just some examples of our perspective with respect to the proposed administration changes in health and human services. We reiterate again our strong concern for the enforcement or the implementation of block grants to the States, especially with respect to title XX programs, medicaid cap, and the Older Americans Act programs.

In conclusion, let me say that the Hispanic elderly, the minority elderly, of course, apply the administration's concern that plague all of us. We do question why the price for us must be so high.

Thank you.

Senator DURENBERGER [presiding]. Thank you, Ms. Lacayo.

[The prepared statement of Ms. Lacayo follows:]

PREPARED STATEMENT OF CARMELA G. LACAYO

Mr. Chairman, as executive director of the National Association for Spanish Speaking Elderly, I speak to you in behalf of a community of minority elderly more than 2 million strong. Before discussing the impact of the President's proposed cuts on our community, let me give you a brief glimpse of the situation of this minority community right now before the proposed cuts take effect. The data that I list comes from official Government sources:

In 1978, 23.2 percent of Hispanic elderly had incomes below the poverty level compared to 14 percent for the entire elderly population.

Two out of three Hispanic elderly living alone were either poor or near poor.

The number of Hispanic elderly who were poor in 1975 had increased by 17.1 percent in 1980.

In 1978, the median annual income was $3,812 for older Hispanic men and $2,455 for older Hispanic women.

It is estimated that the Hispanic elderly receive social security benefits at a much lower rate than the majority elderly.

The list of facts is much longer, but what I have mentioned is enough to give you the picture of a community of elderly, who are already poor. We respectfully take issue with the administration's promise that its proposals will not harm the truly needy, of whom the elderly comprise a large part. Of course, a medicaid cap will force the States to raise eligibility requirements for medicaid. If one out of every five elderly in the United States depends on medicaid, certainly the ratio in the poor and near poor Hispanic elderly community will be even higher. Of course, a 25 percent reduction in health care money will affect the Hispanic elderly. How they will be affected I will address a little bit later. First, let me focus on what to my people is a very serious turn of events.

Historically, the minorities and the poor have turned to the Federal Government because the States were not able to or were unwilling to address their needs. The Congress became a last resort. Some progress has been made in bringing minorities into the mainstream of American life and giving the poor some level of dignity. This we recognize. At this point, however, we are forced to ask whether this momentum for progress for our country's poorest citizens is at an end. Evidence has been placed before this Congress that when Federal dollars go to the States "without strings" as in the Revenue Sharing Act of 1972, I quote from the House Subcommittee on Civil and Constitutional Rights in their hearing on "The Civil Rights Aspects of General Revenue Sharing": "There is clear and strong evidence that widepread discrimination against minorities exists in programs funded by general revenue sharing." Of course the block grant legislation will have appropriate references to title VI of the Civil Rights Act. But in the past this language was powerless to force the States to recognize, for example the health rights of nonresidents. The States consistently refused to recognize the rights of migrant workers. Congress responded with the migrant health program, which we now learn is to be block granted along with 16 other health programs, to be administered at the discretion of the States who in the first place refused to serve the migrants. This is just one example that fuels our fears.

Why should we expect a Governor, be he Democrat or Republican, Conservative or Liberal, not to reward those constituencies that elected him with a bigger piece of the health pie, when the administration that proposes the block grants clearly tries to do the same thing by supposedly saving the elderly programs from the block grant sting because they are, in the words of the Heritage Foundation, a conservative constituency.

Under Secretary David Swoap, in his testimony before this committee, describing the values of the block grant proposal, said, and I quote, "By eliminating many burdensome Federal administrative requirements, standards, and the like, the block grant will permit more efficient State and local administration."

We are to be sure, in favor of more efficient local administration. But "burdensome requirements, standards, and the like?" We ask this committee what requirements? What standards? Those that guarantee that all the needy will be served, regardless of where they live and the color of their skin? We cannot be rest assured of equal services when the proposal offered by the administration speaks in such vague terms as "many burdensome requirements." History has taught minorities that loose legislation can sink the ship of equality.

Finally, in regard to the block grant philosophy, we find it very difficult to understand why the Congress, historically the great defender of the rights of the poor and the minorities, seems to stand mute before this paradox. While the President publicly declares the defense of the truly needy, his proposals give to the sovereign States the power to define just who is, in fact, truly needy, especially in regard to health and human services. Are we to understand that the political pressures of 1981 will force the honorable men and women of this body to "wash their hands" of this sacred responsibility for the sake of the budget?

Now, I will turn to some specifics of the administration's proposal.

SOCIAL SERVICES BLOCK GRANT

Older persons would also be faced with the prospect of sharp cutbacks under the proposed social services block grant measures. The administration proposes to con-

solidate 12 services programs—including title XX social services, rehabilitation services, senior opportunities and services (SOS) and others—into a single block grant with only 75 percent of the existing funds for all these programs. This translates into a $1.2-billion cutback, from $5 billion for the 12 programs in fiscal 1981 to approximately $3.8 billion.

Many of these services do not affect the elderly directly, but several do and the overall reduction would adversely affect low-income aged minorities. Older persons represent, for example, a significant proportion of title XX recipients.

The Asociacion Nacional is concerned about the sharp cutback in funding for necessary services. This represents a double-barreled negative impact because inflation is driving up the cost of service programs. Thus, the total real reduction is probably well above 25 percent when inflation is factored into this equation. The net impact is that block grants with less funds for services means less resources for the elderly—no matter how you cut the funding pie.

MEDICARE

The Asociacion Nacional is deeply concerned about the administration's proposals to repeal the recently enacted measures to: (1) Remove the 100-visit limitation on reimbursable home-health visits under medicare, and (2) make occupational therapy a qualifying primary service for home-health benefits. These provisions were approved last year, with strong bipartisan congressional support, to make home-health services more readily available to older persons.

Today, many older Americans are placed in institutions at a much higher public cost because alternative care is not available. We believe that it makes much more sense to encourage elderly persons to live in their homes where most of them would want to be, instead of being prematurely or unnecessarily institutionalized.

We recognize that some persons have no realistic option but to be placed in a nursing home. But, large numbers of elderly persons are inappropriately placed in nursing homes. Some experts estimate that 20 to 40 percent of all nursing home residents should receive other forms of care.

Our policies should encourage—and not discourage—older Americans to live independently in a family or home setting. This is particularly important for Spanish-speaking persons because most services are provided through informal support systems, such as the family. Older Hispanics have repeatedly emphasized to the Asociacion Nacional that they would prefer to live independently in their homes if at all possible. We strongly support policies to implement this objective, such as providing for unlimited reimbursement for home-health services under medicare, instead of imposing a 100-visit limitation. In addition, we want to reaffirm our support for making occupational therapy a qualifying primary service for home-health benefits. This measure would be especially helpful for stroke victims. And, we urge that it be retained.

Many elderly persons with health problems can live independently in their homes with appropriate care. The vast majority of these individuals would prefer to live at home with their families and be near their friends and neighbors. And, they can if essential home-health care and other appropriate services are available.

OTHER MEDICARE PROVISIONS

The Asociacion Nacional also opposes the administration's recommendation to repeal the measure to provide full medicare reimbursement for pneumococcal vaccine and its administration. About 54,000 older Americans die annually from pneumococcal strains of pneumonia. Low-income elderly persons would be most adersely affected by this proposal because they may not be able to afford the vaccine.

One of the major problems with our health care system today is that it is crisis oriented. Soundly conceived and well-timed preventive measures, though, can be cost effective for older persons as well as our Nation. The Asociacion Nacional has long maintained that preventive measures must be built into our health care system. Otherwise many low-income Spanish-speaking persons will not receive the care that they need until their disease or illness reaches the crisis stage. At that point, it oftentimes is too late.

The Asociacion Nacional further opposes the administration's proposal to permit States to purchase medicare part B coverage (primarily physician's services) for medicaid recipients only once a year. States can now buy in at any time. This measure would impose greater restrictions which would work to the disadvantage of older Hispanics and other aged minorities who simply do not have the resources to pay $9.60 a month for part B supplementary medical insurance. Beginning in July, this premium charge will rise to $11.

Minorities have a lower participation rate in part B because the existing premium change can be a major obstacle for persons struggling on limited incomes. Figures are not available concerning the participation rate for Spanish-speaking persons. However, less than 92 percent of all nonwhites were enrolled in part B in July 1979, compared to 96 percent for Anglos. The Asociacion Nacional opposes efforts to make it more difficult for low-income minorities to obtain part B coverage.

Senator DURENBERGER. Ms. Shields.

STATEMENT OF LAURIE SHIELDS, OAKLAND, CALIF., EXECUTIVE DIRECTOR, OLDER WOMEN'S LEAGUE

Ms. SHIELDS. Thank you.

As you know, my name is Laurie Shields. What you might not know is that like millions of other older women, I am a widow. It was my experience after the death of my husband, that led me to a brandnew career, one in which I broke in 10 pairs of tennis shoes. The 11th pair I am now wearing today. The only addition in the intervening years is the arch supports I am now wearing in them.

I am the executive director of OWL, the Older Women's League, a national membership organization. Launched just last October, after the White House Miniconference on Older Women, with headquarters in Oakland, Calif., but already we have 25 charters across the country, and by the end of the year we will have more than doubled that number.

Our purpose is to do something that has not been attempted before; to organize, nationally, middle-aged and older women to be advocates for themselves on the specific concerns of older women, particularly in such areas as health and retirement income.

Mr. Chairman, I welcome this opportunity to appear before you today as a member of the 51.3 percent of the population, women, to highlight our concerns for an invisible majority who have so far today not been mentioned, older women, and the impact on older women of the administration's budget proposals.

I have submitted a detailed statement for the record, but would like to touch on some of our concerns for you now so that we will have time for questions.

Senator HEINZ [presiding]. Without objection, your entire statement will be made a part of the record.[1]

Ms. SHIELDS. In 1978, there were 8.4 million unmarried women 65 and over, in our country, in contrast to 1.3 million older men. Now, these statistics demonstrate why it is necessary to consider the impact of the proposal specifically on older women as a group. It is these women, mothers, sisters, grandmothers, and eventually today's daughters who bear the brunt of poverty. Sixty percent of older women rely on income solely from social security, and only 18 percent receive pension income, either as retirees or dependents, and I would point out—and I hope not to have it considered as emotional rhetoric—that these are women who have given of themselves all their lives to their families, their churches, and communities and for whom, in their later years, we insist and we believe you agree, society does have an obligation.

Senator Schweiker, the new Secretary of Health and Human Services, in testimony to the House Ways and Means Committee recently, said that:

[1] See page 260.

None of the President's proposals means a turning away from the conscience of the Nation, or our commitment to those who justly depend on existing public programs.

Mr. Chairman and Senator Durenberger, the facts just do not bear that out. We have been asked to speak on the proposed health cuts.

We strongly oppose any cuts in home health care benefits or third-party payments for extended-care facilities. On the contrary, home health care programs should be greatly expanded to keep people out of nursing homes and, I might point out, that 70 percent of the people in nursing homes are older women; because both home health care and long-term care recipients are overwhelmingly female, as are those who provide the services, as the gentleman testified today, at a minimum wage, which is not a tremendous incentive. This is an issue of great concern to women of all ages, races, and political affiliations.

Men will suffer, too, but men more frequently marry younger women who look after them in their last years. There are nine times the number of bridegrooms to brides over 65 despite the larger number of women in that age bracket. Cuts in these areas will overwhelmingly impact upon those who most—to use Senator Schweiker's phrase—"justly depend on existing public programs."

Proposed cuts in medicaid will again hit the poorest, the oldest, and the neediest; namely, elderly women. For these persons, medicaid is a necessity to supplement their limited coverage under medicare.

No one testified to it this morning, but medicare does not cover so-called "custodial" home-health care, although this may keep a poor older woman out of a nursing home, but medicaid does.

If reimbursement rates for medicaid are lowered for doctors, even fewer than now will take on medicaid patients. If lowered for hospitals and other health institutions, the burden of making up the difference would most likely be shifted to the counties and the cities, which are currently closing institutions in their own budget slashing moods.

Closing the 8 remaining public health service hospitals and 29 health clinics may please Mr. Stockman, whose experience with the aging is limited to his own 34 years, but it will also limit the medical resources for poor elderly widows.

Medicare costs are indeed going out of sight, but as this committee surely knows, the out-of-pocket medical costs of an older person are not less, but greater than when medicare was enacted.

The fault, we say, lies not with older women, unless you want to blame them for chronic illness, or living longer, but with a third-party reimbursement system designed to stoke the inflationary fires of medical costs. The remedy indeed is not to deny the needs for which the health care system was designed, but to reform it or replace it with a national health service in which fees for service is not the guiding principle.

In regard to the proposed cuts under discussion, we are also very concerned with the block grant philosophy. The supposed advantage of providing States and localities with flexibility sounds appealing until you recognize that flexibility to do nothing is one option that may become increasingly popular, especially for programs serving persons without political clout.

I am disturbed, too, principally by our semantic kind of approach to changing what are really problems. We have no poverty in this country if we redefine it. I am reminded of a young man I met in Detroit a few weeks ago who, when I asked him what he did, said he was a fuel transfer engineer. He pumps gas at the station.

As in all other block grants such as revenue sharing and CETA, most decisionmaking will not be made on the basis of the particular needs of the community, but on who has the inside track with the local politicians who make the decisions.

Federal programs were instituted by Congress and, I note, Senator Glenn made the point well today; because many States did not or could not develop their own social programs; because Federal guidelines were clearly needed. We should not throw these hard-fought-for programs back to the tender mercies of the States. It just must not be done.

The broad statistics provided by the administration mask the specific groups who will suffer most. The administration has said that only service providers will be hurt. On the contrary, we represent the real victims of these ill-advised and heartless cuts. Unless you wish to put us on an iceflow, as has been done in the Eskimo culture, you must find other ways to balance the budget.

We urge you not to rush these cuts; we who are the mothers, grandmothers, and great-grandmothers of this Nation deserve at least that much.

Let the conscience of this Nation remain intact.

We are hopeful that when Members of Congress go home during the Easter recess, you will hear, loud and clear, what I have heard since October, traveling across this country—yes, we want restrictions in Government spending, but not these kinds of restrictions that undermine the means of livelihood for millions of America's older women.

Thank you very much.

I will be pleased to take any questions.

Senator HEINZ. Thank you very much, Ms. Shields.

[The prepared statement of Ms. Shields follows:]

PREPARED STATEMENT OF LAURIE SHIELDS

My name is Laurie Shields, and I am executive director of the newly formed Older Women's League. Recognizing that the specific concerns of women have not been adequately addressed in public policy related to retirement income, health programs, and other necessary services, we have formed this national membership organization to advocate in our own behalf. Launched just 5 months ago, we now have 25 chartered chapters spread across the country, and by the end of this year will more than double that number. Our function is to develop an effective core of trained citizen advocates which can speak out on older women's issues and forge a link between women's organizations and the aging network. This is our maiden flight in presenting testimony as an organization, but you will be hearing more from us.

Is there a need for an organized voice—specifically for older women? Granted, there are more elderly women than men, but are not the issues common ones? Yes, but they impact quite differently on women, because old women are far more likely to be alone and poor. Consider these facts: The majority of older women are widows, while most older men are married. Sixty-two percent of women 65 and over are widowed, while only 25 percent of men are living without spouses. Or to put it in

numerical terms, in 1978 there 8,414,000 unmarried women 65 and over, in contrast to 1,300,000 men.[1]

It is these same nonmarried women who bear the brunt of poverty. Two out of five nonmarried women over 65 are officially poor, compared to one-fourth of elderly nonmarried men and a tenth of elderly married individuals. If race is added, poverty is still more prevalent. Three out of five nonmarried black women are poor.[2] Poverty in all age groups is becoming more feminized each decade and the old are no exception. The fastest growing segment of the elderly poor are women. As far as retirement income goes, 60 percent rely on social security alone, and only 18 percent receive income, either as retirees or dependents.[3]

When we talk about the basic problems of aging: poverty, isolation, crime against the elderly and institutionalization, these are overwhelmingly the problems of women who have outlived their mates; who have given of themselves all their lives—to their families, their churches, and their communities—and for whom, in their later years, society has an obligation. The Government programs to be discussed today were set up by Congress after long study to help fulfill some of that obligation. So when we talk about budget cuts in these programs, let us keep clearly in mind that we are talking primarily about elderly widows.

Secretary Schweiker said, in testimony to the House Ways and Means Committee recently, that, "None of the President's proposals means a turning away from the conscience of the Nation, or our commitment to those who justly depend on existing public programs. The safety net is not being weakened or withdrawn." Let us look at the proposed cuts which this committee is addressing and see whether the conscience of the Nation would be diminished.

We have been asked to speak first on the proposed health cuts. We strongly oppose any cuts in home health care benefits or third-party payments for extended care facilities. On the contrary, home health care programs should be greatly expanded to keep people out of nursing homes, and to begin to match services which exist in all industrialized countries except South Africa. Because both home health care and long-term recipients are overwhelmingly female (as are those who provide the services), this is an issue of great concern to women of all ages, races, and political affiliation. What alternatives are there for poor elderly widows if home health care and long-term care facilities are cut back or eliminated? Are they being asked to end their lives more quickly in order to balance the budget? Men will suffer too, but men can more frequently marry someone to look after them in their last years. There are nine times the number of bridegrooms than brides over 65 despite the larger number of women in that age bracket. Cuts in these areas will overwhelmingly impact upon those who most (to use Senator Schweiker's phrase) "justly depend on existing public programs."

Proposed cuts in medicaid will again hit the poorest, the oldest, and the neediest, namely elderly women. For these persons, medicaid is a necessity to supplement their limited coverage under medicare. For example, medicare does not cover so-called "custodial" home health care (although this may keep a poor old woman out of a nursing home) but medicaid does. If reimbursement rates for medicaid are lowered for doctors, even fewer than now will take on medicaid patients. If lowered for hospitals and other health institutions, the burden of making up the difference would most likely be shifted to the counties and the cities, which are currently closing institutions in their own budget slashing moves. A cap on long-term care, which funds nursing homes, would send more old women and men into those local hospitals. Where else could they go, except out on the street? Surely no one believes that these old people are freeloading by choosing to go into nursing homes at public expense.

The discretionary health programs are also slated for cuts. For example, grants and loans to health maintenance organizations, which are the only health institutions at the present time which have a built-in incentive to keep people well, seems very shortsighted. Closing the eight remaining Public Health Service hospitals and 29 health clinics may please Mr. Stockman, but again will limit further the medical resources of poor elderly widows.

Medicare costs are indeed going out of sight, but as this committee surely knows, the out-of-pocket medical costs of an older person are not less, but greater than when medicare was enacted. The fault lies not with old women (unless you blame

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[1] "Older Women: The Economics of Aging," The Women's Studies Program and Policy Center at George Washington University, in conjunction with the Women's Research and Education Institute of the Congresswomen's Caucus. 1980. Figures from Census Bureau.

[2] Grad and Foster, "Income of the Population Aged 65 and Over," Social Security Bulletin, July, 1979.

[3] Social Security and the Changing Roles of Men and Women." HEW, February 1979. Statistics drawn from the Current Population Survey, Bureau of the Census, March, 1977.

them for chronic illness and longevity) but with a third-party reimbursement system designed to stoke the inflationary fires of medical costs. The remedy is not to deny the needs for which the health care system was designed, but to reform it or to replace it with a national health service, in which fee-for-service is not the guiding principle.

The Older Women's League has made access to health care insurance its primary target for the year. Today, we have been speaking primarily of women 65 and over, but older women under 65 are particularly vulnerable if they are not in covered employment. They are ineligible for disability benefits under social security; they are not yet eligible for medicare; if they are widowed or divorced, or their husbands retire, they often find health insurance impossible to buy, with exclusions for "existing conditions," or else so expensive that they can't afford it. Even if available, benefits may be miniscule in comparison with today's medical costs. This is one example of the invisible problems of dependent women when we grow old.

In regard to the proposed cuts under discussion here, we are also very concerned about the "block grant" philosophy. The supposed advantage of providing States and localities with "flexibility" sounds appealing until you recognize that flexibility to do nothing is one option that may become increasingly popular, especially for programs serving persons without a political clout. As in all other block grants (such as revenue sharing and CETA), most decisionmaking will not be made on the basis of the particular "needs" of the community, but on who has the inside track with the local politicians who make the decisions. One current rationale for cutting CETA is that the local planners used the Federal money to shore up sagging personnel budget by filling the positions with PSE CETA workers rather than the long-term unemployed. Revenue sharing moneys usually go for favored projects of officials, which may or may not reflect the concerns of the "truly needy." This block grant philosophy may serve the current administration by presenting much reduced pies to local communities and letting them take the heat for the reductions. For us who are on the receiving end, this strategy pits one group of persons who are hurting against the others. Older women do not want to find themselves in a struggle against poor children, nor do we want SSI beneficiaries to be split from AFDC mothers. The bell is clearly tolling for all the poor together.

Federal programs were instituted by Congress because many States did not or could not develop their own social programs; because Federal guidelines were clearly needed; and because Federal standards helped mitigate geographic inequities. Sending these hard-fought-for Federal programs back to the tender mercies of the States is to throw away what little progress that has been made in the war against poverty. Just as in California, where some counties which provide no general assistance (welfare), offered their eligible poor carfare to the next county, those States with more "generous" benefits will see an influx of poor persons from more miserly States. Block grants are a "cop out." If you feel a program has not served its purpose, reform or replace it. The needs have not changed, but on the contrary, are greater than ever, especially for older women. Don't pretend that block grants will make these programs better. They will uniformly become less adequate.

Also, please consider the interrelations of proposed cuts on each other. Loss of food stamps (elderly women are especially affected), compounded by loss of legal services to help overcome the hurdles of access to such lifeline programs as SSI (almost 3 to 1 women), removal of the minimum benefits formula for social security (almost 2 to 1 women), plus possible reduction in Older Americans Act programs (in which women are a large majority), all compound each other to literally take food out of the mouths of elderly widows.

The broad statistics provided by the administration mask the specific groups who will suffer most. The administration has said that only service providers will be hurt. On the contrary, we represent the real victims of these ill-advised and heartless cuts. Unless you wish to put us on an iceflow, you must find other ways to balance the budget. A wise judge in Orange County, Calif., once said in a divorce trial, "A woman is not a breeding cow to be nurtured during her years of fecundity, and then conveniently and economically converted to cheap steaks when past her prime." We urge you not to rush these cuts through without careful consideration of who will be hurt and to what degree. We who are the mothers, grandmothers, and great-grandmothers of this Nation deserve at least that much. Let the conscience of this Nation remain intact.

Senator HEINZ. I want to yield to Senator Durenberger who missed his round of questioning last time. I know he made a special point of being here, Ms. Shields, because he wanted to have a discussion with you.

Senator DURENBERGER. Thank you.

Senator HEINZ. Senator, I am going to go and vote. I will tell you what we can do.

When you have to leave, and if I am not back, Ms. Barbera of the Aging Committee staff, will continue the hearing, and she has some questions that she will be asking you until one or the other of us gets back. It sounds complicated, I know, but it will work.

Senator DURENBERGER. It is preferable to waiting for us, which happens frequently.

I want to start out by thanking you for undertaking to represent a totally underrepresented segment of the population of this country.

I want to thank you also for recognizing the value in the Economic Equity Act, and your contribution and your comments on the Economic Equity Act as it relates to all women, but particularly older women. For the rest, you will find out what the Economic Equity Act is all about on April 7; but I thank you for that.

I thank you also for the comment on block grants. The thing that has bothered some of us most about taking the existing categorical grants and trying to get as many as possible into as few blocks as possible is the strategy of pitting one group of people against the other. It bothers me a great deal when I see the progress that we have made on maternal and child health care in this country, and then see that group of people forced to compete with the elderly. I think what I would say to you, rather than asking a specific question, is that both of you, and the people that you represent, are going to have to be part of a process of identifying the way in which we build some kind of a new relationship between Federal, State, and local government, and the voluntary nonprofit delivery system out there in this country.

I do not think the answer to redefining that relationship lies in cutting, capping, or blocking existing categorical grant programs. I think there is a more effective solution to this problem out there somewhere. I just see our responsibility as national policymakers primarily of insuring that everyone has equal access to those delivery systems that can best meet their needs. We have not done a good job of insuring equal access in the past, because even in the categorical grants system, we have pitted one element of society against another.

You know I am, with another hat on, in intergovernmental relations, and I'm trying to give some definition to that relationship. We do not have time, I am sure, in the next couple of weeks or the next couple of months, to give final definition to that. But there are some of us who are saying that perhaps the Federal Government's responsibility ought to insure equal access to services for people; and State and local government's primary responsibility ought to be those kinds of services that are more mass oriented: The survival of the cities, transportation systems, you know, a variety of these kinds of things.

I think your testimony obviously points up the shortcomings in a short-term approach to redefining these relationships and all I can do, before I go to the floor to vote, is to encourage you both and the many, many people that you represent to become part of a process of change.

I see in the statement relative to Spanish-speaking people in this country something that is obvious to those of us who know the cultural backgrounds of the Spanish-speaking people, that in the areas of housing and home-health care, even in our categorical grant system in this country, we automatically discriminate against the Hispanics. Yet, we need to know how to build a system, based on the home, that does not bankrupt us in some way.

Let me conclude by thanking you for your testimony and for your interest. And let me thank the many people that you represent for the confidence that they have placed in both of you, in allowing you to speak for them at a time of substantial change in public policy in this country.

Ms. LACAYO. Thank you.

Ms. BARBERA [presiding]. I have never been in this position before. Tell me if I am not speaking loud enough. I only have a few questions, I think one for each of you.

Senator Durenberger has already addressed the issue of block grants and some of the short-run potential problems that it may pose if not structured properly.

Mr. Callahan has also cited some important and really rather grim statistics regarding the inclusion of the elderly in some of the programs that the administration has proposed to fold into the block grants program, including title XX, the community health center, and the community mental health centers.

This is a question that is relevant universally to all of the block grant programs, and I address this to both you, Ms. Shields, and Ms. Lacayo.

Do you have any specific ideas as to how we can reconcile the need to target the needy, most vulnerable populations with the wisdom of placing the decisionmaking responsibility for the provision of many of these services closer to the populations that are served?

Ms. SHIELDS. One of the other things I think we need really to do is to invest some money in preventive health care.

Cuts have been suggested for the HMO's. Now, they are the only ones right now who are doing anything in the way of providing preventive health care services. Instead of being cut, they should be strengthened.

As older women, we are at an age when we should talk in terms of changing our lifestyles and our diets, but we are not being encouraged by the medical people to do that. I am further very concerned about medical research, which is, for the most part, done by males. Perhaps we need more devoted women researchers. For example, as long as menopause is seen as a deficiency disease, we are going to have hysterectomies and the prescribing of estrogens, whereas, if only we could turn that thinking around and see menopause as the beginning of a new stage of life and not the end of life, then the stress would be on other things, like diets, therapy, and exercise. It is just a different way of looking at aging and, of course, you know, the double standard does exist—a man of 40 is at his peak; a woman at 40 in this society is considered over the hill. So we do need to change some things.

Ms. LACAYO. When you are dealing with the block-grants issue, we are dealing with a double sword, because everyone is talking about rescinding the restrictions.

We see a recent Washington Post article that said that the Justice Department is really looking at enforcement regulations with respect to permit actions, the EEOC compliance. We are in a situation where, unless someone enforces upon the States mandated services and mandated regulations that if they do not do this, this will happen to them, we cannot be protected.

I will give you one example, as I said in my testimony.

Migrant health workers, it was proven time and time again, that the States were not serving migrant health needs. So Congress then established the migrant health program. By taking that program now and throwing it back to the States in a block grant situation, we are going to go back to where we were.

I cannot rely on the good faith of States and municipal governments to reach the needs of my particular community. We are a nonvoting community; we are close to 20 million strong in this country, but we are not a voting segment of the American population, and unless we have goodwill toward us, we just do not have the political momentum to force local entities and governments, State government, with their sovereignty, to direct themselves to the needs of our community. So unless there is enforcement language in block grants and a strict oversight language with very deliberate delineation of civil rights legislation, I think that we are just going to go back to where we were 20 years ago, and I see very dismal prospects, especially in our community, whereas the Senator was just saying, the complexities of a monolingual population are just very complex, and States do not presently address these needs out of their own volition.

However, there is a dichotomy here, because the present administration is antiregulations, antirequiring States to be responsible for Federal dollars in the sense of really serving all segments of the population, and you know, in Mr. Swoap's testimony before this committee, one of the things he talks about in his block grants benefits is it will allow States to meet particular needs and priorities of their citizens and more efficient use of resources.

I take issue with that because we see now in the State of California where the State office on aging has returned year after year millions of dollars to the Administration on Aging for their inability to decide where that service dollar can be placed and I think that speaks of where they are.

In the title V program, the senior citizens program, time and time again we see that the States returned money because they cannot, for some reason, get their act together to implement their act together. There are examples out there that are well documented, especially in the case of revenue sharing where the Revenue Sharing Act, after research by Congress, came back and determined that when it came to minorities and equitable distribution, the Revenue Sharing Act had not had the appropriations for those moneys.

Ms. SHIELDS. Actually, block grants are copouts. They pass to the States the heat of the reduced funds.

Ms. BARBERA. I would like to pursue what you said, Mrs. Lacayo, with a followup.

On page 3 of your testimony, you quoted Under Secretary Swoap, in his testimony before this committee; and he said, and I quote:

> By eliminating many burdensome Federal administrative requirements, standards, and the like, the block grant will permit more efficient State and local administration.

Now, you took issue with that, too, I think.

Are not there some areas in which the block grant concept can be utilized, though, to lessen the administrative burdens without taking away the basic protections that should be present to insure that the eligible and minority populations are served on an equal basis and as these—as the Congress goes about the work of structuring block grants, or constructing block grants, what exactly—what are the basic protections that you would offer as advice in the development of those?

Ms. LACAYO. No. 1, I believe that the block grant concept in certain areas, in transportation services, in municipal services, in the area of provider State services which are presently regulated to death, that I would see effective use of block grants.

But in the area of human services and health services, I will go back to my original statement. Unless stringent requirements for regulations are built in that guarantee that in the targeting of these services, emphasis will be given to those with the greatest social and economic need and, by that, I mean into the funding mechanism is written language that the State has to guarantee to the Federal Government how they have targeted those communities, a State will argue that that is restricted language and imposing more paperwork.

I see no other way of forcing a State or a local government to show or prove or how they target those with the greatest social and economic needs.

There is no human way right now that a State or an area agency on aging, for example, can say to me that they serve Hispanic elderly out of the goodness of their hearts, because they know where they are, and so on.

Unless they show me in black and white, that they have taken the census data and then endorse the services in that particular community, their language and their highest platitudes are of no use to us.

It is a dichotomy; there is a real situation of, on the one hand saying, we want less administrative work, less paperwork, less burdensome requirements but, from our perspective, we are talking about the truly needy, and that concept of the safety net and if the safety net is not regulatory language that protects us, then I cannot ascribe to the fact that political entities are going to serve our community out of the goodness of their hearts. It just will not work.

Ms. BARBERA. Ms. Shields, I have a question for you that is not entirely related to this particular hearing.

As you may know, this committee held a hearing last week on the impact of the budget in the areas of older persons, in the area of income security, including food stamps, and social security, and you were not with us last week; but there was a question that was

pertinent to the group that you represent, and I would like to ask you about it.

Ms. SHIELDS. It is very pertinent to older women, and on the face of cuts that are proposed, they would seem not to impact on older women. But they will take benefits to students—student benefits, basically, we are talking about the children of widows, and so there are older women involved.

Minimum payments, yes, we need to catch double-dippers, but my God, 76 percent of those getting minimum benefits are older women who are not double-dippers.

Ms. BARBERA. That is exactly where my question is leading.

We heard testimony suggesting that the proposed elimination of the social security benefits might have an impact on women between the ages of 60 and 65 who are now receiving their benefits.

Do you have any specific information on the impact of the proposal on that group? Would expansion of SSI, to make such women eligible be adequate to protect this?

Ms. SHIELDS. Putting them into SSI puts them into a means tested program. It is not easy to get SSI to begin with. So that it suggests to us that short of warehousing us in institutions, there is a desire to pull down further the whole shield of invisibility as far as older women are concerned, and make it tougher to see our needs.

As for the changes in the social security system that have been proposed so far, as I said—I would feel very comfortable if I could be reassured and really feel certain that they had been examined one by one to see what impact they had and on what group, because our research indicates that the greatest group who will be affected by almost all of these, even including the categorical programs, are older women. There are between 10 and 12 million widows in this country, median age, 56; they have not even gotten to age 60 yet, and one-third of all the widows today who are on social security, it is their sole income and they are now living below the poverty level.

I do not know how many more facts we can give you, but I know that Congress is our last resort to save benefits we have an earned right to receive.

Ms. BARBERA. Thank you.

I have no further questions.

Given that they have another vote on the floor, I suspect that they will not be back for some time.

So the hearing is adjourned.

Thank you all very much for coming.

[Whereupon, at 12:20 p.m., the committee adjourned.]

APPENDIXES

Appendix 1

BRIEFING MATERIAL FOR HEARING

MEMORANDUM

TO: Members of the Special Committee on Aging

FROM: Committee Staff

RE: Proposed Cap on Federal Medicaid Expenditures

DATE: March 25, 1981

BUDGET PROPOSAL: CAP FEDERAL MEDICAID EXPENDITURES

The Reagan Administration proposes to place a cap on Federal financial participation in Medicaid beginning in 1981. The limit would be structured to reduce Federal expenditures by $ 100 million below the current estimates in 1981. Federal expenditures would be allowed to increase by 5% in 1982. Thereafter, Federal spending would rise only with the rate of inflation as measured by the GNP deflator. Within the overall spending limit, Federal payments would continue to match State expenditures at current rates. The proposal would also provide for more State flexibility in administering the program. It is described as an interim program to be replaced by comprehensive medicaid reform.

(in millions of dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
Current law:						
Budget authority	17,264	18,830	20,943	23,024	25,106	27,290
Outlays	16,480	18,213	20,441	22,529	24,593	26,732
Reagan's proposed reduction:						
Budget authority	-353	-1,237	-2,213	-3,166	-4,181	-5,318
Outlays	-100	-1,013	-1,986	-2,930	-3,916	-5,021
Reagan's proposed budget:						
Budget authority	16,911	17,593	18,730	19,858	20,925	21,972
Outlays	16,380	17,200	18,455	19,599	20,677	21,711

Budget Issues

Most observers would agree that the open-ended nature of Medicaid has provided very little incentive for efficiency and cost effectiveness in the State Medicaid programs. The need to provide for fiscal discipline in Medicaid is warranted, however. The methodology suggested by the Reagan budget raises a number of issues that merit close examination.

1) The cap treats all Medicaid programs alike, regardless of differences in levels of efficiency, scope of coverage, etc.

2) Medicaid does not currently provide medical assistance to all of the poor, because of its link to the categorically poor, because of its link to the categorically eligible low income groups -- Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). Therefore, there are currently many "gaps" in medical coverage. Despite the pressures to plug these "gaps" and cover the needy, non-categorically linked low-income individuals, some States have cut back on their medicaid programs. Other States have experienced sharp rises in case load due to general economic decline. Still other States are experiencing a decrease in revenues because of a decrease in their tax base.

To cap Federal Medicaid expenditures in light of the above, coupled with the fact that health care costs are increasing at double digit rates, raises serious concerns about their future availability and about the adequacy of Medicaid coverage for many low income individuals in need of medical care.

3) Another possible consequence of placing a cap on Medicaid expenditures is the phenomena of cost-shifting to Medicare and privately insured patients. Because of reimbursement under Medicare, and the allocation of cost procedure employed by hospitals, hospitals may find ways to shift costs no longer paid by Medicaid to areas reimbursed under Medicare. In addition, charges to Medicare and private pay patients may increase to compensate for losses under Medicaid. One additional potential cost shift may result from utilization changes in institutional long term care. Medicaid pays for Intermediate as well as Skilled nursing facilities for institutional, long term care, while Medicare pays only for Skilled nursing facilities (SNF). Limiting Medicaid reimbursement may therefore result in longer hospital stays under Medicare, and inappropriate placement in SNF's under Medicare, thereby further inflating Medicare expenditures.

Compounding this incentive to use more costly skilled care services reimbursed under Medicare may be the Administration's proposed elimination of Professional Standards Review Organizations and Utilization Review -- programs designed to prevent inappropriate individual placement.

4) A ceiling on federal Medicaid outlays combined with fewer federal requirements may increase interstate variation in eligibility and benefits.

OPTIONS FOR ALTERNATIVES TO MEDICAID CAP:

A number of additional and alternative budget saving opportunities have been proposed by various sources.

The Senate Finance Committee has listed the following items that could be used to supplement or supplant the administration's proposed FY 82 reductions:

Revisions approved by Committee in Past:	(Estimated savings in FY 82 (in millions)
Payments to promote closing and conversion of under-utilized facilities	$2
Criteria for determining reasonable charge for physician services	$13
Limitation on reasonable cost and reasonable charges for outpatient services	$26
Freedom of choice provision under medicaid	$227
Additional savings provisions:	
Medicare:	
Increase part B deductible from $60 to $75.	$210
$60 to $100	$530
Index Part B deductible to reflect increases in program costs	NA
Require Part B deductible to be satisfied on an annual basis	$55
Maintain Part B premium at constant proportion of program costs (Revenue increase)	$190
Require coinsurance for home health visits under Parts A and B	$230
Require coinsurance for home health visits under Part B only	$67
Mandate coordination of medicare benefits with private health insurance coverage	$170
Medicaid:	
Eliminate the 50% Federal minimum matching rate	$700
Delete statutory requirements specifying State payment of "reasonable costs" to hospitals	$250
Permit States to require and collect a family supplementation for patients in nursing homes. Amounts would be shared between Federal and State governments based on Federal matching rates	NA
Permit States to require a nominal co-payment on patient initiated services	NA

The National Governors' Association has developed the following recommendations as an alternative to a 5% cap on Federal financial participation in the Medicaid program:

1. States need much greater flexibility to act as prudent purchasers of medical services and supplies. Federal policies should allow states to develop cost-effective financing structures; to establish reimbursement policies that encourage efficiency and discourage waste; and to selectively purchase services from efficient providers.

For example, states should have the latitude to:

- o restrict or preclude the participation of providers whose costs are excessive (with certain exceptions, e.g. specialized care in tertiary institutions);
- o contract with physicians, hospitals, and other providers in a manner that establishes a point of responsibility and accountability for total medical costs. States should be allowed to use all the tools available to private industry, such as prospective budgeting, shared risks, and positive incentive reimbursement policies;
- o use competitive bidding and negotiated contracts for the purchase of laboratory services and medical devices.
- o adjust reimbursement rates consistent with the availability of resources, i.e., consistent with budget constraints;
- o limit reimbursement for certain complex medical procedures of a highly specialized nature -- heart surgery, for example -- to hospitals that have the appropriate expertise and volume of experience; and

- o establish prospective hospital reimbursement rates based upon the cost of care in efficiently-run hospitals, and especially to establish prudent rates for hospital admissions involving certain frequently performed and relatively simple procedures.

2. Medicare retrospective reasonable cost hospital reimbursement policies must be replaced by prospective reimbursement policies that encourage efficiency and that do not subsidize waste.

3. States should have the latitude to enchance the role of Medicaid clients as consumers of care, and to share the savings of cost-effective care with clients in the form of increased income, expended benefits, or extended eligibility.

4. States should have much greater latitude to reduce unnecessary utilization of health care services. Towards this end, the following changes in federal policy are recommended:

- o States should be given wider authority to impose realistic and appropriate sanctions against receipients who willfully over-utilize Medicaid, including the ability to suspend or terminate eligibility for clients who chronically over-utilize services;
- o federally-mandated Professional Standards Review Organizations' (PSRO's) purview over Medicaid services should be removed, and states should be given the authority to establish utilization review programs and policies consistent with state needs and perspectives; and
- o states should be allowed to implement a nominal co-payment

on mandatory services for categorically eligible Medicaid recipients and be given the latitude to selectively apply co-payments only to certain services, diagnostic groups, and settings.

5. States should be given greater flexibility to selectively provide services where the need is greatest and/or where resources will allow.

- o states should be able to provide certain optional services only to selected diagnostic groups whose need for a given service is greatest; and
- o states should have the authority to allow political subdivisions to provide matching funds to obtain federal financial participation for optional services and eligibility groups not covered statewide.

6. Procedural requirements associated with fiscal penalties in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program should be repealed.

7. Federal laws and regulations should be amended to allow the Secretary to waive the 50% Medicaid/Medicare Enrollment mix requirement for Health Maintenance Organizations (HMOs) in medically underserved areas.

8. A maximum 90-day time limit should be established for federal approval of program changes proposed by states. Federal requests for additional information would have to be made within 30 days of a state request for approval of a change, and if a final federal determination has not been made within the 90-day maximum, the proposed change automatically would be deemed approved.

9. As an alternative Medicaid cost reducing plan, NGA proposes that Congress enact:

- o the changes recommended in Items 1 - 8;
- o a 10% limitation on Medicare hospital reimbursement rate increases for FY'82; and
- o a capped block grant for long-term care.

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MEDICAID BUDGET PROPOSAL

Medicaid, authorized under Title XIX of the Social Security Act, is a federally aided, State-administered program of medical assistance for certain categories of low-income persons. An estimated 21.7 million people received program services in FY80. Federal program outlays were approximately $14.0 billion in that year while State funds represented $11.2 billion.

The Administration will be proposing legislation which will place a limit on Federal Medicaid expenditures beginning in FY81. Part I of this paper describes the current Medicaid program while Part II outlines the proposed changes.

I. PROGRAM DESCRIPTION

Each State designs its own Medicaid program within certain Federal guidelines and requirements. Thus there is substantial variation among the States in eligibility requirements, range of services offered, limitations imposed on such services, and reimbursement policies. The Federal Government helps States share in the cost of Medicaid services by means of a variable matching formula that is periodically adjusted. The matching rate, which is inversely related to a State's per capita income, ranges from 50 to 83 percent. (See table 1.) The Federal share of administrative costs is 50 percent except for certain items where the authorized rate is higher.

A. Eligibility

States having Medicaid programs must cover the "categorically needy." In general, categorically needy individuals are persons receiving cash assistance

payments under the Aid to Families with Dependent Children program (AFDC) or aged, blind, or disabled persons receiving benefits under the Supplemental Security Income program (SSI). A State must cover under Medicaid all recipients of AFDC payments. A State is, however, provided certain options (based, in large measure, on its coverage levels in effect prior to implementation of SSI in 1974) in determining the extent of coverage for persons receiving Federal SSI benefits and/or State supplementary SSI payments. States may cover certain additional groups of persons as "categorically needy" under their Medicaid programs. These might include persons who would be eligible for cash assistance, except that they are patients in medical facilities (other than for persons under 65 who are in mental or tuberculosis institutions).

States may also include the "medically needy"--those whose incomes and resources are large enough to cover daily living expenses, according to income levels set by the State, within certain limits, but not large enough to pay for medical care, providing that they are aged, blind, disabled, or members of families with children. States may also include all needy and medically needy children under the age of 21, even though they are not eligible for assistance under one of the cash assistance programs.

All States (except Arizona) and the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands, have Medicaid programs. Twenty jurisdictions cover only the "categorically needy," while 34 cover both the "categorically needy" and the "medically needy."

Coverage Limited to the Categorically Needy

Alabama	Georgia	Missouri	Oregon
Alaska	Idaho	Nevada	South Carolina
Colorado	Indiana	New Jersey	South Dakota
Delaware	Iowa	New Mexico	Texas
Florida	Mississippi	Ohio	Wyoming

Coverage Includes Both Categorically Needy and Medically Needy

Arkansas	Kentucky	New Hampshire	Rhode Island
California	Louisiana	New York	Tennessee
Connecticut	Maine	North Carolina	Utah
District of Columbia	Maryland	North Dakota	Vermont
Guam	Massachusetts	Northern Mariana Islands	Virgin Islands
Hawaii	Michigan	Oklahoma	Virginia
Illinois	Minnesota	Pennsylvania	Washington
Kansas	Montana	Puerto Rico	West Virginia
	Nebraska		Wisconsin

B. Services

Federal law requires States to include the following basic services in their Medicaid programs: inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing facility services for individuals 21 and older, home health care services for individuals eligible for skilled nursing services, physicians' services, family planning services, rural health clinic services, and early and periodic screening, diagnosis and treatment services for individuals under 21. In addition, States may provide any number of other services if they elect to do so, including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21, physical therapy, dental care, etc. (See table 2.)

For both the mandatory and optional services, States may set limitations on the amount, duration, and scope of coverage (for example, a limitation on the number of days of hospital care or the number of physician visits).

Under current law, Medicaid recipients are permitted to obtain medical assistance from any institution, agency, community pharmacy, or person qualified to perform the service if such individual or entity undertakes to provide it. This is known as the "freedom of choice" provision.

C. Payment for Services

States, in general, determine the reimbursement rate for services, except for inpatient hospital care, where they are required to use Medicare's reasonable cost payment system unless they have approval from the Secretary of Health and Human Services to use an alternative payment methodology. States are required to reimburse skilled nursing facilities and intermediate care facilities at rates that are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to meet applicable laws and quality and safety standards. Generally, for other services, States may establish their own reimbursement levels, provided the amounts do not exceed what would be allowed under Medicare. In many instances, the rates are considerably less.

Payments for covered services are made directly to the provider of services and the provider is required to accept the Medicaid payment as payment in full for covered services.

D. Cost-Sharing

Federal law permits States to impose nominal copayments and deductible amounts with respect to optional services for the categorically needy and for all services for the medically needy. In addition, nursing homes residents are required to turn over their excess income to help pay for the cost of their care; as a minimum they are allowed to retain $25 for their personal needs.

ADMINISTRATION PROPOSAL

A. Description of Proposal

Under current law, the Federal Government matches whatever States expend under their Medicaid programs. The Administration will propose interim legislation which will place a limit (sometimes referred to as a "cap") on the amount of Federal expenditures. This limit would be structured to reduce Federal expenditures $100 million below the current base estimated for FY81. For FY82, Federal expenditures would be allowed to increase 5 percent. In subsequent years, Federal spending would be allowed to rise at the rate of inflation as measured by the GNP deflator (which measures relative inflation in the economy). During the period the interim proposal is in effect, Federal expenditures would be allocated among the States so that each State would maintain its current relative share of total Medicaid spending.

The Administration proposal will result in an estimated $1.0 billion reduction in Medicaid outlays in FY82. To enable States to adjust to the reduced funding level, the Administration proposal will include modifications in current Medicaid requirements which will permit States greater flexibility in designing and quickly amending the eligibility, benefit, and payment provisions of their Medicaid plans. The Administration has stated that its proposal will ensure that States have the authority to reorient their program quickly toward essential services to those most in need. It notes that no State would be prevented from providing whatever additional services it deemed appropriate out of its own resources.

The Administration has stated that the "cap" legislation is an interim step. It indicates that in the 1983-86 period, it expects to institute comprehensive health financing and Medicaid reforms to reduce the rate of health cost inflation and to improve Medicaid.

B. Budget Impact

The Administration proposal is expected to result in the following changes in the Federal funding level for Medicaid:

(in millions of dollars)

	FY81	FY82	FY83	FY84	FY85	FY86
Current law:						
Budget authority....	17,264	18,830	20,943	23,024	25,106	27,290
Outlays.....	16,480	18,213	20,441	22,529	24,593	26,732
Policy reduction:						
Budget authority....	-353	-1,237	-2,213	-3,166	-4,181	-5,318
Outlays.....	-100	-1,013	-1,986	-2,930	-3,916	-5,021
Proposed budget:						
Budget authority....	16,911	17,593	18,730	19,858	20,925	21,972
Outlays.....	16,380	17,200	18,455	19,599	20,677	21,711

The Administration budget does not project total Medicaid program costs for the FY81-FY86 period. The Carter Administration budget estimated total program costs of $29.4 billion in FY81 and $32.5 billion in FY82. Federal costs for those years were estimated at $16.6 billion and $18.4 billion, a slight difference from the Administration's current law estimates.

C. Discussion

The specifics of the Administration plan have not yet been submitted. The summary indicates that States will be allowed greater flexibility in designing their programs and allowed to make program modifications more rapidly than under current law. While the specific areas where States might be granted greater flexibility have not been identified, the following is a list of a few of the possible modificaitons which could be included in the proposal:

- Eliminate the "freedom of choice" requirement with respect to institutional services. States would be permitted to designate specific lower-cost institutions as the providers of care in an area, provided the quality of care was not adversely affected.

- Eliminate requirements pertaining to reimbursement levels for services, particularly the requirement that States must reimburse hospitals according to the reimbursement methodology established for Medicare except where they have approval for use of an alternative reimbursement system.

- Permit States to impose cost-sharing on all services for the categorically needy.

There are a number of other requirements State Medicaid programs are currently required to meet including those specifying who must be covered under a State Medicaid plan; those pertaining to health, safety, and licensing requirements for institutions; certification, utilization review, and medical review requirements for certain institutional services; and administrative and reporting requirements. It is uncertain whether any of these would be affected by the Administration plan.

The Administration has indicated that States will be able to modify their Medicaid plans more quickly than is currently the case. It would therefore be easier for States to drop or reduce coverage for certain optional coverage groups, for example the medically needy; to drop coverage of certain optional medical services; to reduce the amount, duration, and scope of covered services; or to impose additional cost-sharing requirements.

Responses to the Medicaid cap would likely vary widely among the States. To the extent they have not already done so, States would probably first try to implement management improvements such as controlling eligibility errors (which the Administration estimates costs $1.2 billion per year) and intensifying their fraud and abuse control activities. If a State was unable to bring its costs below the cap as a result of these efforts, it would then be faced with making substantive program modifications. Some States might focus on eligibility

changes, others on benefit modifications, and still others on reimbursement reforms. States which currently have more limited Medicaid programs will have fewer options than those with more generous plans.

As an alternative to making any substantive program modifications a State could choose to make up any shortfall out of its own resources. However, this is probably not a viable alternative for those States which are currently facing fiscal problems with their Medicaid programs.

D. Impact on the States

The Administration has stated that Federal expenditures under the cap will be allocated among the States so that each State will maintain its current relative share of total Medicaid spending. In practice, this would require the establishment of a separate cap for each State and jurisdiction (i.e., 54 individual caps). The Administration has not, however, specified how this calculation will be made.

The OMB, in informal conversations, outlined a methodology currently under consideration. However, application of this methodology would yield larger Federal savings than the target figures specified in the Administration's budget proposal. It therefore appears likely that this methodology will be modified prior to submission of the legislative package.

TABLE 1. Federal Medical Assistance Percentage by State

State	Effective: 10/1/79-9/30/81	Effective: 10/1/81-9/30/83
Alabama	71.32	71.13
Alaska	50.00	50.00
Arizona	—	—
Arkansas	72.87	72.16
California	50.00	50.00
Colorado	53.16	52.28
Connecticut	50.00	50.00
Delaware	50.00	50.00
District of Columbia	50.00	50.00
Florida	58.94	57.92
Georgia	66.76	66.28
Guam	50.00	50.00
Hawaii	50.00	50.00
Idaho	65.70	65.43
Illinois	50.00	50.00
Indiana	57.28	56.73
Iowa	56.57	55.35
Kansas	53.52	52.50
Kentucky	68.07	67.95
Louisiana	68.82	66.85
Maine	69.53	70.63
Maryland	50.00	50.00
Massachusetts	51.75	53.56
Michigan	50.00	50.00
Minnesota	55.64	54.39
Mississippi	77.55	77.36
Missouri	60.36	60.38
Montana	64.28	65.34
Nebraska	57.62	58.12
Nevada	50.00	50.00
New Hampshire	61.11	59.41
New Jersey	50.00	50.00
New Mexico	69.03	67.19
New York	50.00	50.88
North Carolina	67.64	67.81
North Dakota	61.44	62.11
Northern Mariana Islands	—	50.00
Ohio	55.10	55.10
Oklahoma	63.64	59.91
Oregon	55.66	52.81
Pennsylvania	55.14	56.78
Puerto Rico	50.00	50.00
Rhode Island	57.81	57.77
South Carolina	70.97	70.77
South Dakota	68.78	68.19
Tennessee	69.43	68.53
Texas	58.35	55.75
Utah	68.07	68.64
Vermont	68.40	68.59
Virgin Islands	50.00	50.00
Virginia	56.54	56.74
Washington	50.00	50.00
West Virginia	67.35	67.95
Wisconsin	57.95	58.02
Wyoming	50.00	50.00

MEDICAID SERVICES STATE BY STATE

December 1, 1979

BASIC REQUIRED MEDICAID SERVICES: Medicaid recipients receiving federally supported financial assistance must receive at least t[illegible]ices: inpatient hospital services; outpatient hospital services; rural health clinic services; other laboratory and X-ray services, skilled nursing facility services and home health services for individuals [illegible]older; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning, and physician services. Federal funds [illegible]ipation is also available to States electing to expand [illegible] Medicaid programs by covering additional services and/or by excluding people eligible for medical but not for financial assistance. For the latter group States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

● CN[2]
+ Both CN and MN[3]

BASIC REQUIRED MEDICAID SERVICES

Optional Services in State Medicaid Programs

FMAP[1]	SEE ABOVE		Pediatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Services for Age 65 or Older in TB Institutions: A. Inpatient Hospital Services	Services for Age 65 or Older in TB Institutions: B. SNF Services	Services for Age 65 or Older in TB Institutions: C. ICF Services	Services for Age 65 or Older in Mental Inst.: A. Inpatient Hospital Services	Services for Age 65 or Older in Mental Inst.: B. SNF Services	Services for Age 65 or Older in Mental Inst.: C. ICF Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Services for Age 21 through Age 64	Optician Services	Optician Services: Nurses	Dentures Services	Dentures Services: Dentures	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Additional Services	
71		●		●												●					●															12		AL
50		●		●												●																				16		AK
61		—		+												+																						AZ
73		+		+												+					●	●	●												21		AR
50		+		+												+																				30		CA
53		●		+												+					●	●	●												30		CO
50		+		+												+																				17		CT
50		●		+												+																				24		DE
50		+		+												+																				8		DC
50		●		+												+																				19		FL
67		●		+												+					●	●	●												6		GA
65		—		+												+					●	●	●												12		GU
55		+		+												+																				10		HI
66		+		●												+																				20		ID
50		+		+												+																				13		IL
57		●		●												+																				29		IN
59		●		●												+																				24		IA
54		+		+												+																				23		KS
68		+		+												+																				16		KY
59		+		+												+																				15		LA
70		+		+												+																				33		ME
50		+		+												+																				60		MD
51		+		+												+																				28		MA
57		+		+												+																				23		MI
78		●		+												+																				7		MN
60		●		●												+																				8		MS
64		+		+												+																				14		MO
68		+		+												+																				26		MT
58		+		+												+																				22		NE
50		●		●												+																				18		NV
61		+		+												+																				17		NH
50		●		●												+																				37		NJ
69		●		●												+																				17		NM
50		+		+												+																				39		NY
68		+		+												+																				18		NC
51		+		+												+																				23		ND
50		+		+												+																				16		MNI
54		●		●												+																				33		OH
64		+		+												+																				26		OK
56		●		●												+																				23		OR
55		●		●												+																				16		PA
50		+		+												+																				13		PR
58		+		+												+																				13		RI
71		●		●												+																				13		SC
68		●		+												+																				16		SD
58		●		+												+																				16		TN
58		●		●												+																				12		TX
64		+		+												+																				10		UT
68		+		+												+																				10		VT
50		+		+												+																				9		VI
57		+		+												+																				17		VA
50		+		+												+																				28		WA
61		+		+												+																				20		WV
58		+		+												+																				32		WI
50		●		●												+																				6		WY
●	20	—		●												●																						
+	34	—		+												+																						
	54	Total	39	35	37	31	18	46	34	36	28	28	52	34	49	37	22	18	20	30	27	12	10	43	27	29	50	47	34	8	19	46	46	14		

[1] FMAP Federal Medical Assistance Percentage: Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from October 1, 1979, through September 30, 1981 are rounded.
[2] Categorically Needy: People receiving federally supported financial assistance.
[3] Medically Needy: People who are eligible for medical but not for financial assistance.

Form HCFA 899K 10/801

Department of Health & Human Services
Health Care Financing Administration

MEMORANDUM

TO: Members of the Special Committee on Aging

FROM: Committee Staff

RE: Proposed Social Services Block Grant

DATE: March 25, 1981

President Reagan's FY 82 Budget includes a proposal to consolidate over 40 existing health and social services programs into four block grants -- Health Services, Preventive Health, Social Services, Energy and Emergency Assistance (see attached charts). The proposal is intended to place decision-making closer to the local level and to improve service delivery.

According to the Administration's budget, the FY 82 funding for these will be 75% of the 1981 current service levels. The Administration assumes that the reduced funding levels will be partially offset by increased flexibility permitted to the States and the sharp reduction in Federal administration overhead.

Many of these proposed consolidated programs will have some impact on services for the elderly. Of particular importance to older persons is the proposed Social Services Block Grant, which includes Title XX Social Services.

The programs included in the proposed Social Services Block Grant and funding levels are as follows:

Social Services Block Grant	1981 Current Services	1982 Budget Request
Title XX Social Services	$2,716	
Title XX Day Care	200	
Title XX State & Local Training	75	
Child Welfare Services	163	↑
Child Welfare Training	6	
Foster Care	349	CONSOLIDATED
Adoption Assistance	10	
Child Abuse	7	↓
Runaway Youth	10	
Developmental Disabilities	51	
OHDS Salaries and Expenses	4	
Rehabilitation Services	931	
Community Services Administration	483	
Total Social Services Block Grant	$5,005	$3,800

Source: The Fiscal Year 1982 Revised Budget, U.S. Department of Health and Human Services (DHHS), Washington, D.C., March 10, 1982. p. 64.

According to the White House Report, America's New Beginning: A Program for Economic Recovery, the level of funding for the block grants for FY 82 would remain constant through FY 86 with no cost of living increases. In addition, no state matching funds would be required for the Federal block grants.

Background: Title XX Social Services

Program Description

In 1974, the Congress amended the Social Security Act by adding a new provision, title XX, authorizing and delineating a comprehensive program of social services intended to attain the following five broad national goals:

-- To help people become or remain economically self-supporting.

-- To help people become or remain self-sufficient.

-- To protect children and adults who cannot protect themselves from abuse, neglect, and exploitation and to help families stay together.

-- To prevent and reduce inappropriate institutional care as much as possible by making home and community services available.

-- To arrange for appropriate placement and services in an institution when this is in a person's best interest.

States have considerable freedom in selecting services to attain these goals. At least three types of services must be available to recipients of SSI or State supplementary payments.

The law requires that at least one-half of the Federal funds be used to serve persons eligible for, or recipients of, cash welfare payments (Aid to Families with Dependent Children and SSI) or persons eligible for Medicaid.

Eligibility

Each State determines its beneficiaries. Federal law permits States to give federally subsidized social services to all persons whose gross income is below 115% of their State's median income, adjusted for family size. For persons whose income falls between 80% and 115% of the median, the law requires that fees must be charged; for those with lower incomes, fees may be charged, but at the discretion of the State agency.

Funding

Federal funds for Title XX are allocated among the States on the basis of State's proportional share of the total U.S. population. On a matching basis, 75% of expenditures for social services and 90% for family planning services can be federally funded.

Applications for Federal funds are made in the form of a State plan, which must be published in proposed form and made generally available for public comment. States are awarded funds quarterly based on their estimates of funds needed to fulfill their plans.

Funds available annually for Title XX have been:

$2.7 billion in 1977
2.7 billion in 1978
2.9 billion in 1979
2.7 billion in 1980
2.9 billion in 1981

Title XX funds are authorized to increase to $3.3 billion in FY 85, at the rate of $100 million increase per year.

Services

A broad array of services are provided to eligible recipients under the Title XX program. In information provided to the Special Committee on Aging in April 1980, Secretary Patricia R. Harris of the Department of Health and Human Services estimated that over 1300 services have been identified by the States in their Comprehensive Annual Services Program Plans. In reports submitted quarterly by States, services are summarized in 34 different categories.

Services of most relevance to the elderly include:

Homemaker Services
Health-related Services
Transportation Services
Adult protective services
Counseling Services
Adult day care Services
Legal Services
Chore Services
Senior center Services
Counseling for self-care services
Community home care Services
Individual and family adjustment services
Service planning/case management services
Financial management services
Assessment of need for protective services
Recreational services
Meal Services

The attached chart exerpted from a GAO report released in April, 1979, describes the units of service most frequently delivered to the elderly per quarter in FY 78.

UNITS OF SERVICE MOST FREQUENTLY DELIVERED TO THE ELDERLY PER QUARTER IN FISCAL YEAR 1978

Type of service	Colorado	New Mexico (note a)	Maryland	Penn-sylvania	Ohio	Missis-sippi	Florida
Homemaker	1,838	990	599	1,186	1,656	2,495	1,043
Health-related	1,586	1,238	1,256	-	306	-	230
Transportation	-	-	-	1,422	939	1,446	540
Adult protective	-	146	218	-	-	-	299
Counseling	-	-	-	703	-	-	701
Adult day care	-	540	-	-	-	609	-
Legal	-	-	-	736	-	-	231
Chore	-	258	-	-	290	-	-
Center service for elderly	-	-	-	5,828	-	-	-
Counseling for self-care	-	-	-	-	-	5,601	-
Community home care	-	-	1,786	-	-	-	-
Individual and family adjustment	1,671	-	-	-	-	-	-
Service planning/ case management	-	-	-	1,370	-	-	-
Financial management	653	-	-	-	-	-	-
Assessment of need for protection	566	-	-	-	-	-	-
Recreational	-	-	-	-	-	428	-
Meals	-	-	-	-	374	-	-

a/Fiscal year 1977 data used because fiscal year 1978 data had not been submitted to HEW at the time of our review.

General Accounting Office, April 1979

84-055 O—81——9

Elderly Recipients

It is estimated by the Department of Health and Human Services that $2 out of every $10 of Title XX funds are spent to provide services for the elderly.

Because of the nature of the program and the States' wide latitude to determine the kind and range of social services which they will offer to the eligible population, there is no definitive data on the numbers of elderly served. Another reason for lack of uniform data is that the States may also choose the services according to categories of eligible persons and geographic areas within the States.

In an analysis of expenditures by State and by eligibility category among SSI recipients, in July - September 1977, 38% of the funds were spent for services to the elderly nation-wide. The percentage spent by State ranged from a high of 83.6% for the State of Pennsylvania to a low of 5.5% for the State of Montana. (See attached table prepared by DHHS.)

Of the 4,367,758 persons receiving SSI funds nationwide, 49% were elderly; of this group 13.7% received Title XX services. The percent receiving Title XX services by State ranged from 43.7% for the State of Oregon to 3.4% in the State of Mississippi. Attached: DHHS tables of Title XX expenditures and services for SSI recipients by eligibility categories and by State.

TABLE 6.-- Number of SSI recipients and percent receiving Title XX services by eligibility category, by State, July-September 1977

State	Total number of SSI recipients 1/				Percent receiving Title XX services			
	Total	Aged	Blind	Disabled	Total	Aged	Blind	Disabled
Total	4,367,758	2,139,059	78,652	2,150,047	13.8	13.7	23.8	13.5
Alabama	148,454	95,072	1,974	51,408	7.8	5.8	12.2	11.2
Alaska	3,563	1,509	83	1,971	--	--	--	--
Arizona	29,634	13,616	499	15,519	10.4	10.2	35.9	9.7
Arkansas	86,415	52,768	1,641	32,006	11.3	10.8	22.2	11.4
California	700,317	329,985	16,987	353,345	16.1	14.7	20.5	17.2
Colorado	41,354	22,480	349	18,525	17.1	15.1	26.4	19.4
Connecticut	28,943	10,318	346	18,279	8.4	8.0	29.8	8.2
Delaware	7,286	3,034	211	4,041	11.1	11.6	17.1	10.3
District of Columbia	15,302	4,768	196	10,338	6.2	6.7	10.7	5.8
Florida	165,945	89,920	2,543	73,482	11.2	9.1	20.5	13.4
Georgia	163,539	84,716	2,962	75,861	8.7	6.9	10.8	10.5
Hawaii	10,018	5,342	142	4,534	16.4	14.2	12.7	19.0
Idaho	8,708	3,697	109	4,902	12.4	11.3	13.8	13.2
Illinois	142,523	44,594	1,721	96,208	16.5	14.0	44.1	17.2
Indiana	42,356	19,051	1,068	22,237	10.6	7.1	10.3	13.7
Iowa	27,963	14,037	1,119	12,807	28.3	21.0	16.6	37.2
Kansas	23,090	10,756	346	11,988	11.6	8.9	33.8	13.5
Kentucky	99,953	53,378	2,033	44,542	7.2	4.5	8.6	10.2
Louisiana	151,264	83,152	2,203	65,909	12.0	13.2	10.6	10.5
Maine	23,402	11,892	280	11,230	20.0	17.5	16.8	22.6
Maryland	49,394	18,349	554	30,491	21.4	34.1	41.3	13.4
Massachusetts	129,685	74,258	4,522	50,905	10.3	10.0	44.9	7.6
Michigan	119,543	46,059	1,654	71,830	20.6	17.1	22.1	22.8
Minnesota	37,202	16,737	681	19,784	30.6	11.3	27.8	46.9
Mississippi	121,327	73,828	1,916	45,583	4.9	3.4	15.5	6.8
Missouri	105,385	61,887	2,199	41,299	9.7	9.5	6.7	10.1
Montana	7,964	3,168	144	4,652	34.6	34.1	25.0	35.3
Nebraska	16,156	7,792	252	8,112	26.6	29.7	7.5	24.2
Nevada	6,209	3,532	345	2,332	20.8	14.7	13.4	30.9
New Hampshire	7,642	3,568	230	3,844	14.2	12.0	--	17.2
New Jersey	82,122	35,229	1,031	45,862	22.7	25.9	78.7	18.9
New Mexico	26,377	11,758	423	14,196	16.9	23.8	18.9	11.1
New York	389,017	157,577	3,997	227,443	5.4	8.1	5.2	3.6
North Carolina	149,710	75,125	3,636	70,949	14.3	12.7	64.4	13.4
North Dakota	7,480	4,235	67	3,178	11.1	8.8	20.9	13.9
Ohio	129,881	46,182	2,405	81,294	12.0	7.9	14.0	14.3
Oklahoma	82,293	46,878	1,109	34,306	12.3	13.4	8.6	10.9
Oregon	26,850	10,444	643	15,763	42.7	43.7	62.5	41.2
Pennsylvania	168,951	67,161	4,030	97,760	22.0	40.4	24.5	9.3
Rhode Island	15,871	6,657	185	9,029	12.7	9.8	17.8	14.8
South Carolina	84,189	43,661	1,907	38,621	7.8	8.2	14.2	7.1
South Dakota	8,869	4,888	132	3,849	15.8	14.8	33.3	16.3
Tennessee	137,032	72,633	1,807	62,592	7.8	7.6	6.1	8.1
Texas	277,731	174,007	4,097	99,627	21.0	24.4	26.9	14.9
Utah	8,615	3,060	162	5,393	24.3	22.7	22.2	25.3
Vermont	8,879	4,142	117	4,620	15.8	11.1	19.7	19.8
Virginia	81,076	40,874	1,462	38,740	18.2	17.6	57.5	17.4
Washington	48,665	17,982	521	30,162	19.0	21.7	29.6	17.1
West Virginia	43,550	17,786	641	25,123	20.1	26.7	35.7	15.0
Wisconsin	67,799	34,415	939	32,445	10.1	6.2	19.2	14.0
Wyoming	2,265	1,102	32	1,131	23.3	20.8	18.8	25.8

1/ The number of SSI recipients (total, aged, blind, and disabled) was estimated by adding the number of persons receiving SSI and federally administered State supplementary payments in July 1977; the number of new awards made in August and September 1977; and the number of persons receiving only State-administered State supplementation payments in September 1977.

TABLE 9.-- Title XX expenditures for SSI recipients and percentage distribution by eligibility category, by State, July-September 1977

State	Title XX expenditures for SSI recipients (in thousands)	Percentage distribution			
		Total	Aged	Blind	Disabled
Total	$174,926	100.0	38.0	7.4	54.6
Alabama	2,214	100.0	43.9	1.4	54.7
Alaska	--	--	--	--	--
Arizona	956	100.0	19.2	8.2	72.6
Arkansas	1,302	100.0	37.2	5.5	57.3
California	41,351	100.0	28.4	23.4	48.2
Colorado	2,505	100.0	41.1	1.0	57.9
Connecticut	435	100.0	34.5	2.1	63.4
Delaware	159	100.0	63.8	9.1	27.1
District of Columbia	902	100.0	44.9	1.5	53.6
Florida	3,872	100.0	41.4	2.2	56.4
Georgia	6,877	100.0	30.2	1.6	68.2
Hawaii	478	100.0	45.1	1/	54.0
Idaho	315	100.0	48.0	2.2	49.8
Illinois	4,676	100.0	26.6	3.0	70.4
Indiana	1,266	100.0	16.4	1.3	82.3
Iowa	2,823	100.0	28.5	2.1	69.4
Kansas	1,270	100.0	9.7	1.5	88.8
Kentucky	2,717	100.0	28.3	2.5	69.2
Louisiana	2,962	100.0	66.2	1.4	32.4
Maine	833	100.0	24.8	1.0	74.2
Maryland	2,344	100.0	55.2	1.2	43.6
Massachusetts	5,909	100.0	44.6	3.6	51.8
Michigan	13,123	100.0	33.5	1.6	64.9
Minnesota	3,833	100.0	16.6	2.1	81.3
Mississippi	978	100.0	38.4	5.4	56.2
Missouri	1,322	100.0	41.0	1.2	57.8
Montana	1,738	100.0	5.5	1.1	93.4
Nebraska	2,599	100.0	25.5	1/	74.3
Nevada	222	100.0	30.7	4.6	64.7
New Hampshire	328	100.0	28.0	1/	72.0
New Jersey	1,861	100.0	55.8	3.8	40.4
New Mexico	917	100.0	42.1	1.8	56.1
New York	2,409	100.0	42.0	3.3	54.7
North Carolina	6,284	100.0	46.1	8.9	45.0
North Dakota	449	100.0	41.8	1.8	56.4
Ohio	10,489	100.0	15.1	1.7	83.2
Oklahoma	329	100.0	52.6	1.5	45.9
Oregon	724	100.0	69.8	9.4	20.8
Pennsylvania	5,941	100.0	83.6	1.5	14.9
Rhode Island	937	100.0	25.5	2.1	72.4
South Carolina	2,159	100.0	37.2	2.8	60.4
South Dakota	542	100.0	35.3	1.8	62.9
Tennessee	2,853	100.0	31.5	1.9	66.6
Texas	15,356	100.0	71.6	1.9	26.5
Utah	486	100.0	18.0	1.3	80.7
Vermont	245	100.0	36.5	1.8	61.7
Virginia	2,552	100.0	48.8	4.5	46.7
Washington	3,969	100.0	52.5	1.4	46.1
West Virginia	600	100.0	58.2	4.2	37.6
Wisconsin	5,395	100.0	27.7	1.8	70.5
Wyoming	121	100.0	45.6	2.6	51.8

1/ Less than 1 percent.

Budget Issues

Various arguments can be made regarding the strengths and weaknesses of the Administration proposal to establish block grants. Proponents argue:

1. The reduced funding will be offset by savings in program overhead and more efficient service delivery, and the funding change should not result in a reduction of services.

2. The block grant approach gives the Federal government a more feasible method of controlling Federal expenditures due to the consolidation of numerous categorical programs under a few block grants.

3. The approach would allow decentralized decision-making in which States could determine the priority needs they choose to fund.

4. States could more easily vary priorities from year to year.

5. Elected officials at the State and local levels would be directly responsible to the voters who put them in office, and therefore appropriate decision-making may be more assured under the block grant approach than under the current categorical approach in which funding decisions take place at the Federal level. Citizens have more access to State and local officials and could more easily impact upon decision-making process under block grants.

6. States could redesign the service delivery system to be more innovative and integrated under the block grant

the current funding categories.

7. Fragmentation and duplication said to exist in the categorical funding approach could be reduced making services more efficient and less costly.

On the other hand, opponents of the proposed block grants argue:

1. The proposed reduction of funding available to the block grants could curtail services used by low-income, needy people, and could drastically reduce the Federal role vis-a-vis the needs of vulnerable populations.

2. Placing decision-making for social service programs at the State and local levels could result in a further reduction of service to poor, minority, vulnerable persons due to possible disinterest or differing priorities on the part of such officials. State and local officials may choose to fund programs which are politically more popular than programs for the most vulnerable individuals.

3. Individuals and groups dissatisfied with State decision-making would not have option of bringing their problems to the attention of national leaders in the executive and legislative branches of government.

4. The block grant approach could eliminate the Federal forum for development of national policies regarding social problems.

5. The mechanism for encouraging interstate efforts to address unsolved social problems would be reduced. The block grant approach could allow the Federal Government to divest itself of much responsibility for the most vulnerable populations in the country, including the elderly.

MEMORANDUM

TO: Members of the Special Committee on Aging

FROM: Committee Staff

RE: Proposals Affecting the Older Americans Act

DATE: March 25, 1981

Social and Nutrition Services

Proposal

	FY '81 Budget (in millions)	FY '82 Budget (in millions)
State administration	$ 22.7	$ 22.7
Social Services & Senior Centers	247.0[a]	
Nutrition Services - Congregate	295.0[b]	
Nutrition Services - Home Delivered	55.0	
Social & Nutrition Services TOTAL	$597.0	$597.0[c]

a) Includes $10m rescission by Carter made into a deferral by Reagan.
b) Does not include a transfer of cash and commodity foods from Department of Agriculture estimated to be $85 million in FY '81.
c) Does not include a transfer of $95 million from the Department of Agriculture to AoA.

The Reagan Administration proposes a FY '82 funding for T-III at the FY '81 level - social services and senior centers at $247 million and nutrition services at $350 million. In addition, it proposes to consolidate the funding authority for social and nutrition services into one funding stream and eliminate the federal mandate for priority categories of services in order to provide states and area agencies increased flexibility to meet local needs.

In addition, the Reagan budget includes a transfer of $95 million to AoA from the Department of Agriculture's elderly commodity foods program.

Background

Funding under T-III of the Older Americans Act provides for state and area agencies on aging, a variety of social services such as transportation, homemakers, home health care, legal services and senior centers, meals in congregate settings and home delivered meals. Separate funding authorities are provided as follows: 1) social services including senior centers and area agency planning, advocacy and administrative activity, 2) congregate nutrition services, 3) home delivered nutrition services, 4) state agency on aging administration.

The T-III funds are allotted to States on a formula basis. States distribute these funds to area agencies which in turn contract for social and nutrition services with service providers at the local level.

The Department of Agriculture program provides a reimbursement to states of a certain amount per meal served ($0.43 per meal in 1981). States have the option of accepting the reimbursement in cash or commodity foods. About 90% of the reimbursement is currently taken by the States in cash. The Carter Administration budget estimated that states would receive $85 million from Agriculture in FY '81. Under the Reagan proposal, states will receive cash as a part of the consolidated program authority under Title III of the Older Americans Act. Non-federal financial participation requirements for Title III of the Act will then apply to these funds. The level of cash transferred will be $95 million.

Potential Impact

The proposal to continue the FY '81 level of $597 million in FY '81 is not a cut in funds, but allows nothing for price inflation (food and transportation are big items for T-III spending) so the result may be a reduction in service levels. Also, Congressionally approved increase in T-III social services to $257 million for FY '81 was reduced by a $10 million deferral.

In some states FY '81 social services funds will be less than FY '80 due to this cut and to the loss of elderly population as shown in the 1980 census. In Pennsylvania, for example, FY '81 funds will be $80,000 less than last year.

Several concerns have emerged regarding the "cash out" of the commodity foods program at $95 million in FY '82. First the cash allotment administered by AoA will be a fixed level instead of an open ended reimbursement per meal based on the number of meals served.

Second, the distribution of funds to states on a formula allotment might be different from the current system which awards reimbursement based on performance (i.e., number of meals actually served in a year). Some states stand to lose and others to gain.

Third, states and area agencies will have to generate a non-federal share to match this increased cash whereas the commodities were available without non-federal match.

Discretionary Programs

Proposal

	FY'81 Budget (in millions)	FY'82 Budget (in millions)
Training	$14	$ 8.2
Multidisciplinary Centers on Gerontology	$ 3	
Research	$ 6	$15.0
Demonstration Projector (including long term care)	$22.5	
Total:	$45.5	$23.2

The Reagan Administration proposes a reduction of $22.3 million in discretionary grant programs - almost an 50% cut. The lowest budget does not specify any activity which will be eliminated, but the number of projects under each of the categories - training, research, deomstration and multidisciplinary centers on Gerontology - will be reduced. The Commissioner on Aging and the Secretary of HHS will have more discretion on how to target and best use these funds.

Background

In addition to funding services and service systems for the elderly, the Older Americans Act authorizes a program of discretionary grants for training, reserach, demonstration or model projects and multidisciplinary centers of gerontology. These efforts help to train personnel in the field of gerontology, increase knowledge about the service needs of the elderly and demonstrate systems to improve the quality of services for the elderly, particularly those who need long-term care.

Potential Impact

This is the only area of heavy cuts in the Older Americans Act. A fifty percent reduction will obviously result in fewer new projects and discontinuation of some existing projects.

AoAs discretionary grants program has been criticized as undirected, fragmented, and poorly managed. Those administering Older Americans Act funds, particularly State and area agencies, have complained that the results research and demonstration projects were (1) often irrelevant to the improvement of service delivery, (2) not ever made available after the projects were conducted. Certain training projects funded in the past three years were very controversial and poorly received by the aging network.

The Long Term Channeling Demonstrations were challenged as duplicative of previous projects funded by the Health Care Financing Administration.

Discretionary funds were reduced from $54.9 million on FY'80 to $45.5 million in the FY'81 budget.

Universities, research organizations and national organizations representing older persons are likely to be most concerned about these reductions.

Appendix 2

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. STATEMENT OF THE NATIONAL RETIRED TEACHERS ORGANIZATION/AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman and task force members, our associations are pleased to be here this morning to discuss the budget cuts that the administration has proposed in the area of health and social services in their program for economic recovery. Let me preface my remarks by saying that our associations strongly support the administration's promised efforts to combat inflation, revitalize the economy, and balance the Federal budget. Regarding the Federal budget, we continue to advocate that it be balanced over the business cycle. However, we have reservations as to how the administration proposes to achieve this balance. Specifically, we would contend that sudden and drastic reductions in Federal support for certain health and social service programs would leave gaping holes in the "social safety net" that the administration contends it has created for the truly needy, dependent and vulnerable among our elderly population.

In keeping with the purpose of this hearing I would like to comment on those budget cuts that disturb us most, the reasons for this concern, and the consequences of such reductions. Subsequently, I will provide you with a number of alternative recommendations for reducing Federal spending in this area.

The administration's budget cuts in health programs are based upon the contention that Federal and State regulatory efforts have failed to contain the rising tide of health care costs due to the underlying cost-promoting bias in the financing of services. Therefore, a number of interim measures have been proposed by the administration prior to the adoption of comprehensive legislation to remedy market distortions and encourage competition in the delivery of health care. Our associations believe that the elimination of certain programs and the devastation of others through reduced Federal support is at best shortsighted. We believe, as many of the members of this committee must, that the transformation of the health care marketplace contemplated by the administration is not possible in such a short time-frame. While developing meaningful (price) competition in this market is indeed a desirable (long-term) goal, we hardly think it justifies the extreme interim spending reductions proposed by the administration in certain programs.

A. Medicaid

The new administration states that the medicaid program contains excessive benefits provisions, overly generous eligibility criteria, and is poorly managed—all leading to excessive cost increases. The complaint is expressed as to the 15 percent a year growth in total medicaid spending over the past 5 years (as hospital costs continue to escalate at annual rates of 16 to 18 percent). As an interim measure, therefore, the administration proposes a cap on Federal expenditures which would reduce outlays by $100 million in the current fiscal year, allow an aggregate increase of only 5 percent in fiscal year 1982, and thereafter limit the increase in Federal matching payments to no more than the rate of inflation (measured by the GNP price deflator). The administration contends that this can be done "without reducing basic services for the most needy"—though there is some question as to how or by whom "basic services" and the "needy" would be defined. Furthermore, during the 1983-86 period the administration expects to institute comprehensive health financing and medicaid reforms, as yet unspecified, to reduce the rate of health care cost inflation and to improve medicaid.

Our associations oppose this "interim" measure because we believe that strong Federal support of the medicaid program is an essential component of the "social safety net" for the poor, especially the most vulnerable of this group, the elderly poor. Approximately one in five older Americans are medicaid recipients. Currently, 41 percent of total medicaid expenditures are going to nursing home care. Expenditures for nursing home care constitute the single largest health care liability for persons over the age of 65 and are the major source of catastrophic health expenses for this group—of which over 20 percent will at some point in their lives need to enter a nursing home. The importance of the medicaid program to the elderly is further highlighted by the fact that 87 percent of all public expenditures for nursing home care ($8.8 billion and 49 percent of all spending for nursing home care in 1979) were medicaid dollars.

The administration's proposal is expected to reduce the total Federal payment to State medicaid programs in fiscal year 1981 by $300 million and in fiscal year 1982 Federal spending would be reduced from $18.2 billion to $17.3 billion as a 5 percent cap is implemented, resulting in all but three States receiving reduced (Federal) payments. The implications of such action are serious. Current trends toward dual systems of care for medicaid beneficiaries will intensify and access to care become even more difficult. Indeed, the $900 million in savings projected for fiscal year 1982 (with savings exceeding $5 billion by fiscal year 1986) represents a false economy, as the demand for long-term care services is already creating a substantial backup in our acute-care hospitals. The impact of this "capping" proposal on the medicare program, therefore, deserves immediate attention.

Our associations believe that the "capping" of the medicaid program alone without taking effective, across-the-board measures to restrain the uncontrolled escalation of health care costs represents an abrogation of responsibility on the part of the Federal Government as the primary purchaser of health care services. In this instance, taking the expedient course of action recommended by the administration will seriously impact the availability of quality care for many elderly medicaid recipients, the most vulnerable and dependent of all groups. This seems to be in stark contrast to the avowed purposes of the administration's budget proposals and at variance with its repeated pledge to protect those truly needy individuals dependent on Federal assistance.

Our associations believe that the administration's medicaid "capping" proposal deserves serious and thoughtful consideration and that all alternative proposals should be carefully evaluated. This is not to say that we do not share the administration's view that the entire Federal mandating process should be reviewed. The States clearly should maintain and perhaps even be allowed to expand their authority to restructure medicaid benefits to most appropriately meet local needs. However, in light of the dependency of the elderly on the medicaid program for essential long-term care services and the nonavailability of meaningful alternatives, our associations oppose the capricious reduction of Federal support for the medicaid program and urge you to reject this portion of the administration's budget package.

The Congress has expressed a desire to see that cost-effective alternatives and options to nursing home care are developed (most recently in the medicare home health care liberalizations of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980). Yet placing an "interim cap" on the Federal matching payment to already severely strapped State medicaid programs would only cause further restrictions to be placed on the availability of mandatory home health services and (optional) community-based personal care services.[1] Currently, access to home health care is at best difficult in those many States where reimbursement levels are far below even the medicare rates. Instead of moving to dismantle the semblance of an integrated national health care program for the poor, the administration and Congress should be working (through appropriate incentives) to obtain State-to-State uniformity in the range and scope of benefits that are available—with obvious concerns as to the availability and need for particular service mixtures.

Additional and significant reductions in Federal support for the medicaid program as proposed by the administration will have a serious impact on the availability of quality health care services, particularly institutional long-term care services. State medicaid rates for nursing home care are clearly inadequate in most cases and medicaid patients are often only maintained because facilities' private pay patients subsidize their care. Further reductions in Federal support will undoubtedly make what is at present a bad situation worse. In this regard, we would note that medicare and medicaid are and should remain complementary components of any "social safety net" the Congress and the administration construct beneath needy older Americans.

B. Medicare

There is evidence that the Congress is supportive of an incremental, systemic evolution in the delivery of home health services. In the closing days of the 96th Congress, a number of liberalizations in the medicare home health program were approved as part of the Omnibus Budget Reconciliation Act of 1980 (Public Law 96-499). Our associations, like most of the members of this committee, strongly supported these changes, which included (section 930): the removal of current 100-visit limits under parts A and B of medicare; removal of the 3-day prior hospitalization requirement under part A; the inclusion of occupational therapy as a qualifying ("skilled") service; the nonapplicability of the part B deductible for home health services; the elimination of discriminatory licensing requirements based on the tax

[1] Only 4 States offer personal care services to their categorically needy under medicaid while 10 provide such benefits to this group and the medically needy as well.

status of a home health agency (as a qualifying condition to receive provider status under medicare); the establishment of an HHS-approved training program for home health aides; and (section 931) the establishment of regional intermediaries for home health care. The administration now proposes to repeal or rescind these "low priority" reforms along with provisions in Public Law 96-611 which provide coverage for pneumococcal pneumonia vaccine under medicare. To repeal these needed changes in the home health program, costing an estimated $35 million in fiscal year 1982, is not only ill-timed but extremely shortsighted. At the same time that our "at risk" population of older Americans with chronic degenerative conditions is mushrooming, our various public and private home health programs are meeting the needs of only some 25 percent of those in need of such long-term care services. In fiscal year 1978, medicare home health expenditures ($520 million) constituted only 2 percent of total program outlays while hospital care amounted to 74 percent of expenditures. As for medicaid, only 1 percent ($211 million) of total medicaid dollars was spent on home health—and three-fourths of this in New York State. In the absence of public policy changes, estimates are that in the year 2000 some 2 million persons—89 percent of them over the age of 65—will reside in a nursing home, an increase of 54 percent; by the year 2030 there will be nearly 3 million nursing home residents, a 132 percent increase. Yet even these projections do not reflect likely increased utilization due to changes in family structure. Expenditures for nursing home care are expected to more than triple by the year 1990 (reaching $76 billion) and remain the fastest growing area in the health sector. Further compounding this problem are other ominous trends. These include the fact that the growth in the number of nursing residents continues to outpace the growth of the elderly population in general and, as the growth in nursing home outlays continue to exceed the growth in the elderly's income, that private pay nursing home residents will exhaust their resources and "spend down" to medicaid at an even faster rate in the future. Although a program to provide pneumococcal pneumonia vaccinations to the elderly under medicare would entail a net cost of $43 million in the first year, a recent study by the Congressional Budget Office shows that the inclusion of this service under medicare would actually save the program $6 million in the fourth year and $11 million by the fifth year as a result of a reduction in costly hospitalization. In addition to its cost effectiveness, it is estimated that this provision of Public Law 96-611 would save 5,500 lives over a 5-year period.

To start to counter these trends, our Associations strongly recommend that the aforementioned amendments to the medicare program be reaffirmed. To not allow these reforms to be implemented (effective July 1, 1981) would reflect an inadequate understanding of the dilemma this Nation faces in the delivery of long-term care and preventive health services to an aging population. It would also be pennywise and pound foolish.

C. Health Planning

Another area of concern to our Associations is the proposed phasing out of health planning over the 1981-83 period, supposedly in concert with the administration's 2-year timetable for the development of a comprehensive package of health care financing reforms aimed at encouraging competition in the health sector. Frankly, to us this is not a "quid pro quo." It is highly unrealistic to expect such comprehensive reforms aimed at constraining the health care cost spiral to be implemented within this period. At the same time, the Federal Government would be dismantling the only national cost containment program it has in place—and one with a proven track record of broad-based community involvement and success in containing health care costs.

The administration proposes a reduction of $28 million in fiscal year 1981 funding for State and local health planning programs, $100 million reductions in fiscal year 1982, and a complete phaseout by fiscal year 1983. Unfortunately, the administration's view of health planning is undimensional; that is, it serves merely a public utility function. To the contrary, our associations view health planning and the certificate-of-need process as a viable State and local decisionmaking process with demonstrated successes. It remains one of the few tools government and health care consumers have in the battle against rising health care costs.

While many speak of the well recognized need to change our inadequate and cost promoting reimbursement system, this alone will not solve the problem. We have to look at the supply side, and through the health planning process, continue to discourage, disapprove, or modify capital projects that are not effective. It seems ill-advised to jettison Federal financial support for local health planning at the very time it is needed most and when our growing senior population is most vulnerable to the health inflation spiral.

Health planning is impossible to evaluate on the basis of outcome measures alone. In fact, in terms of its clearest objectives the performance of the planning process is

best reflected in things that did not happen or in things that happened in a qualitatively better or more responsive fashion. For example, annual expenditures for health facilities construction has continued to decline in constant dollar terms since the early 1970's, falling 26 percent in the last 4 years (1976-79). Planning agencies have also disapproved approximately 20 percent of the $5 billion per year reviewed by local planning agencies. This process, in successfully avoiding capital expenditures where demonstrated surpluses already exist, help reduce medicare and medicaid outlays otherwise expended to maintain unnecessary and costly beds, facilities, and equipment. And yet, the real dollar savings in public programs and systemwide come with projects that are delayed or modified as a result of Health System Agency (HSA) review prior to formal submission of the project under either CON or 1122 review. In part as a result of health planning, hospitals' own institutional planning—as reflected in the quality of their capital expenditure proposals—has improved dramatically in the last 5 years. In a 1979 national survey of hospitals, 64 percent said they had expansion plans and 21 percent of these indicated that they had postponed or dropped such plans due to the need for planning agency approval.

It is also interesting to note that on a per capita basis more expenditures are being approved in rural areas than in urban areas and that planning agencies are approving much higher net increases in hospital beds in areas of high population growth while fostering net decreases in areas of population loss. At the same time, approval rates have increased sharply for needed alternative, new, or "other facilities and services" when compared to approval rates for hospitals and nursing homes. This would seem to counter the arguments being advanced by the Office of Management and Budget (OMB) that market access (and thus competition) is being unwisely restricted by CON, 1122 review and the health planning process in general.

Other positive changes at the local level, readily discernable but not easily quantifiable, include the timely allocation of new resources into underserved areas, educating the public about health and health care problems, and creating new coalitions of business and labor to tackle health care costs. The cost—less than $1 per year per capita for all health planning in an industry costing more than $1,000 per year per capita and the elderly more than $2,500 per year—is relatively small. Should health planning be eliminated it has been estimated that there would be a 50 percent increase in capital construction over the next 4 years, or $10 billion more than under the current system.

Our associations believe that the health industry's voluntary effort (VE) to contain health care costs offers older Americans vary little in the way of relief. We are disturbed at what seems to be a growing tendency on the part of the Federal Government to eliminate or deemphasize its own capacities as a prudent buyer in the name of market forces and to back off from its responsibility to constrain our rapidly rising national health bill (and the Federal share of it).

Simply stated, the alternative advanced by the administration, implementation of pro-competition legislation, is not a near-term possibility. By the same token we would note that planning is and will remain essential to the implementation of any competitive health system. Local planning agencies are well positioned to provide major consumers and purchasers of health care information that is needed in order to make those informed and price conscious choices that are basic to the effective functioning of a competitive system. We believe that organizations such as ours must work with the Congress and the planning community to strengthen the local health planning process, making it even more effective and responsive to local needs.

At the same time we must realize that health planning is a recent development and must have time to develop. Results cannot and should not be expected overnight. To eliminate Federal expenditures for health planning only 2 or 3 years after much of the machinery for this process was put in place would epitomize "waste" in government spending. To quote from an unexpected source, Congressman David Stockman, during the debate on funding for health planning in the 96th Congress, "if funding reductions are to be made, it seems far more sensible to me to channel the bulk of available funds to the local health planning effort, rather than to State or Federal health planning administrators who are further removed from the immediate needs of the community." We agree with Mr. Stockman's assessment and we hope you will when the Senate considers the administration's proposed phaseout of local health planning.

D. HMO's

Starting with rescissions of $37 million to the loan fund in fiscal year 1981, the administration proposes completely phasing out Federal support ($54 million in

fiscal year 1981) for the development of Health Maintenance Organizations (HMO's) by the end of 1983. We find this proposal inconsistent with the stated intent of the administration to encourage the development of alternative health care delivery systems, the necessary lead times required of most HMO's to become fully viable, the demonstrated cost saving HMO's generate, and the significant support State and Federal Government provides (primarily through tax expenditures) to such high-cost institutional providers as hospitals and nursing homes. We would contend that these modest levels of Federal financial support are needed to expand access to the HMO alternative in those many areas of the country where private (venture) capital has not been invested in HMO development yet where there is significant potential for growth and where health care costs are out of control. Indeed, the major impediment to HMO development is not overly restrictive requirements for Federal qualification found in the HMO Act but the inadequacies of our reimbursement system. Should the Congress decide to further limit access to HMO's by eliminating Federal support during the initial years of development we would hope that the Congress would act to provide elderly medicare beneficiaries equal access to HMO's through changes in the way HMO's are reimbursed for services. As individuals, the elderly for the most part cannot enroll in HMO's. Changing reimbursement from a cost-plus to a prospective, prepayment basis for medicare beneficiaries, with required open-enrollment periods, would act as a powerful incentive for the development of the HMO option for all segments of the population. Clearly, retrospective, cost based reimbursement is not financially attractive nor viable for all but the largest and most capital-rich HMO's.

While our associations' contention that Federal financial assistance should be maintained at current levels is for the most part the product of our deep concern over escalating health costs, we do believe that the current support program should be more carefully targeted and selective. The focus of this program should be on areas with high growth potential as well as on HMO's serving special or otherwise unserved population groups. The later goal may not be as easily a subject of prescriptive financial analysis and HMO's serving such high rise groups are likely to find initial private financing unavailable without early Federal financial support in the form of loans, loan guarantees and grants.

E. Consolidation of Categorical Grant Programs

Our associations have serious misgivings about the administration's proposal to consolidate a myriad of categorical grant programs into a series of block grants. It is clear to us that while the consolidation of a multitude of narrow grant programs into a comprehensive block grant may be advisable, the rationale should not be that a reduction in Federal funding for such programs is necessary in the effort to curb inflation. Quite to the contrary, the impact of substantially reduced Federal financial support may be cost-promoting and create false economies to the extent the elimination of such in-kind benefits forces beneficiaries into direct public assistance programs.

We acknowledge that block granting a wide variety of health and social service programs to the States would lead to reduced overhead and allow State and local officials to target funding to the most urgent needs of localities. However, we see nothing in our past experiences in providing services to the needy that would indicate State government is inherently a more effective and competent administrator than the Federal Government of such programs. To the contrary, many of these categorical grant programs were established in the first place because certain deserving and needy segments of our population were not being helped. In many instances the inadequacies of the State resource allocation and decisionmaking process necessitated the adoption of a categorical approach to begin with; and I would add that the elderly have traditionally fared rather poorly in this allocation process. The Office of Management and Budget (OMB) has itself articulated another objective we have to such massive block grants; that without minimum Federal standards and control the Federal Government cannot assure taxpayers that their dollars are being effectively spent. The true need, for followup and continuity of care in these health and social service programs can best be addressed through a closer coordination of separate grant programs and better case management—with emphasis being placed on programmatic linkages.

The administration is seeking new legislation which would consolidate some 40 categorical grant programs (with fiscal year 1981 funding of $9.1 billion) into four major block grants. Funding for fiscal year 1982 would be 75 percent of the current (fiscal year 1981) base, or approximately $6.6 billion. The block grants would be: (1) Energy and emergency assistance (e.g., low income energy assistance)—$1.410 billion; (2) basic health programs (e.g., community health centers)—$1.138 billion; (3) preventive health programs (e.g., family planning)—$0.260 billion; and (4) title XX

and other categorical grant programs, i.e., social and community services—$3.8 billion. Beyond our criticism of the philosophical underpinnings of this proposal, we are particularly concerned about the impact of reduced Federal funding on several grant programs of importance to the elderly.

TITLE XX SOCIAL SERVICES

This program, which will represent nearly a third of total outlays for all the targeted programs in fiscal year 1981, is of special importance. Substantial assistance is provided through the "core services" of this program for homemaker/chore and other in-home services that serve to prevent premature and oftentimes unnecessary institutionalization. The State of California, for example, utilizes over a third of all its title XX funds for this purpose. Also, this program is essential to many older Americans since it provides access (i.e., transportation) to service providers, day care, counseling, meals-on-wheels, needs assessment, and health related services. In essence, the title XX program provides the States a highly flexible funding source which enables many elderly individuals to achieve or maintain independent living and economic self-support.

Within the broad confines of the requirement that the States expend at least 50 percent of their Federal payment (75 percent of total program costs) for AFDC, SSI and medicaid eligible, State governments already have a block grant concept at work here. They have wide discretion in establishing eligibility criteria, in choosing service priorities and in serving special populations.

Our associations believe that each State's comprehensive annual services program plan (CASP) should specifically allocate funds and plan for services for the elderly. While States for the most part define services as they wish, relatively few services provide for a major portion of title XX expenditures. At the same time, the "cap" on title XX funding has not allowed Federal funding to approach recent high rates of inflation. As a result, those 40 States charging fees for services have had to increase this cost-sharing liability and in the process deny access to services for needy individuals. We believe title XX funding should be determined on the basis of a formula which takes into consideration local demographic trends, data on the homebound or disabled, income levels, the local incidence of particular health and social problems, and expenditures for the previous 3 years. States and local communities need to be able to develop different packages of services—as they do under title XX—but they also need to develop standards and a better sense of accountability for those services they do provide. In this sense the Federal Government has an obligation to see that its financial contribution is well spent.

The administration contends that the planning and community participation aspects of the title XX program should serve as a model for this block grant concept. We disagree. Improvements are definitely needed in this planning process in order to make it more responsive, coordinated, and efficient. Greater consistency in State planning, budgeting, and legislative activities could be achieved if States were allowed to use a multiyear program period. This would help coordinate activities and reduce administrative difficulties and overhead. In any event, a substantial reduction in Federal financial support is likely to prevent improvements being made in this process while forcing many elderly beneficiaries into higher cost institutional settings.

MENTAL HEALTH SERVICES

The importance of mental health services to the elderly and the full funding of such services can most clearly be seen in the debate which led to the passage of the Mental Health Systems Act (Public Law 96-398) toward the end of the 96th Congress. Traditionally, the elderly have been discriminated against in the delivery of mental health services by community mental health centers, private practitioners, and the mental health delivery system in general. The Mental Health Systems Act, in recognizing this problem and attempting to address it through grants to public or nonprofit private entities to serve the mental health needs of the elderly, is a modest step in the right direction. For the first time, the mentally ill elderly in communities and nursing homes have been targeted as a special population group for such services as outreach, case management, differential diagnosis, and services to those elderly who reside in nursing homes and who are in desperate need of trained, professional care and treatment. Importantly, this legislation has also established authority for grants to link nursing homes (where hundreds of thousands of mentally ill individuals have been "dumped") to mental health practitioners and rationalize as well as better coordinate the roles of local, State, and Federal governments in the delivery of mental health and support services.

We enlist the support of this committee and the Congress in general in order to retain present funding levels for mental health services should a block granting of these programs be approved. Specifically, we urge you to reaffirm your support for the modest funding levels under Public Law 96-398, section 204, "Mental Health Services for Elderly Individuals and Other Priority Populations" ($30 million in fiscal year 1982).

COMMUNITY HEALTH CENTERS

Another program which our associations feel has a demonstrated track record of success in serving the needy and truly dependent elderly is the community health centers program. We ask that you support this program at the fully authorized level in fiscal year 1982 ($356 million) with the full realization that such financial assistance will still result in a real reduction in services and activities.

Over 23 percent of those individuals seen at community health centers are elderly. These centers, annually serving some 6 million persons—many in medically underserved areas—provide primary health care to the indigent and working poor where there are few if any other providers. In effect, the health centers insure their local communities against the cost of care for the uninsured; and even if providers were available to serve these persons, the cost of their care would have to be met through increased State and local taxes or shifting costs to the private pay patient.

Community health centers have successfully increased their volume or services, their productivity and their collection of third-party reimbursements while reducing their costs per encounter by 25 percent (in real terms). This program, with the linkages it provides to other grant programs (e.g., in mental health services) deserves the support of the Budget Committee.

Our associations have a number of suggestions to make for reducing Federal outlays for health care that we believe are preferrable to those being advanced by the administration.

First of all, as we all know hospital costs (which represent some 40 percent of all health care costs) continue to increase at rates far in excess of the general rate of inflation, driving up medicare and medicaid costs. In January of this year alone, hospital costs (CPI-U) increased 2 percent while the all items CPI rose 0.7 percent. Our associations have long urged the Congress to place Federal limits on increases in hospital revenues per admission. Such an across-the-board approach would not single out medicaid or medicare beneficiaries for special restrictions.

Since the Congress has rejected such a uniform imposition of limitations on the rate of increase in hospital costs, we believe as an alternative it should encourage the adoption of State ratesetting programs (a total of seven States already have mandatory rate review programs). This would reduce Federal and State outlays as well as payments by private purchasers of hospital care. We would also suggest that the Congress could direct the Federal Government to share a greater portion (e.g., one-third) of the savings in medicare and medicaid costs that are achieved through such rate review with the States. Providing financial incentives for additional States to initiate effective rate review is in concert with the goals of H.R. 2626, the Hospital Cost Containment and Reporting Act of 1979, as approved by the 96th Congress. Based on rather conservative assumptions, the Congressional Budget Office (CBO) estimates 5-year (1982-86) savings of $2.4 billion to the Federal Government from such an initiative (assuming 25 percent of costs are reviewed and one-third of medicare savings passed on to the States).

In the area of tax expenditures, our associations believe that the exclusion from taxable income of employer-paid health insurance premiums deserves the committee's attention. This exclusion or subsidy will reduce tax revenues by $21.4 billion and social security trust fund revenues by another $7 billion in fiscal year 1982. Our associations support limiting this exclusion to a fixed, regionally determined monthly dollar figure (e.g., $120) if as a "quid pro quo" some form of catastrophic or stop-loss protection was adopted as a required part of all qualifying health plans and if such benefits were conveyed to individuals upon retirement. This minimum, catastrophic protection should include some degree of protection against long-term costs. Cumulative 5-year savings from the imposition of such a ceiling would approximate $17.9 billion.

On the supply side, severe and immediate limitations should be placed on the tax exempt status of hospital bonds.[2] Approximately half of the funding for hospital capital projects comes from tax-exempt bonds ($3.4 billion of these bonds were issued in 1979). The direct Federal revenue loss from all outstanding hospital bonds in fiscal year 1982 will be $700 million. We seriously question the efficacy of this

[2] For hospitals able to demonstrate the need for new construction in a growth area, this subsidy could be retained.

subsidy which allocates resources on the basis of a hospital's financial standing rather than the need for such facilities. Also, the magnitude of the subsidy promises to increase greatly should local health planning and the certificate-of-need process be phased out as the administration has proposed. Such tax-exempt status for hospital bonds in those many areas of our country which are overbedded also further escalates medicare and medicaid reimbursement levels for empty, unneeded beds. Every $1 saved by borrowing hospitals costs $1.33 in lost Federal revenue.[3]

In the area of medicaid expenditures, we believe the States should be allowed greater flexibility in setting hospital rates. In many States, reimbursement rates could be set at levels less than average treatment costs (current law) yet high enough to exceed the marginal or incremental cost of each medicaid patient. We would add the stipulation that hospitals could not "dump" or refuse to accept medicaid patients. In any event, if the medicaid program is "capped" hospitals face the prospect of receiving significantly reduced reimbursement for such patients. Assuming a 5 percent reduction in medicaid hospital reimbursement as a result of vigorous State implementation of such a statutory change, savings to the Federal Government over the 5-year period 1982-86 would be approximately $1.6 billion.

A number of additional items have been proposed as alternatives or supplements to the administration's proposed fiscal year 1982 reductions. The Finance and Budget Committee staffs have formulated several options for additional savings in the medicare program—most of which we find troubling. For the most part, these options would call for significant increases in cost-sharing liability on the part of beneficiaries. One type of proposal would increase the part B deductible to as much as $100, index the deductible to reflect increases in program costs, and/or require that it be satisfied on an annual basis. One senses from these alternatives a conviction on the part of committee staff that the elderly should bear a greater portion of the burden of these programs. To us, this seems rather incongruous since the health care cost spiral continues to push the total cost of health care for older Americans well beyond their growth in income. The intent of such a proposal seems clear—to reduce utilization of part B services on the part of the most vulnerable of the elderly, those in poor health and needing treatment. Older Americans already pay 3.4 times ($2,026/CY 1978) the $596.82 per year an under 65 individual spends on health care. Of this, 37 percent ($746) is from private funds—exceeding the total per capita amount paid by those under the age of 65. When one factors in the deductibles, coinsurance, and premium payments required under medicare, direct expenditures for health care services on the part of the elderly exceed the portion of their annual health bill covered by medicare. The elderly already spend 44 percent more of their budgets on out-of-pocket health expenses than the nonelderly (those under the age of 65). Considering (part B) physician services alone, beneficiary liability is approximately 69 percent of total physicians' charges due when deductible, coinsurance and unassigned claims are included. And as we know all too well, on only 45.8 percent of services do physicians accept medicare payment as full reimbursement.

At the same time, greater cost sharing is being asked of the elderly their share of income relative to the nonelderly continue to decline sharply. According to a study commissioned by our association in 1980, "Inflation and the Elderly" by Data Resources, Inc. (DRI), 1981 will usher in a new era of relatively declining fortunes for the elderly. Data Resources, Inc., has forecast that over the period 1979-85, the growth rate of elderly income will remain below anticipated gains for other age groups. Already 31 percent of elderly-headed households have annual incomes at or below $5,000 and 62 percent of such households at or below $10,000. Even factoring in the value of in-kind benefits does not alter the fact that many older Americans subsist on low and quite often extremely inadequate incomes. This trend we refer to has in fact, already begun, according to the Census Bureau, as in 1979, the poverty rate for the elderly jumped from 13.9 percent to 15 percent—the largest rate of increase since the Bureau began collecting these statistics. Also of concern is the fact that the rate of near poverty for the elderly (125 percent of the poverty level) rose from 23.4 percent to 24.7 percent of the elderly population (compared to a rate of 15.2 percent of the under-65 population). This hardly seems to be a propitious time to increase cost sharing for the elderly who have very little flexibility in shifting consumption patterns to accommodate higher prices in such necessities as health care services. This burden seems likely to increase in the near term, as DRI

[3] CBO, Reducing the Federal Budget: Strategies and Examples, fiscal year 1982-86, February 1981.

has projected continued inflation in the core necessities out-stripping increases in the overall CPI.[4]

In addition, requiring coinsurance (we assume 20 percent) for home health benefits under parts A and B or part B alone will only serve to further deny access to community based alternatives to nursing home care. As we have noted, access to home health care is already severely limited. Moreover, over half of all individuals with annual health expenditures exceeding $5,000 are institutionalized in long-term care facilities. Implementing this Finance Committee staff proposal for home health as well as the increased part B deductible solely for budgetary reasons is extremely ill-advised. It would represent a significant regression on the part of the Congress at the very time the elderly can least afford it. In combination with severe restrictions in medicaid funding for fiscal year 1982, any hope for progress in the development of a meaningful and cost effective continuum of long-term care service will be lost. Again, we find it highly objectionable that the aged are being called upon to generate cost savings in medicare, medicaid, and other on-budget public health programs while the Congress continues to forswear placing similar constraints on provider reimbursement. We would also note that our association do support the coordination of medicare benefits with private health insurance coverage.

We would further note that in light of the severe reductions that are scheduled in Federal matching payments for the medicaid program and the untenable situation many States face in funding this joint Federal-State program, eliminating the 50 percent Federal minimum matching rate would be unnecessarily extreme and have a serious impact on those elderly so dependent on the medicaid program (i.e., the poor, frail elderly in nursing homes). We are also curious as to the rationale behind requiring a "nominal" copayment (only) on patient initiated services. We would remind the Congress that medicaid covers only approximately one-third of those individuals below the poverty level and that the median income of medicaid households is $5,990. Frankly, we do not believe even "nominal" copayments on mandatory or optional services are justified under these circumstances.

As we have already stated, our association also hopes that as these budget cuts are considered a number of tax revenue or tax expenditure reforms will seriously be considered in order to broaden the tax base and preclude the need to even consider savings provisions such as those discussed herein.

SUMMARY

In summary, our associations support the administration's effort to reduce Federal expenditures, balance the budget, reduce unacceptably high rates of inflation, and revitalize the economy. However, we do not ascribe to the theory that such fiscal restraint in tandem with massive tax cuts will abate the inflation spiral—the paramount concern of older Americans. Most assuredly, the cuts in health and social service programs we have described above will only serve to further exacerbate the increasingly serious problems the elderly face in coping with inflation and in receiving quality health care. There are numerous alternatives to the administration proposals we have discussed that would act to constrain the on-budget health expenditures of the Federal Government while maintaining a "social safety net" for the truly needy. We hope this committee and the Congress fully realize the importance of such programs as medicaid, title XX, and health planning to the elderly and that you will seriously and carefully explore other options prior to supporting the administration's reductions "en toto."

ITEM 2. LETTER AND ENCLOSURE FROM EDWARD HUMBERGER, REGION IV LOW-INCOME COUNCIL OF ELDERS, HENDERSON, N.C., TO SENATOR JOHN HEINZ, CHAIRMAN, SENATE SPECIAL COMMITTEE ON AGING, DATED APRIL 21, 1981

DEAR SENATOR HEINZ: On behalf of the Southern Council of Low-Income Elders and the North Carolina Senior Citizen's Federation, I wish to thank you and your staff for the opportunity to submit written testimony on the impact of the proposed budget cuts on the elderly poor. We submit this relative to the hearings your committee held on March 27 and more recently in April on energy assistance. We would like this testimony to be inserted in the record for both hearings.

The Southern Council represents the interests of over 1 million elderly poor in eight States of the South. The enclosed testimony presents the views of both the Council and the Federation on the impacts which these cuts will have on this, our

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[4] For the period 1979-85, DRI estimates an annual CPI increase of 8.7 percent but increases in health care of 10.1 percent, fuel 9.9 percent, and food (at home) of 8.7 percent.

most vulnerable population group. In this testimony, we describe the conditions of the elderly poor, evaluate the impacts of the cuts and rescissions on their life prospects, and propose an alternative policy. This policy has two parts: A survival net which guarantees the elderly poor can live the remainder of their lives independently and in dignity; and a mechanism for effective delivery of programs, namely the national network of 900 community action agencies.

Our primary concern is that the cuts not be passed. In fact, more funds should be targeted to the 6 million elderly poor. Further, if these funds, particularly those of the Community Services Administration are to be block-granted, we want those funds targeted to the elderly poor through Community Action Agencies.

Thank you again for your interest in our work. If you need any further assistance, please call me.

Sincerely yours,

EDWARD HUMBERGER.

Enclosure.

THE IMPACT OF THE BUDGET CUTS ON THE ELDERLY POOR

INTRODUCTION

This testimony comes to you from the North Carolina Senior Citizens' Federation (NCSCF), in Henderson, N.C., and the Southern Council of Low-Income Elders, which represents the elderly poor in eight southern States. NCSCF has a membership of 20,000 low-income elderly from across North Carolina, while a member group, the Alabama Caucus on the Black Aged has 15,000 members. The Southern Council represents the interests of 1.5 million elderly poor across the South. These organizations are responsible for finding ways to insure that the survival needs of the elderly poor are met, and to find ways to improve their prospects for independence, self-reliance, and an improved quality of life.

The Federation and its executive director, Inez Myles, have worked for 10 years to insure that the elderly poor obtain those benefits which are their birthright, and their human right. Ms. Myles is largely responsible for creating the council, and serves as well as the chair of the Elderly Committee of the National Community Action Agency Executive Directors Association. This statement represents the views of Ms. Myles, NCSCF, and the Southern Council.

The primary objective of this testimony is to present our views on the impact of the proposed budget cuts, rescissions, and program terminations on the elderly poor who are supposed to be protected by the "social safety net." We fail to find that net. Without that net, we estimate that thousands of the elderly poor will either die or experience enormous suffering or irreparable physical or mental damage.

There are two points we want to emphasize in this discussion. First, the budget cuts, rescissions, and program terminations will have their greatest negative impact on the most "truly needy"—the elderly poor. The cumulative and interactive effects of these cuts cannot be precisely determined due to a lack of data, although any reasonable analyst would have to conclude that they will result in major hardships. Further, the proposed termination of the Community Services Administration (CSA), the only Federal agency mandated to serve the poor and elderly poor through community action agencies, means that there will be no specific national emphasis on the problems of the poor, and no national focus on efforts to increase independence and reduce welfare dependence. CSA has, in particular, served the needs of the elderly poor, with fully 20 percent of $85 million of its budget being directed to meet the needs of the elderly poor. This targeting has been accomplished at only 6 percent overhead, when calculated on a national average, for community action agencies. The block-granting of these funds to the social services block grant, and its reduction to 75 percent of current value, means there is no guarantee whatsoever that the needs of the elderly poor will be met, reopening the gap which CSA has effectively filled for years.

Second, there are at least two major contradictions in administration policy toward the "truly needy." First, the public stance of the President has been a commitment to serve those most vulnerable in the society. The elderly poor are certainly the most vulnerable group in the nation. And yet the budgetary ax has threatened to eliminate, rescind, or severely cut back those programs that enable them just to survive. (See Appendix II, III).

Second, and related to this first point, this administration says it is committed to reducing dependency on public programs, and to increasing independence and self-reliance. A careful analysis of the budget cuts tells a different story. The elimination or reduction of programs which benefit the elderly poor will have the net effect of increasing dependence on public dollars. By eliminating or cutting back on services which link the isolated elderly to meals, health care or social support, there

is a much greater likelihood that the 800,000 elderly poor served by CSA will have to be institutionalized or receive other tax-supported services at the State or local level.

We fail to see the logic, the political reality, or basic human compassion in these contradictory positions. The administration has apparently decided to cut just for the sake of cutting. They lack an understanding of the programs or how existing community-based institutions work to achieve self-reliance, and do so at a far lesser cost than other comparable institutions.

Now, the administration would argue, as Mr. Stockman has on several occasions, that the elderly poor have fared well, since the Administration on Aging has been spared budget cuts. We would hasten to make two points very clear. First the Administration on Aging is not mandated to serve the poor. In fact, in the 1978 amendments to the Older Americans Act, Congress made it quite clear they had no intention of making this program "means-tested" or a poverty program. AoA, on the other hand, contends that it has served the poor quite well. In our examination of their 1980 performance data, however, we find no valid or reliable basis to support that contention.

Second, and even more important, is the fact that even if AoA's programs did target the elderly poor, they would miss the key ingredient of the CSA approach to dealing with poverty: namely to promote self-reliance and independence for the poor. Services alone make the poor dependent. Efforts to empower the poor and to enable them to become effective citizens so they can serve themselves is the objective of the CSA program. We can expect the transfer of responsibility for the elderly poor to either AoA or Human Service block grants to result in more, not less, dependency on public tax dollars at all levels of government.

But we intend to do more than just criticize the administration for its confusion, contradictions, and lack of compassion for the elderly and the poor. We propose an alternative formulation for a policy which consists of two parts: A program, and a mechanism for its implementation. The program is the guarantee of a survival net for the elderly poor—a livable income, and the necessary housing, medical care, and supportive social services so they may live in dignity. the mechanism is already in place—community action agencies. They are community-based and accountable, extremely cost-effective, and have proven their capacity over the last 15 years to provide the necessary outreach, gap-filling, education and training, innovation, advocacy and support to insure the independence of the elderly poor. It is less expensive to keep this mechanism in place than to create another system, and in no way could another system duplicate the capacity of CAA's to be accountable and responsive without replicating their structure.

In the balance of this discussion, we will describe the conditions of the elderly poor, and the need for the survival net, the impact of the budget cuts on them, why block grants do not work for the poor, and our alternative program to serve the elderly poor.

I. THE ELDERLY POOR NEED A SURVIVAL NET

There were 5.9 million elderly poor in 1979 (at 125 percent of poverty), or 16 percent of all the poor at that line, and 25 percent of all the people over the age of 65. In 1978, just a year earlier, there were 5.4 million elderly poor, an increase of one-half million people in 1 year. The poverty rate in the last few years has been increasing, with a 1.3 percent jump in a single year. Both inflation and an overall increase in the number of elderly have combined to reverse a trend toward less poverty. As the number of elderly increases over the next decade, so too will the number who are poor. Clearly their problems will get worst before they get better.

While all elderly poor are vulnerable and "truly needy," some are more vulnerable than others. The cuts will have a particularly devastating impact on four subgroups of the elderly poor who are at extreme risk:

1. The Frail Elderly

Those elderly who are over 75 years of age, a group growing more rapidly in size than any other. In 1900, they were 25 percent of those elderly over 65; by 1975, that percentage had grown to 37 percent. They had severe physiological and psychological problems, little money, and are least able to afford the nutritious meals, health care, heating oil they need to stay alive.

2. Minority Elderly

In 1978, there were 3.9 million elderly blacks over the age of 55. Of these, 30 percent are poor, compared to 10 percent for whites. Among those blacks over 65, the poverty rate has been fluctuating between 34 and 36 percent since 1974, com-

pared to 12 and 14 percent for whites. Among families headed by an elderly black in 1978, they were 4 to 5 times more likely to be poor than whites. Finally, the proportion of elderly blacks who are poor is 2½ times that of elderly whites. There are 1.1 million Hispanic elderly and 500,000 Pacific Asian and Native American elderly. Although there is limited data on these elderly, their median incomes tend to be lower than those of blacks.

3. Rural Elderly

We know relatively little about the rural elderly poor except that 36 percent of the elderly poor live in rural areas. The most significant problem for this is isolation and the related problem of little transportation. Without a car or public transit, their lifeline is literally nonexistent, unless dial-a-ride or minibus services are available from organizations like community action agencies.

4. Single, Black, Elderly Women

Fully 61 percent of the elderly women are single. There are 100 females to every 69 males over 65. On the whole they have 50 percent of the median income level of their male counter-parts. Single black elderly women are among the poorest of the poor—80 percent of this group are below 125 percent of the poverty line.

The litany of problems the elderly poor face should be well known by now. These conditions will be substantially exacerbated by the proposed cuts. We agree with the administration on one point: inflation, particularly in the basic necessities of housing, energy, health care and food, is the most serious problem the elderly poor face. From 1973–80, the Consumer Price Index rose over 80 percent, while their real incomes could not keep pace. In the basic necessities, inflation for 1980 alone rose 18 percent. But we do not agree with the administration's solutions to the inflation problem. Tax incentives which benefit the rich do not help the poor. And the decontrol of prices on heating oil and gas have pushed the poor to the financial precipice. Home heating oil costs, from 1973–80, rose 241 percent.

The conditions of the lives of the elderly poor place them in a most precarious position. A major jolt in just one aspect of their lives, like heating oil, can tip the balance, making it virtually impossible to survive. We have summarized these conditions in appendix I. In the energy area, for example, without budget cuts, over 25,000 elderly poor die each year from accidental hypothermia. Fully 2.5 million are at risk from exposure either to too much heat or cold. In health care, chronic conditions like arthritis, heart disease, high blood pressure, and diabetes affect 86 percent of the elderly population not in institutions. Similarly serious problems exist in nutrition, housing, transportation, mental health, long-term care, and social services.

Across the board, these people are the most vulnerable in our society, the most needy of the "truly needy." The severity of these needs, and the marginality of their existence, means that even without cuts of any kind their prospects are bleak. With the cuts, their hopes for any decent form of life in their later years will disappear altogether. The elderly poor must have a survival net which guarantees a minimum level of security and insures their dignity.

II. IMPACTS OF THE PROPOSED BUDGET CUTS, RESCISSIONS, AND TERMINATIONS

A thorough review of the cuts proposed by the administration has been made by NCSCF and the Southern Council, and they have reviewed them in terms of their impacts on the elderly poor. The cumulative and interactive effects of these cuts, rescissions and terminations cannot be precisely calculated at this time. However, any reasonable analyst would have to conclude that they will result in hundreds of deaths, and thousands of people suffering severe hardship and irreparable physical or mental damage. Further, we can anticipate an increased public tax burden as those elderly poor once able to live independently are forced by these cuts to seek assistance from public welfare at the State or local levels.

What is particularly disturbing to us is that the proposed cuts, rescissions and terminations come in the areas most essential to the elderly poor: Social security, medicaid, food stamps, housing, energy assistance, and social services. Of particular concern to us is the proposed termination of the only agency which has been mandated to meet the needs of the elderly poor: the Community Services Administration. It is clear to us that without these programs, and the Community Services Administration, there is no safety net, and no prospect that the needs of 6 million elderly poor will be effectively met.

The Budget Cuts

For fiscal year 1982, the administration has proposed a total of $45 billion in cuts which either directly or indirectly affect the elderly poor. A selected list of cuts which most directly threaten their survival is presented in appendix II. Among the more significant cuts are medicaid, which is slated for $5 billion in cuts through fiscal year 1986, while $2.3 billion is being cut from food stamps, meaning 3.3 million poor people will have their benefits reduced.

The Budget Rescissions

In addition, $14 billion in program funds are to be rescinded for fiscal year 1981. A selected list of these rescissions which impact on the elderly poor is included as appendix III. In section 8 assistance for low-income renters, for example, $4.8 billion is being rescinded, while $2.2 million will be withdrawn from the National Institute on Aging. An additional $14.5 million will be rescinded for 13 new senior companion programs, and $10 million will be taken back from title III Older Americans Act social services.

Program Terminations

The administration has also proposed a series of agency or program terminations effective October 1, 1981. The elimination of the Economic Development Administration, for example, means cuts in elderly housing. Perhaps the most serious proposal for the elderly poor, however, is the termination of the Community Services Administration, the Nation's only agency mandated to serve the poor. Twenty percent of CSA's budget, or $85 million, is expended or services for the elderly poor, while 54 percent of CSA's individual program beneficiaries are in this group. There is a national network of over 900 community action agencies and limited purpose organizations, including 210 senior opportunities and services programs, which reach out to find the frail, rural, isolated and homebound elderly. They provide transportation links to hospitals, doctors, grocery stores; they provide emergency energy assistance; they fill critical service gaps, and link those in need to resources necessary to survive. The termination of CSA means the end of the only agency dedicated to promoting independent and self-reliant living for the elderly poor.

The Tax Cuts

The President's across-the-board" tax cut plan will not help the elderly poor either. They would receive at most $1 per month if they earned less than $5,000 a year. Less than 36 percent of the elderly population would receive any more than that under these proposals.

The cumulative and interactive impact of these cuts, rescissions, and terminations at this point is unknown, and difficult to calculate. We know, however, that they will result in death and unnecessary suffering. But that burden will be borne by the individual, and will largely be hidden from public view. If a single, rural, frail elderly woman dies in her home in Alabama or Utah because they lacked food or transportation to the local hospital, could we say with any certainty that it was Mr. Reagan's fault? What is most insidious about these cuts is the climate of fear it has created for the elderly poor, resting their proposals on the assumption that poverty is the individual's fault. The administration's lack of compassion is awesome, and their rationalizations for failing to support their rhetoric about a safety net with dollars, represents a cruel hoax, a new kind of technician's viciousness, and a failure to understand what our Nation's moral obligation is to the elderly poor.

III. BLOCK GRANTS DO NOT WORK FOR THE POOR OR ELDERLY POOR

It seems silly to have to argue against block grants again in 1981 when it was patently clear 5 years ago that this form of trickle down doesn't work for the poor. Once moneys are given to the State or local governments, even with guidelines which specify the poor as an eligible group, the funds go to other groups, to the underwriting of capital expenditures, to subsidize existing personnel slots, or to the pet projects of those who have the most political influence with the chief executive. Without guidelines, this problem will simply be exacerbated.

Our experience with revenue sharing, and block grant programs in community development (CDBG), law enforcement, and title XX social services have shown us that the poor do not benefit. In fact, a recent national impact evaluation of the CDBG program, in terms of the poor, found that in 65 to 75 percent of the cases, the program did not serve its intended purposes. For the poor this meant that economic

development meant displacement from their homes, and that housing assistance went to the moderate income group.

And there are other major problems with block grants beside their failure to ultimately impact on the poor. Careful research has found:

1. No Accountability

Without targeting, reporting procedures, monitoring, there is no way to hold local or State officials accountable for the expenditure of public funds.

2. More Bureaucracy

Instead of one Federal agency, there will 50 State bureaucracies, and in many States with local option, hundreds of county or city bureaucracies implementing these programs.

3. Significantly Higher Costs

State bureaucracies implementing similar programs have a 15 percent operating cost. Community action agencies have a 6 percent cost.

4. Severe Startup Problems

State and local agencies have little or no understanding of the Federal programs which for 15 years have effectively met the needs of the poor. They will have to be trained, issue guidelines, gear up, allocate funds, and begin administration before any services will be provided. This could easily take 9 to 12 months. It will occur during the winter of 1982, meaning the elderly poor may easily not get energy assistance needed to stay alive. Supporting this position we find the National Governors' Association which has recognized the seriousness of this problem and the State capacity to handle it.

5. Fewer Service Dollars

Cutting the total amount of funds available by 25 percent means fewer services will be available to the elderly poor.

6. Only the Strong Survive

Certainly this will be true for individuals. It is also true for organizations serving them. They will have to compete against far more potent political forces—such as local governments, line agencies, and trade associations—for dollars.

7. More Fraud, Waste, and Abuse

As the number of agencies involved in fund decisions increases, and as monitoring and accountability provisions are eliminated, the potential for fraud, waste, and abuse increase geometrically.

8. No Citizen Input Means Ineffective Programs

Without effective citizen participation, whatever dollars do get to the poor are more likely than not to be improperly applied. State and local bureaucrats simply have little sensitivity to or experience with the real needs of the elderly poor.

Again, it seems silly to debate this point. Block grants simply do not work for the poor. They will only benefit the more powerful interests in our society. Thus, even what the administration has offered up as a continuation of programs is a cruel hoax for the elderly poor.

IV. SURVIVAL NETS AND COMMUNITY ACTION AGENCIES

The first principle of an alternative program for the elderly poor is a guarantee that they can survive in dignity. This means, at a minimum, congressional commitment to the survival net of programs: A guaranteed income (social security and SSI), housing, food, social services, health care, transportation, energy assistance, recreation, employment and educational opportunities. It means that they must be targeted to the elderly poor. In practical terms it means:

(1) Not passing the proposed cuts, rescissions, and terminations.

(2) Redirecting the tax cut package to benefit the poor.

(3) Rejecting the block approach to programs for the poor and elderly.

(4) Reauthorizing the Economic Opportunity Act, EDA, and other jobs and development program which target assistance to the poor.

(5) Insisting that if block grants are to be implemented, they be line-itemed for the poor and elderly poor; that strict guidelines and monitoring provisions be included.

(6) Reallocating defense dollars to survival net programs.

(7) Closing tax loopholes so upper income individuals and corporations pay their fair share.

The second principle of an alternative program is the maintenance of a community institution to serve the poor, namely community action agencies, and their limited purpose counterparts. The elderly poor must have an ombudsman, an intermediary which can translate complicated State and local programs and regulations into terms the elderly can understand. They need an advocate, a planner, a service provider which is sensitive to their needs, permits them to participate in decision-making, and listens to their opinions. They need a community institution which is dedicated to their independent living and self-reliance.

Community action agencies were originally mandated to provide services and advocate for the interests of the poor. This program has gone well beyond that role. It has created new ways to serve the poor, as in the case of Head Start or Job Corps. It has leveraged millions of dollars from private and public sources, created jobs, and started new businesses. It has trained and educated a generation of low income people to participate effectively in the political system. It has established self-reliance and self-help as its primary objective, and has enabled thousands to move off of, or stay off welfare as a way of life.

The community action agency is an institution that must be preserved. It is the ombudsman for the poor. Without it, local and State governments will, of necessity, have to confront the poor directly.

CONCLUSION

We ask you to consider the implications of these cuts, rescissions, and terminations for the elderly poor. We ask you to reconsider the administration's proposals, and to insist on the survival net and community action agency alternative.

As the richest nation on earth, we have an obligation to the 6 million elderly poor which is beyond the demands for a balanced budget. As a God-fearing people, we have a moral obligation to honor the dignity of the elderly poor as human beings, and to protect their birthright as Americans, and to respect with our financial and political support their 50-plus years of hard labor which has built this country. For us to turn our backs on them now is the worst form of treachery.

Appendix I

CONDITIONS OF THE ELDERLY POOR

PHYSICAL HEALTH AND HEALTH CARE

Chronic conditions such as arthritis, heart disease, high blood pressure, and diabetes affect 86 percent of the older population not in institutions. These require trips to the doctor, special diets, exercise, drugs, rehabilitation therapy, and special provisions for daily living. Good health care is hard to get for the elderly poor, however, since there are not enough trained personnel, lack of access and transportation, a complicated medical system that must be negotiated, few or no cost controls, and incomplete coverage by medicaid and medicare. These problems are pronounced for the black elderly where an estimated 40 percent have unmet health care needs.

MENTAL HEALTH

Fully 25 percent, or one in every four suicides in the United States is committed by persons over the age of 65; 13 to 15 percent of the older population are in need of immediate mental health services. As of 1980, it was estimated that 80 percent of those in need of mental health services did not receive them. The incidence of mental health problems is also much higher in those population groups that are poorer.

ENERGY AND HYPOTHERMIA/HYPERTHERMIA

This is one of the greatest threats to the elderly poor in either the winter or summer. It is particularly acute for the 56 percent of them who live in the Northeast/Midwest where increasing oil prices make heat difficult to purchase. Fully 2.5 million elderly are at risk. Exposure to even mildly cool temperatures, e.g., 65 degrees, can trigger accidental hypothermia (cold). We do not know yet how many

people die each year since the epidemiology is still new, and there is inadequate data, however a conservative estimate is 25,000. Without sufficient funds to pay for energy bills, the elder poor are increasingly being forced to choose between food and heat. The decontrol of oil and natural gas prices will hit them the hardest.

FOOD AND NUTRITION

Certainly good and nutritious food is the best defense against illness and institutionalization. It is difficult to document the nutritional status of the elderly, but we can say that many depend on their one hot meal a day for their diet. Food is clearly the number one financial cost for the elderly poor, with one-third of their budget spent on it, on the average. They are increasingly being forced to make tradeoffs among the basic necessities of life, which Federal programs targeted to them obviate.

HOUSING

Isolation is one of the biggest problems, particularly for the homebound or the rural elderly poor; 25 percent lived alone in 1976, compare to 16 percent in 1960. Rising taxes and fuel costs, as well as condominium conversion, are forcing these people out of their homes and into rental units, halfway houses or institutions. The shock and trauma associated with moving the elderly, particularly the frail elderly, adds substantially to their physical and mental stress.

LONG-TERM CARE

The "at risk" population with chronic degenerative conditions is mushrooming as the elderly population grows. And yet public and private home health programs meet only 25 percent of that need. 20 percent of all elderly will at some point in time spend time in a nursing home, which will have to be paid by medicare or medicaid.

TRANSPORTATION

Mobility is one of the biggest problems of the elderly poor. Fully 40 percent of all elderly are without a car, and for those who have them, insurance premiums are among the highest. For those who must rely on public transportation, it is either very expensive or it is infrequent, inaccessible, or doesn't exist at all. For the 5.7 million elderly who have some form of mobility limitation, for those in rural areas especially, transportation is a serious impediment to their independence.

SOCIAL SERVICES

Many of the elderly poor get no supportive social services at all. For others, however, homemaker, homebound, telephone reassurance, transportation, and other nutrituion or support services are the key difference between a life of independence and an institution. For blacks, however, a number of service equity studies recently showed that less than one-half of those eligible for benefits actually got them.

Appendix II

THE BUDGET CUTS AND THE ELDERLY POOR [1]

1. SOCIAL SECURITY

The minimum payment of $122 per month is to be eliminated as are death benefits; the cost-of-living adjustments are to be delayed; the eligibility age for receiving social security is to be increased to 68. 3 million persons now receiving the social security minimum benefit will have their benefits reduced. Only 145,000 will apply for extra SSI benefits, of 580,000 eligible. 700,000 will be affected by the termination of death benefits, and thousands will be pushed onto welfare rolls, or already crowded nursing homes.

2. MEDICAID

$5 billion are to be cut from the budget by 1986 through a spending "cap." This could translate into sharp reductions in the health benefits available to 5 million

[1] This data has been compiled from association sources as well as the House Select Committee on Aging, "Analyses of the Impact of the Proposed Fiscal Year 1982 Budget Cuts on the Elderly," Apr. 6, 1981.

elderly poor who depend on medicaid. We fully anticipate an intensified dual health care system, States having to pay the difference in costs, with millions going without medical care at all. Further hundreds of thousands of others will be unable to meet the medicare coinsurance and deductible costs, since medicare covers only about 40 percent of their health care costs.

3. FOOD STAMPS

Tightening up on eligibility, and rigidly enforcing the 130 percent poverty line will mean $2.3 billion dollars in cuts, the elimination of benefits for 125,000 elderly, and 920,000 elderly and disabled individuals to continue receiving the stamps will be denied a small increase approved by Congress to offset their high health expenditures.

4. HOUSING ASSISTANCE

Increasing the contribution to 30 percent reductions in outlays for construction and improvements; terminated funding for congregate housing. This means 727,340 elderly poor tenants will have to pay an average of $202 more per year in rent for subsidized housing. 52,447 elderly will lose rent subsidies that would have allowed them to live in decent affordable housing through section 8. An additional 1,150 elderly will lose the low-income housing that was to be built under Farmers Home Administration assistance.

5. MEDICARE

It will be cut so that necessary home health benefits would be denied to 3,100 persons, reimbursement would not be available for a vaccine that would save 5,000 lives over a 5-year period, and thousands of nursing homes would be inspected less frequently.

6. CETA

Funding that provided jobs to 50,000 older persons will be eliminated; 26,000 elderly workers will lose their jobs immediately; as many as 262,000 will be unable to receive badly needed services that had previously been provided by CETA public service employees.

7. SOCIAL SERVICES

The termination of the Community Services Administration will mean loss of targeted benefits to 800,000 of the most hard to reach elderly poor. This will result in increased hardship, death, and institutionalizations, as well as increased State welfare costs as they shift to dependency status. A 25 percent cut in the social services programs will mean less assistance to 1 million elderly, 400,000 of them on SSI.

8. HOMEMAKER SERVICES

86,804 elderly and disabled persons are likely to lose homemaker and chores services that make it possible for them to remain independent. It will increase institutionalization.

9. LEGAL SERVICES CORPORATION

187,000 older persons will be denied Federal legal services if the corporation is terminated.

Appendix III

BUDGET RESCISSIONS AND THE ELDERLY POOR

The following list of rescissions is selective, from a total of $14 billion the Reagan administration proposes for fiscal year 1981 alone. We have selected cuts which impact on the elderly.

(1) The Economic Development Administration will be terminated, including programs for elderly housing.
(2) Reduction of $30 million in adult education.
(3) Reduction of $6 million in handicapped educational services.
(4) Rescind $4 million to eliminate the home health agency startup program.
(5) Eliminate $8.1 million in Native American health facilities.

(6) Rescind $2.2 million of the National Institute on Aging.
(7) Phase out public health service hospitals.
(8) Rescind $10 million in title III Older Americans Act funds for social services.
(9) Rescind $580,000 for the Federal Council on Aging to reduce activities in improving long-term care and evaluation of programs under the Older Americans Act.
(10) Rescind $4.8 billion for section 8 rental assistance, and $300 million for modernizing public housing.
(11) Phase out temporary public service employment for low-income individuals in time of high unemployment.
(12) Rescind $14.5 million for 13 new senior companion programs and $1.7 million in VISTA.
(13) Rescind $28.1 million in health maintenance organization program and phase it out.

ITEM 3. STATEMENT OF THE ASSOCIATION OF COMMUNITY HEALTH SERVICE AGENCIES, INC., MILLDALE, CONN.

A Policy Statement on the Reappraisal of Long-Term Care

The association notes that the Federal Government is engaged in a major reappraisal of programs of long-term care, in an effort to contain costs. Some proposals, so far advanced, may not only seriously affect health services for the poor, elderly, abused and disabled, but may actually offer institutionalization as the only viable alternative.

Proposals causing serious concern are those involving block grants to States. The social services block grant would consolidate 13 programs including title XX. The health services block grant would consolidate nine programs, including home health services, mental health programs, and drug and alcohol abuse. The preventive health services block would include 11 programs and the energy and emergency assistance, two programs. The block grants would include only 75 percent of the combined 1981 funding levels for programs consolidated in the grants, necessitating at least a 25 percent reduction in services. States would be allowed broad discretion in allocation of the funds.

Total medicaid expenditures would be subject to an overall cut of 5 percent. It is also expected that provision of unlimited home health visits and the designation of occupational therapy as a qualifying service for medicare will be repealed.

Knowing that the administration is genuinely concerned with providing needed health services at reasonable cost to persons unable to care for themselves, we believe that the proposals cited will defeat this purpose for the following reasons:

(1) Increased financial burdens on the State will inevitably reduce availability of services to persons in need.
(2) If funding does not keep pace with need, noninstitutional services may be sacrificed to insure funding of nursing homes.
(3) Persons unable to receive noninstitutional care will be forced into institutions. This will increase costs and further reduce the availability of in-home or community care, creating a vicious cycle.

A State like Connecticut which has successfully demonstrated a system of long-term care which focuses on noninstitutional care as an important component of the total health care system will be in particular jeopardy.

We support Connecticut's concern over the nature and timing of waivers to be granted by the Department of Health and Human Services. Waivers should permit reduction of unnecessary institutional expense as well as the inappropriate use of institutional resources. A danger of developing two classes of health services exist if the poor and elderly are forced into institutions because of unavailability of care in the home or community.

ITEM 4. LETTER AND ENCLOSURE FROM CHARLES C. BELL, CHAIRPERSON, ADVOCACY COMMITTEE, CHRONIC ORGANIC BRAIN SYNDROME SOCIETY, PITTSBURGH, PA., TO EILEEN BARBERA, STAFF MEMBER, SENATE SPECIAL COMMITTEE ON AGING, DATED MAY 5, 1981

Dear Eileen: Please find enclosed the written testimony of the Chronic Organic Brain Syndrome Society concerning the impact of the Reagan administration budget cuts on that very special and grossly neglected segment of the elderly population, the senile.

On behalf of the Society, I express our continuing appreciation to both you and Senator Heinz for your great interest in the needs of senile persons and, generally, the needs of all long-term care patients.

Please don't hesitate to contact me or any other representative of the Society if we can be of any further assistance or help.

With kindest regards, I am

Sincerely yours,

CHARLES C. BELL.

Enclosure.

The Chronic Organic Brain Sydrome Society presents this written testimony on behalf of those who are unable to speak for themselves, the citizens of our country who are afflicted with degenerative brain diseases commonly known as "senility."

The Society also presents this written testimony on behalf of those who are only now coming forward to speak: the forgotten family members and caretakers of the victims of "senility."

Senility is a term that has been widely misunderstood in America. Traditionally, senility has been described as a natural process of aging. When an elderly person becomes confused, disoriented, or forgetful, the response of all aspects of society is to cluck sympathetically and say: "Well, that's what happens when you get old." Since senility has traditionally not been considered a medical problem, an attitude has developed that there is nothing which can be done for the victim. This attitude has permeated throughout social welfare planning by the U.S. Government.

In order for the impact of the Reagan administration proposed budget upon this segment of the elderly to be understood, certain heretofore little known facts about this affliction must be presented.

First and foremost, senility is in fact a medical problem. To be more precise, researchers and neurologists are able to diagnose pathological changes in the brain of the victim. The recent mini-White House Conference on Alzheimer's Disease and the Related Disorders of Aging, occurring in January 1981, at the National Institute on Aging, gathered together many of the leading medical researchers in the country concerning their findings into the precise pathological changes and research into medical causes.

Second, there is a strong correlation between aging and "senility." While no hard data exists, the best expert estimates are that 10 percent of the age 65 or older population suffer from one of the several forms of senility. Other expert estimates are that 3 million persons suffer from senility, and that half of these victims, or 1.5 million, suffer from Alzheimer's disease.

Third, not only does the disease destroy the victim's cognitive functioning, it also destroys the victims's central nervous system. The victim loses the ability to control limbs and bodily functions. In many respects, the victim, in physical appearance may eventually not differ from a stroke victim.

Fourth, the victim is cast adrift by existing hospitalization and health programs, including medicare, because he or she is not considered to have a medical problem or because it is a long-term care problem. Only medicaid provides any form of direct assistance.

Fifth, while institutionalization has become an integral part of the life continuum of many elderly persons, this is particularly true for the victim of senility. Because of the lack of treatment alternatives or settings, the family of the patient often has no recourse but to institutionalize a loved one. According to the General Accounting Office, nursing home aggregate costs for 1980 were estimated to be $25 billion; for 1990, the projected total is $75 billion.

Finally, some individuals displaying symptoms of senility may actually have a reversible condition. While no hard data exists, expert estimates are that 10 to 30 percent of all individuals displaying symptoms of senility may be suffering from some other medical or psychiatric condition. In addition, there are both physical and mental therapies available which slow the progression of this disease.

It is against this factual background that the Society makes the following critical comments on behalf of the victims of senility and their families concerning the Reagan administration's proposed budget reductions.

The proposed budget reductions in social welfare spending will have both a direct and an indirect impact on the special segment of the elderly who suffer from senility.

The direct detrimental impact occurs in the proposed medicaid cutbacks and limitations. The Reagan administration proposes to "cap" the amount of money which may be paid to support an indigent person receiving medical assistance. The proposed "cap" is on the aggregate lifetime benefit of the recipient.

Rightfully or wrongfully, medicaid has been used by victims of senility and their families as a government subsidy for the cost of institutional care. The victim and

his family driven to this alternative because of the lack of existing community, government, or insurance resources to assist in home care or to supplement or pay for needed noninstitutional or institutional care. The great reliance of victims of long-term care illnesses, especially senility, and of the victims' families upon the medicaid program is a well-known fact to both this committee and the House Select Committee on Aging.

Thus, the proposed "cap" will serve to limit the length of often required institutional care of the patient and begs one very pertinent question: what happens to the victim receiving medical assistance when he reaches his "cap" level? Two alternatives, shifting the burden to another level of government, and simple charity by the institution, just are not realistic. A third alternative is that the victim/patient will be discharged from the facility at a time when he has nowhere to go because of his deterioriated condition or because of lack of family support.

Thus, the ramification of the medicaid limitations must be carefully considered by the administration and by Congress.

The detrimental indirect impact of the budget proposals is two-fold. First, there will be less money available for existing social welfare programs. Second, individuals previously neglected under social welfare programs will have a harder time in gaining recognition through government benefits of their needs. In the expected social welfare scramble for a piece of the shrinking budget pie, the senile person will likely continue to be neglected. This expected continuing neglect is extremely shortsighted when the correlation between aging and senility, as previously mentioned, is projected into the future.

Demographic trends indicate that, first, life expectancy is gradually increasing and, second, that shortly after the turn of the century some one-third of the American population will be 60 or older. Thus, 10 percent of one-third of our population, at a minimum, will be suffering from senility in thirty years.

The senile person requires a continuum of social, medical and financial assistance if he or she is to live with the dignity which any ill person deserves and requires. This assistance generally includes hospital care, therapies, home-care services, hospital equipment, senior centers, adult day care centers, nursing services, and institutional care.

The Society presents the following position to the Senate Special Committee on Aging. If the Reagan administration is in fact concerned about cost-consciousness, then it must do more than cut back on the total amount of subsidized institutional care presently provided under medicaid. In fact, the administration would be wise instead to restructure the government's traditional outlook that institutional care is a first resort for long-term care, and replace this with the view that home-based and/or community care using the family as a primary resource should be the first resort. The Society submits the proposal, presently being tested through AoA sponsored studies,[1] that community-care is cost-effective versus institutional care. Government subsidies in conjunction with financial contribution by the victim of senility and/or his family for community-based home care would effect an overall social welfare budget savings.

In conclusion, the Chronic Organic Brain Syndrome Society is distressed when it hears spokespersons for the administration assert that a safety net for the truly needy will not be removed by the budget proposals. In fact, one insufficient safety net, Medicaid, is being shrunk without any indication that another safety net will be constructed.

The Society, therefore, presents the plight of the senile person as a plight of the truly needy who have the barest of government support. the COBS Society commends this grossly neglected segment of the elderly to the careful consideration of the Senate Special Committee on Aging relevant to the budget cuts of the Reagan Administration.

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[1] The Gerontologist, vol. 20, No. 3, 1980.

Applebaum, Seidl, and Austin: The Wisconsin Community Care Organization, Preliminary Findings from the Milwaukee Experiment.

Eggert, Bowlyow, and Nichols: Gaining Control of the Long-Term Care System: First Returns from the ACCESS Experiment.

Hodgson and Quinn: The Impact of the Triage Health Care Delivery System Upon Client Morale, Independent Living and the Cost of Care.

Skellie and Coan: Community-Based Long-Term Care and Mortality: Preliminary Findings of Georgia's Alternative Health Services Project.

Taber, Anderson, and Rogers: Implementing Community Care In Illinois: Issues of Cost and Targeting in a Statewide Program.