

URGENT

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

LRM NO: 1899

FILE NO: 1109

7/7/95

LEGISLATIVE REFERRAL MEMORANDUM

Total Page(s): 23

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FROM: Janet FORSGREN (for) *Janet L. Forsgren*
Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI 395-4871
Legislative Assistant's line (for simple responses): 395-7362

SUBJECT: HHS Proposed Testimony on Medicaid Program

DEADLINE: 2:00pm Monday, July 10, 1995

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URGENT

Testimony of
Bruce C. Vladeck
Administrator
Health Care Financing Administration
Before the
Committee on Finance
U.S. Senate
July 12, 1993

Mr. Chairman and Members of the Committee:

I welcome the opportunity to be here this morning to discuss State flexibility under the current Medicaid program and this Administration's efforts in expanding and assisting States in using that flexibility. The Medicaid program was conceived as a Federal/State partnership, and this Administration has made major strides in strengthening the relationship. Nonetheless, we recognize the need for additional work to build on this partnership.

Introduction

Before beginning our discussion about State flexibility, I would like to highlight some essential facts about the Medicaid program.

First, Medicaid's spending growth has moderated. A widespread myth holds that Medicaid is growing out of control, far faster than other parts of the health care sector. Chart 1 shows the contrary. In fact, the growth in Medicaid spending on a per person basis has not exceeded the growth in private health insurance since the period between 1989 and 1992. At that time, States used provider taxes combined with disproportionate share hospital payments as a means of increasing Federal matching funds.

Second, the lion's share of Medicaid spending is devoted to the aged and disabled. As chart 2 indicates, the aged and disabled represent 30 percent of Medicaid recipients and account for 70 percent of the spending.

Third, Medicaid is a critical safety net for a wide variety of populations with very diverse health needs. State Medicaid programs cover prenatal care for low and moderate-income pregnant women, health care for children, and long-term care for low-income senior citizens. They also provide a variety of rehabilitative and adaptive services for persons with disabilities, chronic care for individuals with special needs, and supplemental coverage for low-income Medicare beneficiaries. For many of these populations, whose disabling conditions or medical costs preclude them from purchasing insurance, Medicaid is the only system of care.

Chart 3 shows how Medicaid coverage increased between 1989 and 1994 while employer-based insurance declined. Medicaid brings an important stability to the health care marketplace by offsetting losses in private insurance coverage. Although different populations are involved, Medicaid coverage increases have leveled the overall percent of uninsured and thereby maintained an essential balance in the cost shift to the private sector.

State Flexibility Under Current Law

Medicaid was enacted in 1965 to provide access to coverage for low-income Americans. Medicaid represented a consolidation of several Federal grant programs administered by the States. The nation's most vulnerable populations -- low-income senior citizens, individuals with disabilities, and children -- are Medicaid eligible in every State.

Nevertheless, the current Medicaid program is actually 56 different programs. The States have tailored their programs to meet the varying specific needs of their individual populations. The diversity across States' Medicaid programs is a direct result of the inherent flexibility of the program.

The States' Medicaid programs are dynamic. In partnership with HCFA, States are continuing to find innovative ways to improve health care delivery, enhance access, and control rising health care costs.

Flexibility in Coverage

The original Medicaid statute only required States' Medicaid programs to provide a set of five core benefits, including inpatient hospital services, outpatient services, physician services, laboratory and x-ray services, and skilled nursing home services. States could also cover any of ten optional benefits.

Over the past 30 years, Congress has added seven services to the list of required benefits and has expanded the list of optional benefits that States may offer to include 30 services.

States use their flexibility to cover optional services to customize their Medicaid programs to serve the special needs of their vulnerable populations. For example, Utah provides 28 optional benefits to its Medicaid beneficiaries while Delaware offers 15

optional benefits. A few benefits, such as prescription drugs and clinic services, are offered by almost all the States. On average, the States cover about 24 optional benefits. Only 44 percent of Medicaid spending in 1993 was for mandatory services provided to mandatorily eligible individuals. Chart 4 shows that over 50 percent of the total Medicaid spending was for optional services and populations elected by the States.

Flexibility in Determining Eligibility

States have significant flexibility in determining who is eligible for their Medicaid programs. The largest portion of the caseload are those on the Aid to Families with Dependent Children (AFDC) program. The eligibility standards for this program are directly determined by States.

States may also extend Medicaid coverage to low-income families above the Federal minimum guidelines and to individuals with large medical expenses. The States use this flexibility to make their institutionalized aged and disabled populations eligible for Medicaid.

Medicaid statute requires States to cover pregnant women and children under age 6 up to 133 percent of the Federal poverty guideline. In addition, States must also phase-in coverage for all other children over age six born after September 30, 1983. Thirty-three States use Medicaid flexibility to expand coverage for pregnant women and children with family incomes beyond the Federal minimum guidelines. Twenty-seven of those States

cover pregnant women and infants to at least 185 percent of the Federal poverty guidelines.

In addition, States have further flexibility to liberalize financial eligibility criteria for certain high-priority populations under the authority of section 1902(r)(2) of the Social Security Act. Under this provision, States are able to apply more liberal financial eligibility standards by disregarding certain income and/or assets.

Several States have used the authority of section 1902(r)(2) as a means of expanding eligibility for children beyond 185 percent of the Federal poverty level and accelerating the phase-in coverage for children below the poverty level. For example, both Delaware and West Virginia have used the 1902(r)(2) authority to cover all children under age 19 up to the Federal poverty level.

Flexibility in Service Delivery and Financing

States have additional flexibility to design their Medicaid programs through various program and research waivers.

Managed Care Programs

Under freedom-of-choice waivers, States can establish primary care case management programs, require Medicaid beneficiaries to choose among managed care plans, and selectively contract with hospitals, nursing facilities, or other providers. States use this

flexibility to target coordinated and comprehensive managed care systems to their high-risk populations and to purchase services in a cost-effective manner.

States are taking full advantage of the flexibility to design managed care programs for their Medicaid populations. Thirty-nine States now operate 75 managed care programs covering 8 million Medicaid eligible individuals.

States have also developed managed care programs to target a number of specific priorities. For example, the Kansas Primary Care Network (PCN), which was established in 1984, was one of the first managed care programs to provide physician case management to beneficiaries. Under this program, the State assigns each Medicaid beneficiary in the seven most populous counties to a physician case manager. The case manager is responsible for managing all of the recipient's health care. Over 30 percent of the State's Medicaid eligibles are now enrolled in this PCN program. HCFA reviews have shown the program to be cost effective as well as providing better access to services for the participating Medicaid beneficiaries.

Similarly, Florida has developed MediPass, an extensive primary care case management program. The State pays MediPass primary care providers a \$3 per member per month case management fee to coordinate care for their MediPass enrollees. These providers manage many of their patients' health needs, including specialty referrals, but continue to be paid on a fee-for-service basis for the health care services they provide.

Utah has developed a ground-breaking prepaid mental health program for Medicaid beneficiaries. The State contracts with three community mental health centers to provide inpatient and outpatient psychiatric and related physician services. The first year results indicate that contractors were able to reduce utilization of inpatient psychiatric services while increasing the percentage of eligibles served in their catchment areas.

Home and Community Based Services Programs

Home and community based services waivers give States the ability to establish home and community based care programs that provide services to beneficiaries in the community setting rather than in nursing homes and hospitals. Home and community based services programs allow States to manage care provided to the elderly and disabled populations in an efficient manner while increasing the consumer's satisfaction with the services provided.

States have made extensive use of this authority as well. Over 205 programs are now operating. Every state is currently serving developmentally disabled and aged individuals under a home and community based services program. States are also serving people with HIV/AIDS, those with traumatic head injury, and medically fragile children.

HCFA is actively involved in encouraging and assisting States in using this flexibility. Recently, Alaska officials requested HCFA assistance in developing their home and community based services program. Our staff went to Alaska and helped the State

design four home and community based services programs to meet the unique needs of its citizens. The programs were quickly reviewed and approved. Other States are also increasingly seeing HCFA as a partner in the development of their programs.

Service Delivery and Financing Demonstrations

Medicaid's research and demonstration authority, section 1115, gives States much broader opportunities to develop and test new and innovative ideas. States can use this authority to develop sub-state and statewide demonstrations of new approaches to health care financing and delivery.

This Administration has approved ten statewide section 1115 demonstrations. Several additional States have submitted proposals that are currently being reviewed. No previous Administration had been willing to give States a comparable degree of flexibility as the Clinton Administration. We have actively encouraged States to develop innovative reform demonstrations including managed care approaches working with the private sector and public health providers.

One of the first acts of this Administration was to approve the Oregon Reform Demonstration. The Oregon request, which was the first approval of a statewide demonstration in 10 years, had been denied by the previous Administration.

Since that point, innovative reform proposals have been approved in Hawaii, Tennessee,

Rhode Island, Kentucky, Florida, Ohio, Massachusetts, Minnesota, and Delaware.

These States are experimenting with new ways of financing and delivering essential health care. For example, Delaware has created seamless coverage for those below the Federal poverty level. Rhode Island is testing the effectiveness of extending family planning benefits and contracting with an FQHC-based managed care system.

In addition, the Administration has approved twenty-three smaller, more targeted section 1115 demonstrations. Some of these demonstrations provide preventive services to children, test extended family planning services, and establish alternative delivery systems.

For example, under the Iowa Drug Utilization Review Program, the State conducts on-line prospective drug utilization review. There are 250 pharmacies participating in the project either as randomized control or experimental entities.

Further, the multi-State Nursing Home Case-Mix and Quality Demonstration which is operating in Kansas, Maine, Mississippi, New York, South Dakota, and Texas, will test a combined Medicare and Medicaid nursing home payment and quality monitoring system. This system will significantly enhance the quality assurance process in nursing facilities.

Flexibility in Program Administration

States have considerable flexibility in establishing provider participation criteria. Certification requirements for institutions such as hospitals and intermediate care facilities for the mentally retarded, physician qualification requirements, and requirements for other providers are determined primarily by the States.

Similarly, States have latitude in setting provider payment rates. Although the Boren Amendment and Medicare accounting principles provide general lower and upper bounds with respect to payments for hospitals and nursing homes, States have significant flexibility to establish payment rates for these providers. States have still greater flexibility for other classes of providers.

Another area in which States have flexibility is targeted case management. States use the Medicaid program to coordinate not only medical services but a range of social, educational, housing, or other services for Medicaid beneficiaries. States have the ability to use case management for as many segments of the Medicaid population as they believe would benefit from such coordination.

For example, States have established programs to coordinate the service needs of mentally retarded individuals, the mentally ill, individuals with HIV/AIDS, high-risk pregnant women, and at-risk children. In each case, the State is afforded the flexibility to define the level of service coordination provided, the target group, provider

qualifications, level of payment, and any limits on the scope of services. This has enabled States to develop individualized plans of care for their most vulnerable citizens that weave together a tapestry of support from the diverse threads of Federal, State, local, and private resources.

With HCFA cooperation and assistance, many States are collaborating with various health-related and community organizations to design and implement programs that meet a comprehensive range of health needs of children. Because children's health is frequently affected by a number of socioeconomic conditions such as poverty, substance abuse, and fragmented health resources, no single agency or program can address all of their needs. Increasingly, communities are using public/private arrangements to develop integrated services networks. These networks disseminate information and serve as referral links between women and children in the community and the State's Medicaid, Maternal & Child Health, Women Infants & Children, and primary care programs.

Further, States have pursued a wide range of administrative and programmatic innovations. HCFA has encouraged and supported State program improvements, including:

- - - Introducing magnetic-strip cards to provide immediate access to information about eligibility and third-party liability; and
- - - Implementing automated drug utilization review to control fraud and improve the quality of pharmacy services.

Improving the Medicaid Program

As you know, the President recently suggested a number of ideas for enhancing the Federal-State partnership and controlling Medicaid costs. The President proposes a combination of policies to expand State flexibility and reduce the growth of Federal Medicaid spending. This combination includes expanding managed care, reducing and better targeting Federal payments for hospitals that serve a high proportion of low-income people, and limiting the growth in Federal Medicaid payments to States for each beneficiary. I believe these strategies represent the right approach to improving the Medicaid program.

We believe the best strategy for improving the Federal-State Medicaid partnership is to pursue changes that protect beneficiaries yet give States additional program flexibility and cost-control mechanisms. This improvement can best occur within the current Federal-State partnership. The Medicaid program can and does provide flexibility for States, but the program's structure also ensures an important degree of continuity across States. This continuity is particularly important in program eligibility -- low-income senior citizens, individuals with disabilities, and children are Medicaid eligible in every State. Under the current Federal-State relationship, States also draw on Federal expertise and assistance to achieve program goals.

The President's proposal seeks \$54 billion in Medicaid program savings over seven years. We want to work with this Committee and the Governors to determine how we can best

achieve these savings. We are interested in significant changes. For example, we want to give States more flexibility to pursue certain widely used managed care models by replacing current waiver requirements with new statutory authority that would make these types of Medicaid managed care a program option that States could elect without extensive Federal review.

We are also interested in building upon our work with the National Governors' Association (NGA). For example, we worked with the NGA to encourage States to expand their home and community-based services programs. We believe that State flexibility in these programs could be further enhanced. HICFA supports the NGA recommendations to repeal requirements for payment rates to obstetricians/pediatricians and to replace the HMO enrollment provisions called the "75/25 rule" (which requires HMOs to maintain at least 25 percent private enrollment) with more outcome-based quality assurance methods. We support provisions that would allow managed care entities to better serve rural areas. We are also evaluating new strategies for guaranteeing access to high-quality services that are more refined than the current Boren Amendment.

We recognize that the growth in Medicaid should be contained. However, we do not want to do this in a way that risks Medicaid enrollees losing coverage. Instead, the President has proposed per capita limits on Federal Medicaid spending, which will provide an additional incentive for States to control program spending but will not force

them to restrict Medicaid eligibility. Under per capita spending limits, Medicaid enrollment can continue to expand and contract with economic conditions and individual needs. With enhanced flexibility, States will be able to manage within these limits, while Medicaid beneficiaries -- including senior citizens, disabled people and children -- will retain their health care coverage.

Comparison to Other Proposals

We believe the reductions required in the conference agreement on the budget resolution would damage this critical safety-net program and harm the States, beneficiaries and providers. These impacts would be driven by the dimensions of the spending cut, its likely influence on State spending, and projected cuts in Medicaid enrollment.

The magnitude of the spending cut -- \$182 billion over seven years -- is too big to be absorbed through efficiencies alone. Simply limiting overall Federal matching payments will not make health-related costs disappear. Neither wholesale use of managed care nor any other programmatic change will provide sufficient savings to maintain current coverage levels.

In addition, enrollment growth would absorb most of the lower growth rates permitted under the conference agreement. As Chart 5 demonstrates, The Congressional Budget Office's (CBO) projections of Medicaid enrollment growth alone edge very close to the

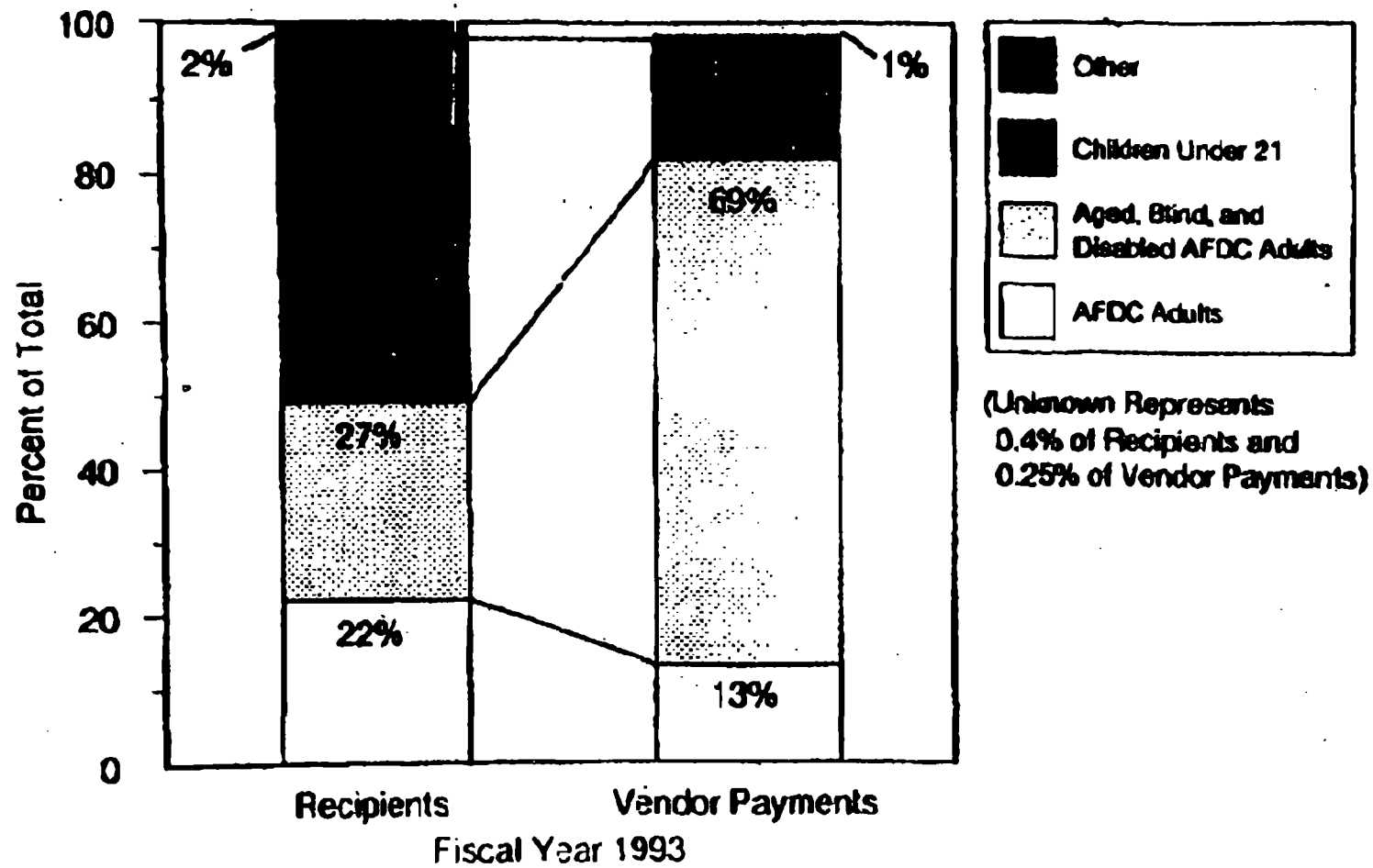
proposed spending limits in the budget resolution. As you know, medical inflation impacts public health care spending as well as private spending. Inflation, added to CBO's anticipated enrollment growth, will drive projected program costs well beyond the spending limits envisioned under the budget resolution. Given the many fiscal, legal and political pressures at work on States, it will be virtually impossible for States to maintain coverage of essential medical services for current Medicaid beneficiaries under the budget resolution.

The President's plan and the budget resolution are fundamentally different. We rely on per capita limits to allow for changes in enrollment, while the budget resolution caps spending to the point that any unexpected change in enrollment would shift considerable cost to the States or force a reduction in coverage. We fear that States may be forced to reduce coverage, thereby adding to the number of uninsured at an alarming rate. The States and Congress can realize meaningful savings and additional flexibility without completely dismantling the Medicaid program.

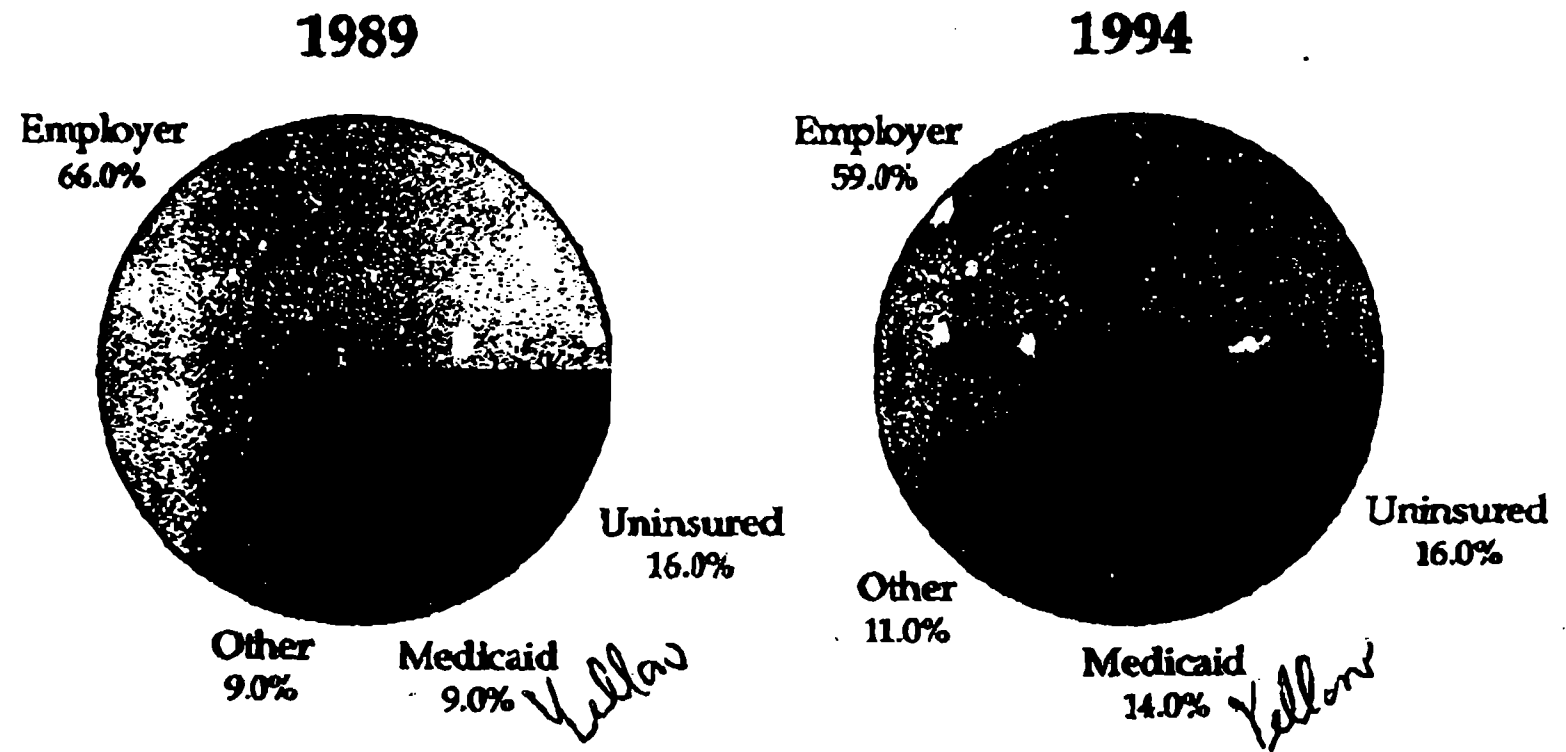
Conclusion

The Medicaid program affords States a considerable amount of flexibility in the design of their individual programs. The Clinton Administration has worked with States to further increase flexibility and permit States' use of innovative means of service delivery and cost containment.

Percent Distribution of Medicaid and Vendor Payments by Basis of Eligibility



Medicaid is a Critical Safety Net



SOURCE: HCFA, Office of the Actuary and Urban Institute, 1995.

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Total Expenditures for Mandatory and Optional Medicaid Services and Populations: FY 1993

(Dollars in Millions)

	Mandatory Services	Optional Services	Total
Mandatory People	47,885	23,681	71,566
Optional People	12,052	26,358	38,409
TOTAL	59,936	50,039	109,975

As A Percent of Total

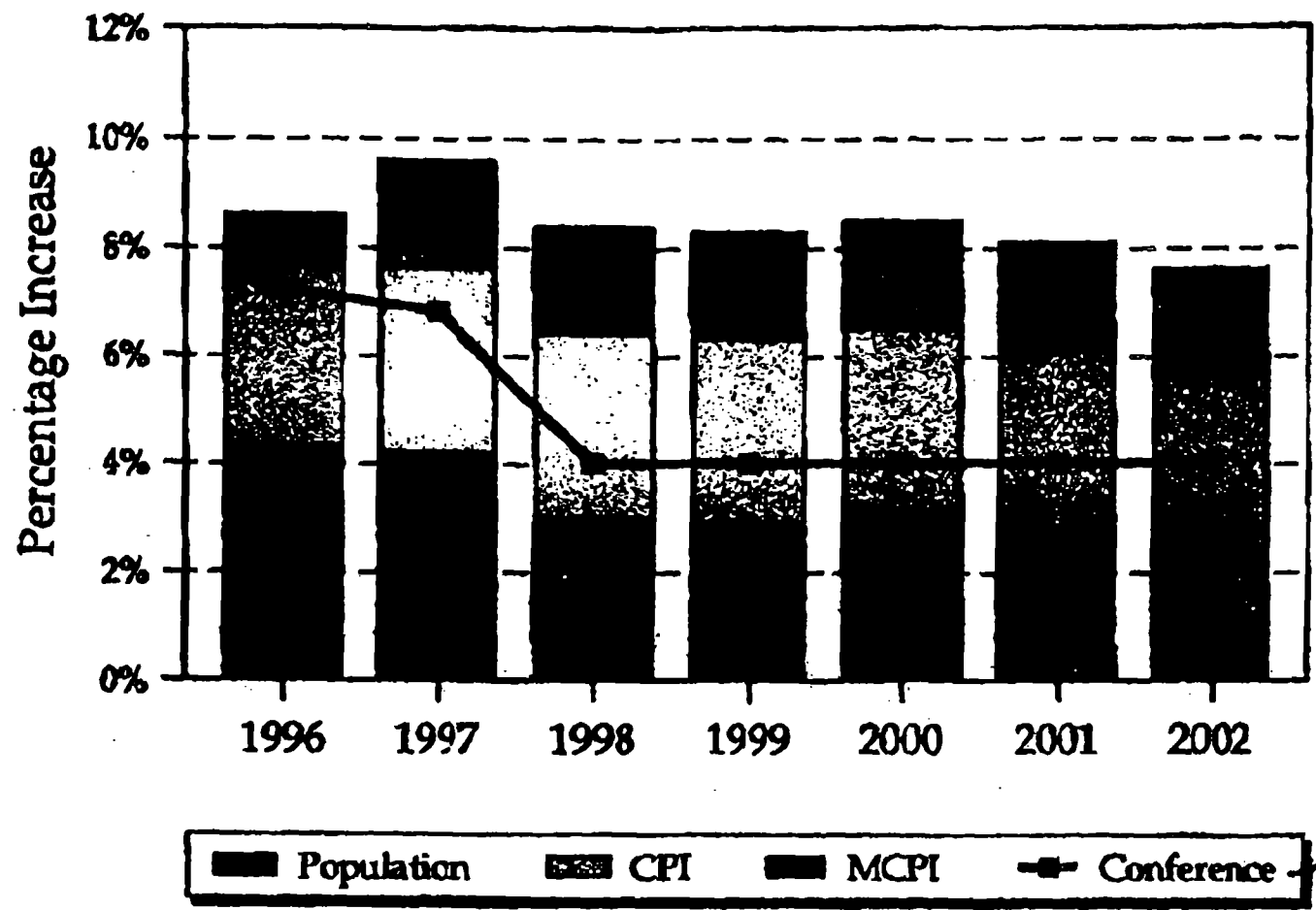
	Mandatory Services	Optional Services	Total
Mandatory People	43.5%	21.5%	65.1%
Optional People	11.0%	24.0%	34.9%
TOTAL	54.5%	45.5%	100.0%

Excludes DSH, collections and adjustments

Chart 5

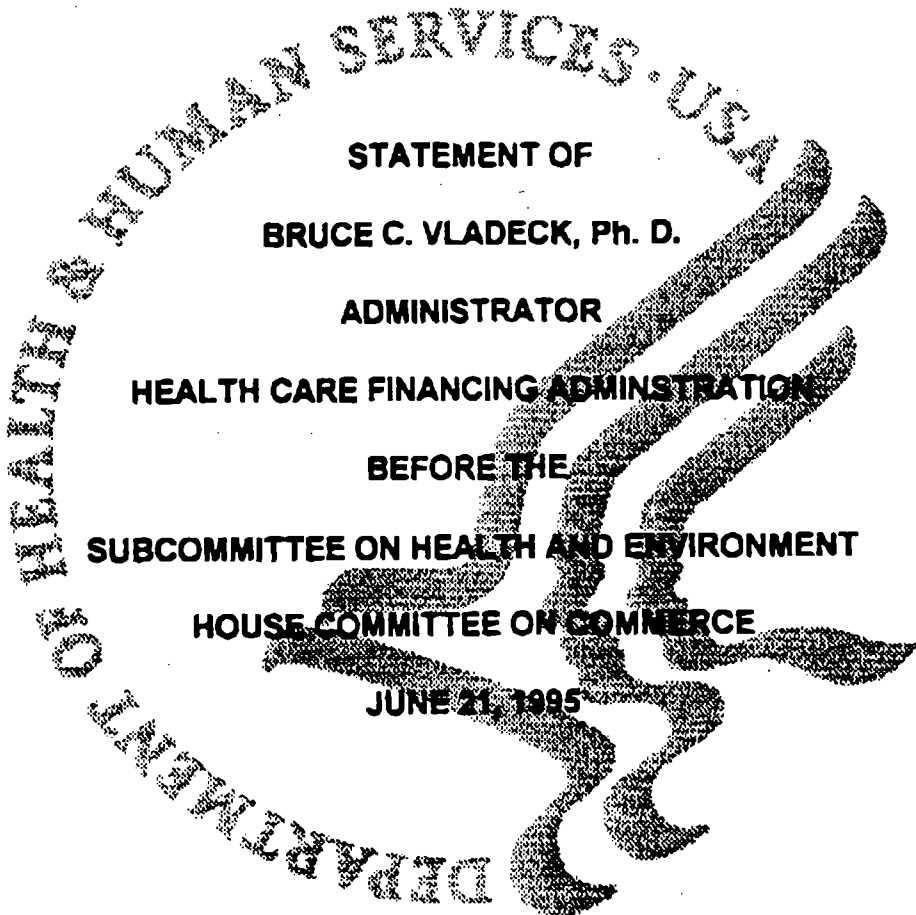
Medicaid Population and Inflation Growth

CBO Projected Annual Increases 1996-2002 for All Beneficiaries



Agreement

1995-07-06



STATEMENT OF

BRUCE C. VLADECK, Ph. D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

HOUSE COMMITTEE ON COMMERCE

JUNE 21, 1995

Mr. Chairman and Members of the Committee:

I welcome the opportunity to be here this morning to discuss the history, accomplishments and future direction of the Medicaid program. This Administration has been working to strengthen Medicaid's inherent partnership between the Federal government and the States. We know we need to continue building on this partnership to make necessary improvements to the Medicaid program.

Introduction

Medicaid provides health coverage for 36.1 million Americans -- children, senior citizens, individuals with disabilities and others -- through a partnership between the Federal government and the States which provides States with substantial flexibility over eligibility, benefits and delivery systems.

Recently, States have also been seeking additional flexibility in the Medicaid program. We have responded by using our demonstration authority to enable States to pursue a number of innovative approaches to covering additional populations and redesigning Medicaid delivery systems. Just last week, the President also proposed important new reforms that will control Medicaid cost increases and provide States with additional programmatic flexibility.

Except for the period between 1989 and 1992, the Medicaid program has grown less rapidly than the private sector on a per capita basis (Chart 1). The unsustainable growth rates during this time were caused by several factors, including a national recession, States' use of statutory loopholes to leverage Federal dollars, and increased provider payments. In response, the Executive Branch worked with Congress and the States to bring program costs under control while maintaining the Medicaid program as an important source -- often the only source -- of coverage for low-income Americans. Our new cost containment proposals continue this commitment.

Medicaid is a Critical Safety Net

Medicaid is the primary source of coverage for a wide variety of Americans with diverse health care needs. It covers preventive care for low and moderate-income pregnant women and children and long term care for low-income senior citizens. It also provides a variety of rehabilitative and adaptive services for persons with disabilities, chronic care for individuals with special needs, and supplemental coverage for low-income Medicare beneficiaries.

Generally, Medicaid acute-care coverage mirrors the employer-based coverage available to most Americans, but Medicaid also provides long term care benefits for senior citizens and individuals with disabilities that are rarely available or

affordable through other sources. Because Medicaid covers these services, the program ultimately helps a large number of working American families care for their chronically ill family members. For example, 61 percent of all nursing home residents rely on Medicaid to help pay for their care. Many beneficiaries have complex health needs or need long term care and therefore are very expensive to care for. In 1993, spending on all services for elderly and disabled individuals constituted approximately 70 percent of all Medicaid spending, excluding payments to disproportionate share hospitals (DSH). Approximately half of these dollars were spent on long term care in nursing homes. Without Federal Medicaid funding, many of these individuals -- the elderly, chronically ill, disabled and mentally ill -- would be the sole responsibility of States, local communities and their families. The remaining thirty percent of Medicaid spending is dedicated to care for low-income adults and children who use primarily hospital and physician services (Chart 2).

Americans who qualify for Medicaid are assured of financing for their essential health services. While eligibility varies from State to State, certain national standards apply to all States -- notably coverage for low-income pregnant women and children, and the low-income elderly and disabled. States provide the full range of services to beneficiaries, from childhood immunizations to nursing home care. Within these parameters, Medicaid has had substantial success serving diverse low-income populations. For

example, Medicaid coverage improves continuity of prenatal care for low-income pregnant women and increases disabled children's access to physicians.

Over the past few years, employer-based coverage has declined while Medicaid coverage has expanded. For example, while employer coverage fell from 66 to 59 percent of individuals under age 65 between 1989 and 1994, Medicaid coverage grew from 9 to 14 percent for the same population (Chart 3). Medicaid provides a safety net for some individuals and families who would otherwise be uninsured and picks up costs that do not disappear from the health system just because an individual loses private health insurance.

Medicaid's Management Successes

HCFA and the States have worked together to develop an efficient program. Our low Federal and State administrative costs -- 3.7 percent of total program spending in 1993 -- are an example of our success in minimizing administrative burden. As a result, we can target program dollars towards beneficiaries and their health needs. In addition, the Medicaid program has pioneered a number of innovations that enhance program efficiency, expand access to services, improve quality of care, and create new delivery mechanisms that better serve beneficiaries.

Using the flexibility inherent in the Medicaid program, States have developed programs that target their unique needs and have pursued a wide range of administrative and programmatic innovations. HCFA has encouraged and supported State program improvements, including:

- Replacing institutionalized, nursing home care with home and community-based services for disabled and elderly beneficiaries, thus reducing nursing home costs while improving quality of life for these patients;
- Introducing magnetic-stripe cards to provide immediate access to eligibility information, third party liability and electronic claims filing;
- Experimenting with new, gatekeeper-oriented forms of managed care to maximize enrollee choice while also controlling costs; and
- Implementing automated drug utilization review to control fraud and improve the quality of pharmacy services.

The Federal government continues working to provide substantial assistance to the States and forge new paths for the Medicaid program. Some notable examples include:

- Developing innovative Federal quality assurance guidelines for Medicaid managed care organizations;
- Spearheading the effort to define outcomes measures for Medicaid enrollees to provide greater assurance that

managed care enrollees receive high quality health services;

- Developing "best practices guidelines" for the States on significant program innovations, such as: primary care case management programs; Early, Periodic Screening, Diagnosis and Treatment (EPSDT) implementation; and quality-assurance in community-based programs;
- Implementing a national drug rebate program -- thus holding per person drug expenditures to 1988 levels -- and providing States with day-to-day technical assistance to simplify rebate requests;
- Strengthening our waiver approval process and developing streamlined waiver applications -- these improvements have eased State efforts to expand managed care enrollment, which now includes over 23 percent of all Medicaid beneficiaries; and
- Developing quality standards to protect seniors and others in nursing homes.

Many of these Federal efforts focus on ensuring Medicaid's fiscal integrity, protecting beneficiaries and ensuring that public dollars are well spent on high quality services, all within the broader context of providing substantial support to State programs.

Since 1993, this Administration has taken remarkable steps to build upon HCFA's history of partnership with the States. We are working with a number of States to test new, broad-based approaches to health financing and delivery through Statewide health reform demonstrations under Section 1115 of the Social Security Act. This authority gives the Secretary broad latitude to permit demonstrations that further the goals of the Medicaid program. Through these programs, States may test the effectiveness and efficiency of their own ideas. Historically, States had sought demonstration authority to test relatively narrow changes, such as changes to the Medicaid benefit package, payment methodologies or eligibility requirements for a defined group of beneficiaries or services. Since 1993, States have begun to develop broad, Statewide reform programs under this demonstration authority.

To date, this Administration has approved ten Statewide health reform demonstrations, and we are considering several additional proposals. These States will experiment with innovative financing and delivery systems on a broad scale. For example, Florida intends to develop a revolutionary health alliance system that will broker private health coverage for low-income and uninsured Floridians through a community purchasing network, while Hawaii has achieved insurance coverage for more than 95 percent of its population through a combination of Medicaid expansions and an employer mandate.

We continue our efforts to control growth in program spending. The substantial program growth of the late 1980s and early 1990s was largely driven by States' use of provider taxes, voluntary donations and disproportionate share hospital (DSH) payments to leverage Federal matching dollars. Fortunately, because of our work and Congress's efforts -- through this Committee and others -- the worst abuses have been tempered.

Today, we project that year-to-year expenditure growth in the Medicaid program will average 9.3 percent through 2000. Because enrollment growth has driven much of the spending increases in Medicaid, our per capita growth rates are much lower. We estimate that Medicaid's annual per capita growth will average 5.4 percent through 2000.

Improving the Medicaid Program

As you know, the President recently suggested a number of ideas for enhancing the Federal-State partnership and controlling Medicaid costs. I believe these strategies represent the right approach to improving the Medicaid program.

We believe the best strategy for improving the Federal-State Medicaid partnership is to pursue changes that protect beneficiaries yet give States additional program flexibility and cost-control mechanisms. We believe that this can best be achieved within the current Federal-State partnership. The

Medicaid program can and does provide flexibility for States, but the program's structure also ensures an important degree of continuity across States. This continuity is particularly important in program eligibility -- low-income senior citizens, individuals with disabilities and children are Medicaid-eligible in every State. Under the current Federal-State relationship, States also draw on Federal expertise, buying-power and technical assistance to achieve program goals.

The President's proposal seeks \$54 billion in Medicaid program savings over seven years. We want to work with this Committee and the Governors to determine how we can best achieve these savings. We are interested in significant changes. For example, we want to give States more flexibility to pursue certain widely used managed care models by replacing current waiver requirements with new statutory authority that would make these types of Medicaid managed care models a program option.

We are also interested in building upon our work with the National Governors' Association (NGA). For example, we worked with the NGA to encourage States to expand their home and community-based services programs. We believe that State flexibility in these programs could be enhanced further. Finally, we are evaluating new strategies for guaranteeing access to high-quality services that are more refined than the current Boren Amendment and other provider payment requirements.

Beyond increasing State flexibility, we know that Medicaid cost-containment must be continued. However, we do not want to do this in a way that risks Medicaid enrollees losing coverage. Instead, the President has proposed per capita limits on Federal Medicaid spending, which will provide an additional incentive for States to control program spending but will not force them to restrict Medicaid eligibility. Under per capita spending limits, Medicaid enrollment can continue to expand and contract with economic conditions and individual needs. With enhanced flexibility, States will be able to manage within these limits, while Medicaid beneficiaries -- including senior citizens, disabled people and children -- will retain their health care coverage.

Comparison to Other Proposals

We believe the House budget proposal would damage this critical safety-net program and harm the States, beneficiaries and providers. These impacts would be driven by the dimensions of the spending cut, its likely influence on State spending, and projected cuts in Medicaid enrollment.

The magnitude of the House spending cut -- \$187 billion over seven years -- is too big to absorb through efficiencies alone. Simply limiting overall Federal matching payments will not make health-related costs disappear. Neither whole-scale use of

managed care nor any other programmatic change will provide sufficient savings to maintain current coverage levels.

In addition, enrollment growth would absorb most of the lower growth rates permitted under the House proposal. As the attached chart (Chart 4) demonstrates, Medicaid enrollment growth projections edge very close to the proposed spending limits on block grants. As you know, medical inflation influences public health care spending as well as private spending. Inflation, added to anticipated enrollment growth, will drive projected program costs well beyond the spending limits envisioned under the House proposal. Given the many fiscal, legal and political pressures at work on States, it will be virtually impossible for States to maintain coverage of essential medical services for current Medicaid beneficiaries under the block grant proposal.

To maintain current coverage levels, the House budget proposal would force States to either absorb a large cost-shift from the Federal government, causing the proportion of State to Federal dollars invested in a State's Medicaid program to increase as States are forced to adjust to lost Federal matching payments. The Urban Institute concludes that if States chose to fill the gap, States would, on average, have to increase their spending by 39 percent to make up for the loss of Federal funds. However, in the current fiscal climate, few States may be able to devote new State dollars to their Medicaid program.

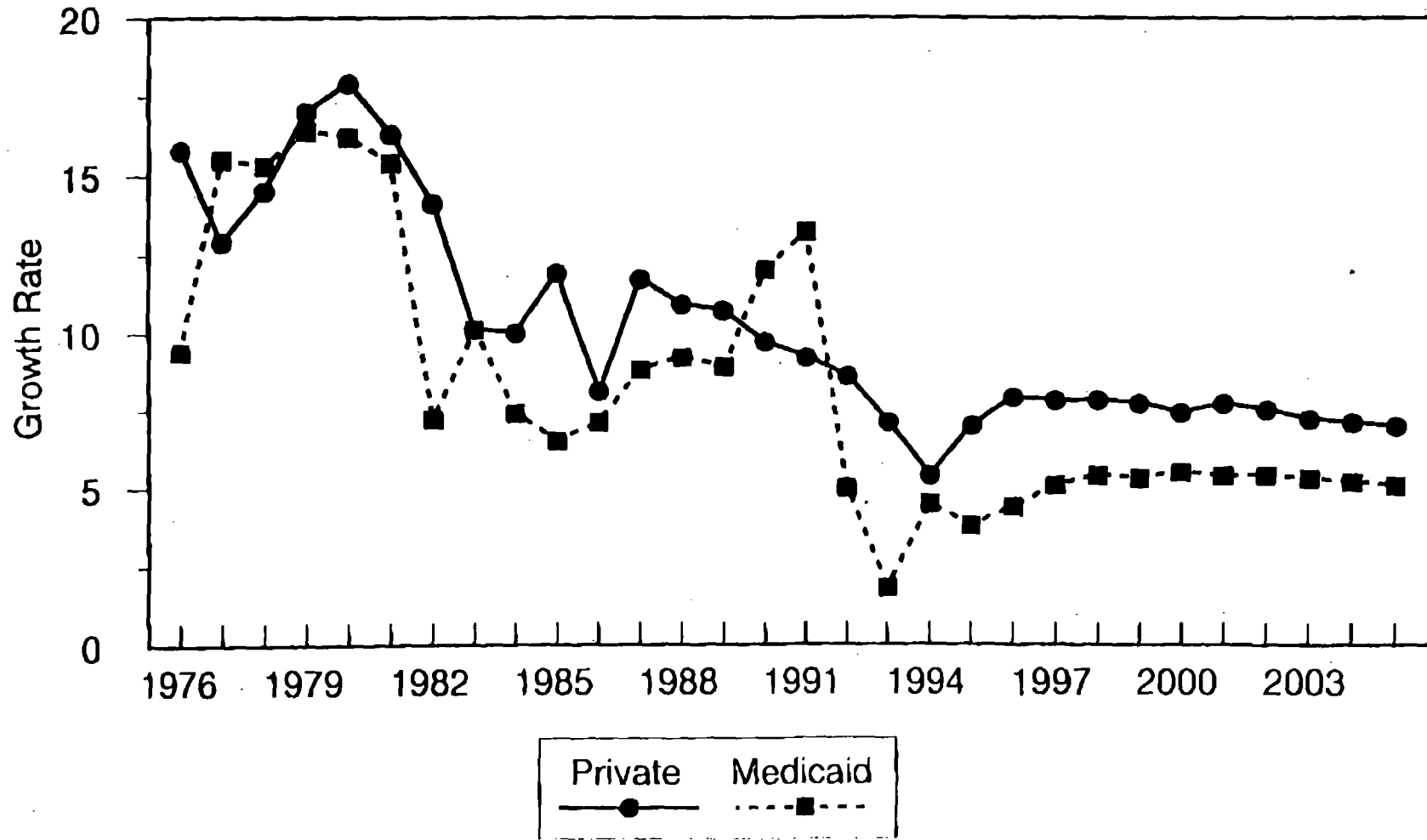
There are fundamental differences between the President's plan and the House budget resolution. We rely on per capita limits to allow for changes in enrollment, while the House proposal is based on an aggregate cap and therefore does not provide room for enrollment growth. In addition, we believe that the States and Congress can realize meaningful savings and additional flexibility without resorting to a block grant.

Conclusion

The Medicaid program has a substantial history of success -- together, the Federal government and the States have provided an essential safety net for children, seniors, nursing home residents, the disabled, and other vulnerable Americans.

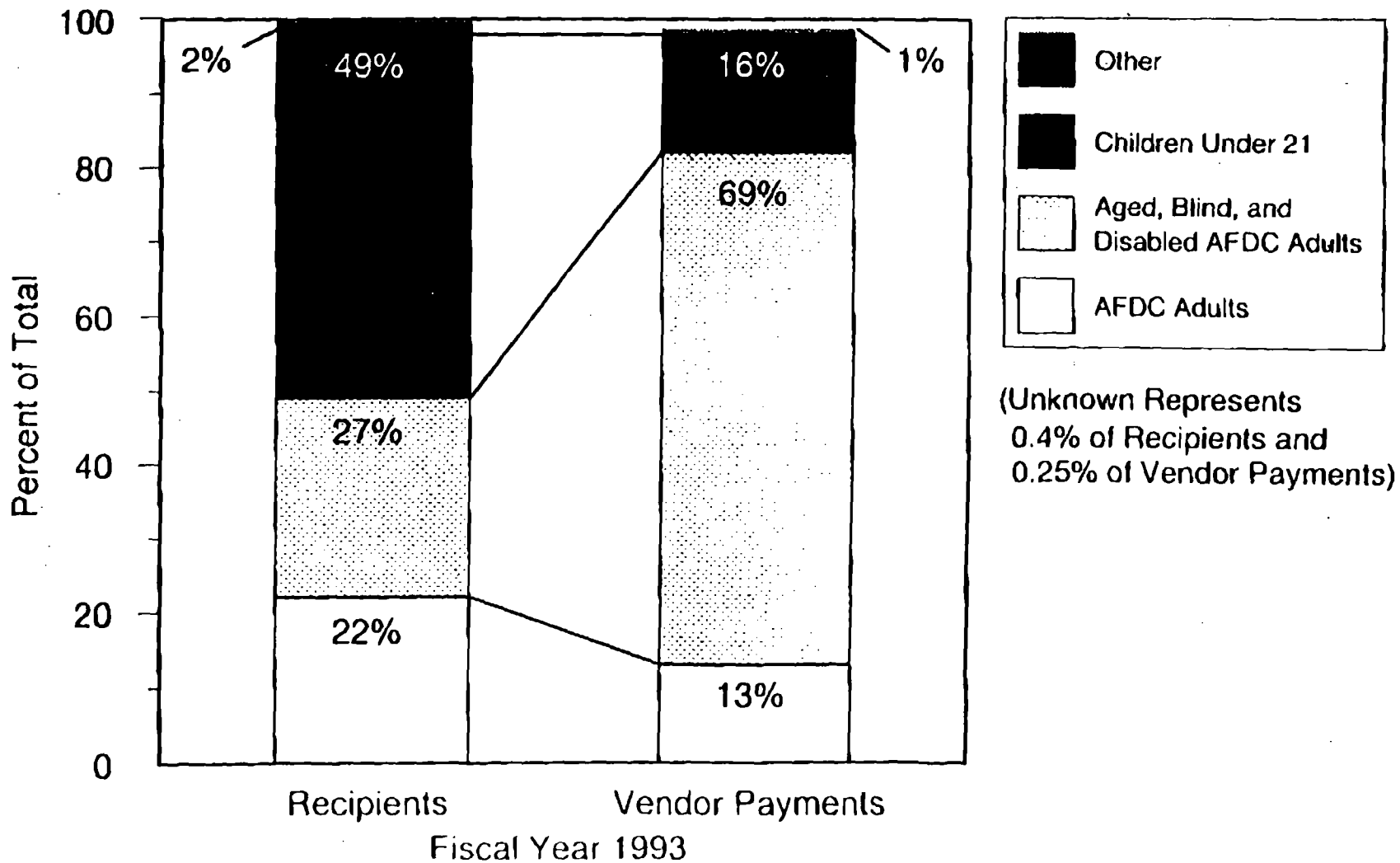
We are committed to maintaining and building upon Medicaid's successes in order to better serve our beneficiaries. We believe this can best be achieved by making the changes that we know will [REDACTED] Federal government and the States control costs and [REDACTED] for the Americans we serve today.

Annual Percent Increase in Medicaid Expenditures per Enrollee vs. Private Health Insurance 1976-2005



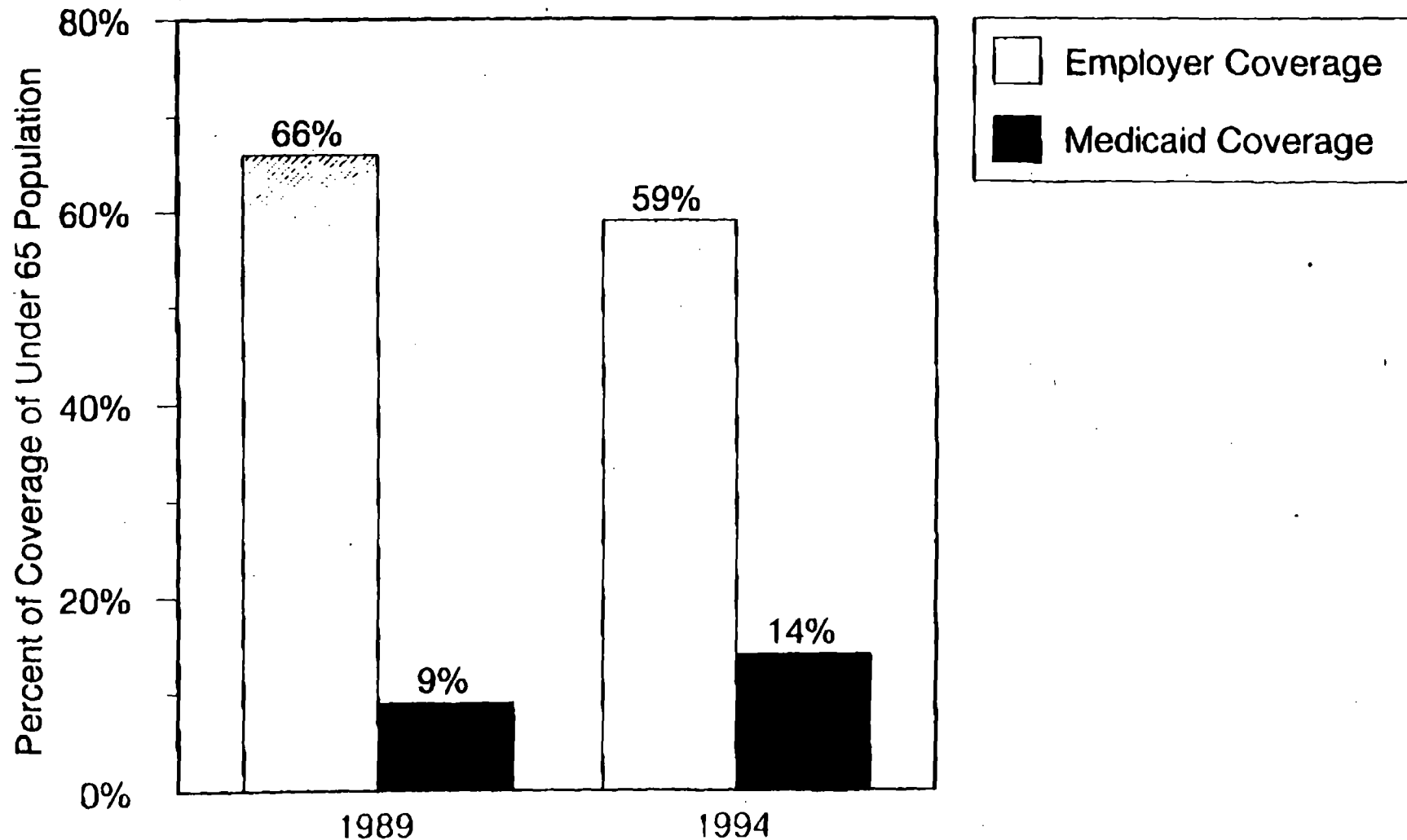
*Private health expenditures per insured person & Medicaid Expenditures per recipient
 Source: HCFA/OACT

Percent Distribution of Medicaid and Vendor Payments by Basis of Eligibility



Medicaid is a Critical Safety Net

Employer Coverage Reduced, Medicaid Coverage Increased



Source: HCFA, Office of the Actuary, and Certain Legislative Committees

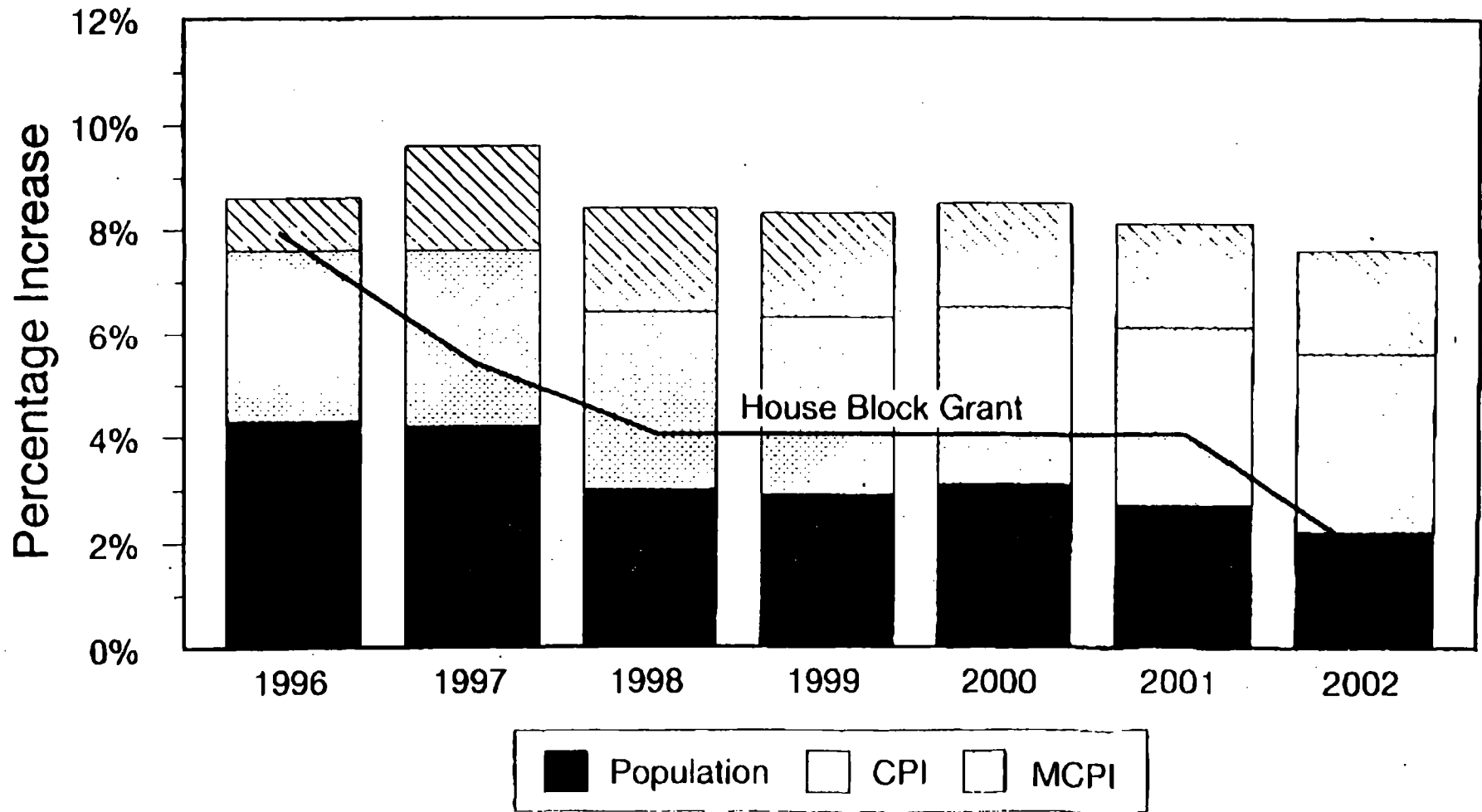
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06/21/95 11:14 202 401 7321 HHS ASPE/HP 017/018

Medicaid Population and Inflation Growth

CBO Projected Annual Increases 1996-2002

All Beneficiaries



facsimile

TRANSMITTAL

to: Jennifer Klein
fax #: 456 - 2070
re:
date:
pages: 9 pages, including cover sheet.

From the desk of...

Julie Darnell
Research Associate
Center for Health Policy Research
The George Washington University
2021 K Street, N.W., Suite 800
Washington, D.C. 20006

202/296.6922
Fax: 202/296.0025

ONE HUNDRED FOURTH CON

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U. S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515-6115

JAMES E. DERDERIAN, CHIEF OF STAFF

SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

DATE: Thursday, June 8, 1995
TIME: 9:30 a.m. in Room 2322 Rayburn House Office Building
SUBJECT: Transformation of the Medicaid Program

Testimony will be given by:

The Honorable Jim Edgar
Governor
State of Illinois

The Honorable Mike Leavitt
Governor
State of Utah

The Honorable Don Sundquist
Governor
State of Tennessee

The Honorable Lawton Chiles
Governor
State of Florida

The Honorable John Engler
Governor
State of Michigan

**Testimony Presented To
Health and Environment Subcommittee
Of the House Commerce Committee
Washington, D.C.**

**The Honorable Jim Edgar
Governor of Illinois
June 8, 1995**

Mr. Chairman and members of this important subcommittee, I greatly appreciate this opportunity to testify before you. You are focusing on an issue of tremendous importance to you in the Congress, to every Governor in this nation and to the people we all serve.

We must boldly reform the way in which health care is provided to low-income families and individuals. The Medicaid system is outdated and out of control. Its skyrocketing price tag has played havoc with state budgets across this nation for years and years. And it will play havoc with bringing the federal budget into balance unless we overhaul it. Not tinker with it. Not adjust it. Incremental reform has been tried, and it's simply not enough. The reform must be sweeping, and it must come quickly -- or we will totally lose our capability to provide health services to the truly needy, particularly poor children, at a manageable cost.

Medicaid now ranks as the third largest entitlement program of the federal government. Only Social Security and Medicare top it. Without sweeping reform, the federal government estimates that Medicaid's annual cost will soar to \$260 billion by the year 2000. In other words, it will double over the next five to seven years. And the growth in this program already has been mind-boggling, not to mention budget-busting.

Consider this. Medicaid accounted for 10 percent of total spending by state governments in 1987. Today it consumes twice that. The federal government has micro-managed the program by heaping mandate after mandate upon the states. It has told us whom we must serve and dictated how we must provide the service without regard to cost. In 1966, the first year of Medicaid, Illinois spent \$87 million on the program. This year, we will spend 64 times that much or nearly \$6 billion.

In Illinois, the tab for recent federal mandates alone tops \$480 million this year. Because of those mandates and rising health care costs, we increased spending for Medicaid between 1991 and 1995 more than we were able to boost funding for education, child welfare, prisons, mental health and law enforcement combined. That's right, more for Medicaid than for all of those other vital, worthwhile programs and services combined.

There's something very wrong with this picture. It's not the picture we wanted. It's the one that was forced upon us as we sought to balance our state budget while living within our means. I would have preferred to spend more on education, more on mental health, more on law enforcement. But we had much more control and far less federal government interference in setting budgets for education and other services outside of the Medicaid realm.

The Governor of any large, industrial state could give you comparable testimony. This is not a partisan matter. Republican and Democratic governors alike have been grappling with this failed system. I can't imagine how anyone can defend it. We need to bring some fiscal sanity to the Medicaid program. And the only way we can do it is through a total revamp -- a revamp that will allow us to deliver care to the neediest of our citizens without bankrupting the states and the federal government.

We need to cure Medicaid of its various financial and bureaucratic ailments. And this dramatically different Congress can produce the right medicine. I make this appeal as the Governor of Illinois and as Chairman of the Medicaid Task Force of the Republican Governors' Association: Take the bold steps that are needed. Get the federal government out of the business of micro-managing Medicaid. Let the states make Medicaid more cost-effective. Let us innovate without coming hat-in-hand to Washington seeking waivers from the Medicaid mandates. It simply has taken too long to get relief from entrenched, unelected and unaccountable bureaucrats who fight change. And when reform has come, it has been piecemeal at best.

Unfortunately, I have experienced first-hand the frustration of trying to reform Medicaid through the waiver process. Last July I signed into law legislation to create a managed care program in Illinois. It was a product of a consensus that few believed could be reached. Health care providers, advocates for Medicaid clients, Republicans and Democrats in the Legislature -- all supported the new law.

Of course, we needed a federal waiver to implement it. We made the request in September. Since then, the Health Care Financing Administration has delayed and delayed and delayed. The bureaucrats ask questions. We rush to respond. And then we wait and wait. The bureaucrats then ask more questions. More quick responses. And still more waiting and waiting. But no action.

This stack of papers in front of me is made up of copies of every single piece of paper required by HCFA concerning our waiver request. Nine months of waiting. A pile of paperwork. And still no waiver.

Millions of dollars that could have been saved to federal and state taxpayers have not been saved. President Clinton felt the frustration as a Governor. And he has told the governors time and time again that he wants the waivers to come quickly. We were listening. But the bureaucrats weren't. They would rather fiddle and quibble.

Clearly, Medicaid as it exists today is a broken system. And the cumbersome waiver process is only part of the problem. The federal government has dictated benefits that are far more generous than those normally provided to working men and women through private insurance programs. In fact, we recently made a decision to forego federal matching funds for some alcoholism and substance abuse treatment programs because it would be more cost-effective for us to manage the program under our rules.

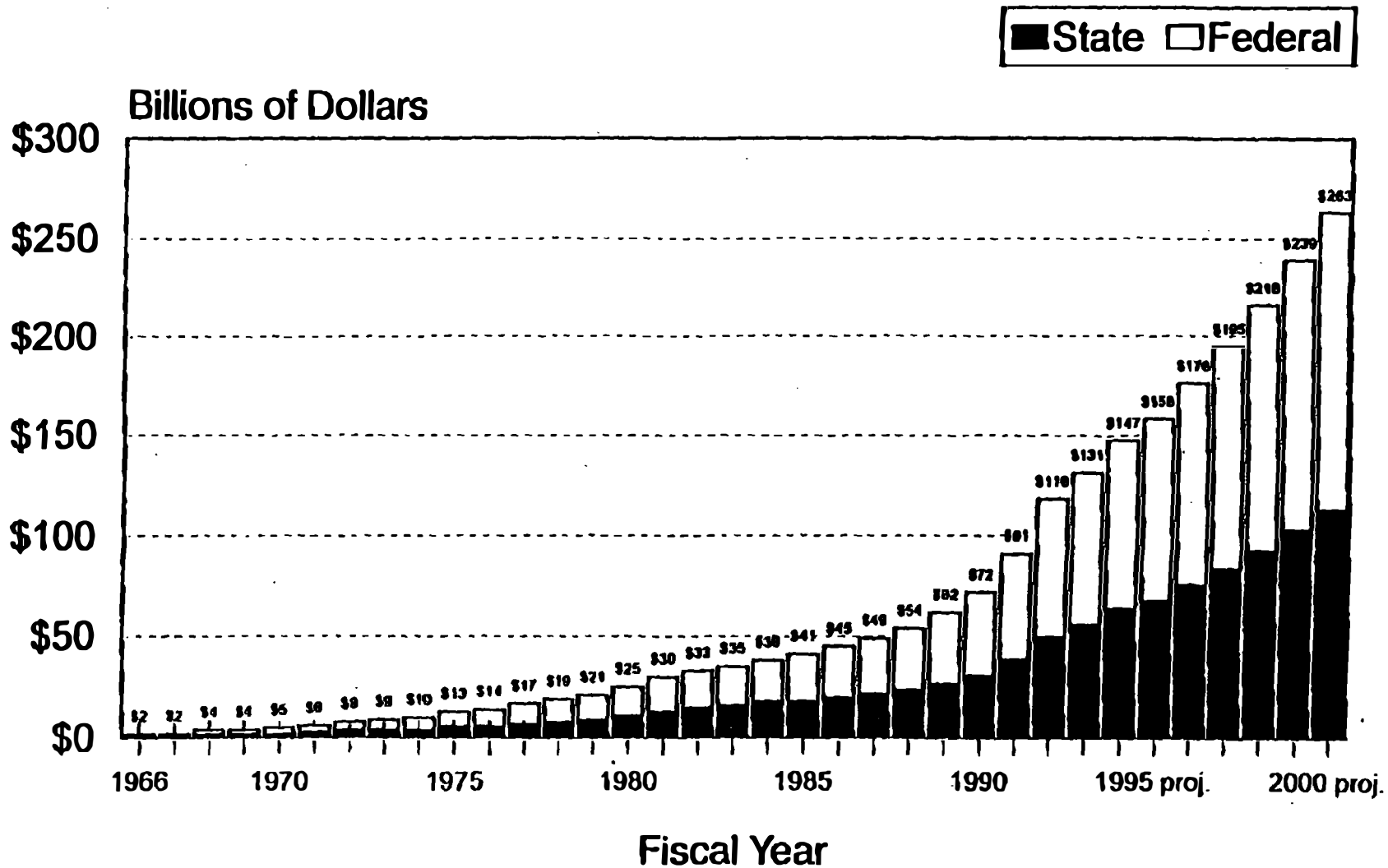
Moreover, under the current Medicaid system, states cannot limit access to health care providers as a means to negotiate the best rates possible. In stark contrast, virtually every private insurer limits the choice of providers under Preferred Provider arrangements or Managed Care plans. The states should be able to operate like any large insurer and negotiate the best rates with only the number of providers necessary to deliver the service. And we should be able to negotiate those rates free of the threat of lawsuits posed by the Boren amendment.

The amendment was well-intentioned. It was to provide a ceiling for provider rates. But the federal courts have interpreted it as a floor and put states on the defensive, costing them hundreds of millions of dollars. It is difficult to drive a hard bargain when the providers believe they can steer the dispute to the federal courts.

We need to repeal the Boren amendment. We need to do that and much more to reform Medicaid. Clearly, the taxpayers of this nation cannot afford to pay the skyrocketing cost of a broken system. And, therefore, it ultimately will fail the needy who rely on it for benefits. Massive reform has been long overdue. It needs to happen now. And we, as governors, look forward to working with you to make it happen.

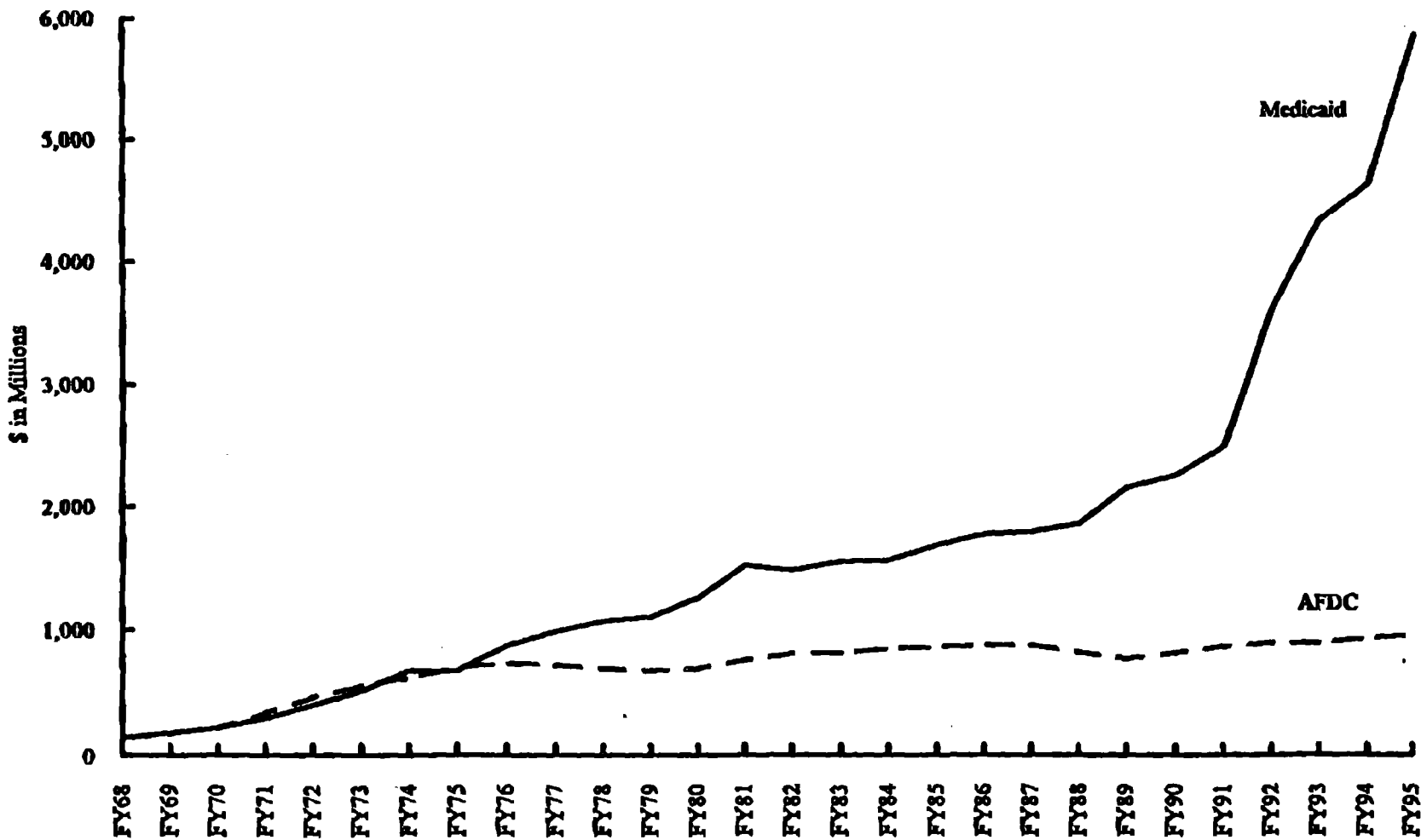
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Growth in National Medicaid Spending



Source: 1966-1994: Congressional Research Service, 1995-2000 CBO projections

Illinois Medicaid and AFDC Expenditures



TESTIMONY
of
Governor Lawton Chiles, Florida
before the
House Commerce Subcommittee
on
Health and the Environment

RESTRUCTURING MEDICAID

June 8, 1995

**Remarks of
FLORIDA GOVERNOR LAWTON CHILES
House Commerce Subcommittee on Health and the Environment
June 8, 1995**

Good Morning.

I want to thank the Subcommittee for inviting me to testify today.

I especially want to thank the Chairman, Mike Bilirakis. Florida is fortunate to have Mike as well as Cliff Stearns and Peter Deutsch on this Subcommittee looking out for our elderly, disabled and kids.

I spent 18 years here as a member of the United States Senate and I have been involved in my share of budget-balancing fights. I know what it is like to try to slay the deficit dragon. And, I especially appreciate the tough job that lies ahead for this Committee as outlined by the budget resolution.

As you well know, that budget resolution directs you to save \$185 billion in the Medicaid program over 7 years. It also says that there will be \$350 billion worth of tax cuts. We should all be mindful of the real choices we are making as we balance the budget.

On the surface, the concept of block grants sounds fine -- more flexibility and more power shifted to the states. In fact, I've been talking about flexibility for the Medicaid program since the beginning of my administration. I submitted a flexibility proposal to the federal government in August, 1992, outlining my recommendations for making the Medicaid program more state friendly.

I also submitted and received approval last year for the largest Medicaid waiver demonstration project in the country. That waiver, when approved by the state legislature, frees us from cumbersome categorical restrictions and eligibility requirements. It will allow us to serve more people with less money. And in so doing, give the state and federal governments real savings. More importantly, it will reduce the number of uninsured in my state, keeping health care costs low for businesses, particularly small businesses with less than 50 employees.

So I watched with great interest as I learned that the Congress was looking to provide governors with more flexibility to implement their own solutions to health care problems in their states.

I know that this is only the beginning of the process in designing the new program, but I must say I am very disturbed by what some of my friends, a few governors from other states, have been suggesting.

I understand that some of my fellow governors here today think that this new program should lock-in the inefficiencies of the past program into a baseline and apply a one-size-fits-all growth rate for each state. It doesn't make a bit of sense that a state like Michigan or Wisconsin, with lower population growth than states like Florida, Texas and California, should receive the same growth rate under the cap. That kind of proposal would pose a real danger to kids, the disabled and the elderly in Florida and other growth states.

This is serious business. Medicaid is the vital life support system for our most vulnerable citizens. While most think it's mainly for poor welfare families, the fact is that two-thirds of Medicaid funds are spent on the elderly and disabled.

That is why Medicaid costs soar in states like Florida -- the fastest growing group of Medicaid recipients in Florida are people over 85. And you all know that long-term care is the costliest of medical care. Middle-class families in America have become familiar with Medicaid when they seek care for parents who need home health or nursing home care.

And in the growth states, population increases across-the-board in the program – among children, the elderly and the disabled – mean continued pressure on state budgets.

Even under the most conservative scenarios, Florida's Medicaid program is estimated to grow between 10 - 12% per year over the next seven years. These increases reflect a growing and aging population. Some of these characteristics are currently unique to Florida but many states will be facing them in the future:

- Florida has the largest percentage of elderly people in the nation;**
- The percentage of our uninsured is increasing. More than 20% of our non-elderly citizens have no health insurance;**
- We have the second highest poverty rate (nearly 18%) among the large states; AND**
- Florida is a destination not only for thousands of migrants from other countries, but also from other states, particularly during periods of recessions.**

Many of these new arrivals require health, economic and other financial assistance from the state. When you factor in the certainty of recessions, the pressure on state budgets builds.

Medicaid caseloads, that is the number of people on the program, typically peak about a year after a recession hits in Florida. In the year following our last recession, in the early 1990s we saw caseload increases of more than 25%.

No amount of state flexibility can fully remedy that situation.

Clearly, a proposal that ignores growth factors in the individual states would be disastrous.

We need to be mindful of who we are affecting with these cuts.

America's needy people – north or south, east or west – are the children living in poverty.

They are the elderly – many from middle-class homes – the disabled and poor families.

Their daily struggle would be nearly impossible without some help...the critical safety net of the federal/state partnership.

What would a proposal to cap each state's Medicaid program at the same rate mean for the needy in our states? If you look at this first chart [see attached] in the first year of a block grant the differences would be startling.

A needy person in Massachusetts would receive \$4,800 – two-and-a-half times as much as a needy person in Florida or Illinois – less than \$2,100. And, a needy person in Wisconsin would receive \$3,400 – while a California needy person would receive \$2,000. New York’s per person in poverty allocation would be more than double that of Texas’.

That level of inequity will never be acceptable to Florida or to other growth states.

Again, Florida is willing to absorb a fair share of cuts – but, I cannot let Florida families be treated with less regard than families in Massachusetts, Wisconsin or anywhere.

Dollars must follow a path to needy people -- wherever they live. When they move, the dollars should move, too.

I hope that this subcommittee would not endorse a proposal to let a state use federal Medicaid dollars for non-health purposes – especially when some states will be receiving far less than they’ll need to meet the needs of the elderly, disabled, and kids. You’ll be sending federal funds for the Medicaid program to one state that will have the ability to divert those funds over to other programs while states like Florida, Texas and California will be cutting thousands off our Medicaid program.

I think you’ve seen the results of that kind of gimmickry in the Disproportionate Share program.

Shifting new responsibility to the states without a fair, equitable shifting of resources is NOT any kind of "New Federalism." It is an unwise attempt to balance the federal budget on the backs of high growth states— and, even worse, on the backs of children, the elderly, the poor and the sick. That's just plain wrong.

And that is the issue that should trouble us all – how this proposal would disproportionately hurt the elderly, disabled and kids who live in growth states.

I think this next chart [see attached] illustrates that point. Keep in mind these are conservative estimates. If, and it is a very big IF, states could, with all the flexibility that has been promised, keep spending increases per recipient to no more than the inflation rate, we'd see dramatic reductions in the number of people served for the growth states, while some states would emerge relatively untouched.

Michigan would have to reduce the number of elderly, disabled, pregnant women and kids by less than 4% but, Georgia would have to cut over 15% or 234,000 people off the program.

New Jersey would have to reduce enrollment by a little more than 4%, while North Carolina would have to cut almost 20% off the rolls.

And, Wisconsin would see about a 5% reduction in people served, while Florida's reduction would be over 15% or more than 430,000 of our elderly, disabled, kids and pregnant women.

And as I said, these are conservative estimates. I think the Governor of Wisconsin and Governor Engler (I'll let him speak for himself) expect to get a windfall out of this.

That kind of inequity should not be allowed.

We need to look carefully at how this plan impacts the people in states like Florida and other growth states. I know this Committee does not want to endorse a proposal that:

- Says the elderly in Florida are not valued as much as the elderly in Michigan; or that**
- Says children in Texas are not worth as much as children in Wisconsin; or that**
- Tells the poor and the sick in Virginia they won't receive the same level of care as the poor and the sick in Massachusetts; or that**
- Says federal support won't accompany the children and families, the elderly, the poor and the sick who move to Florida, or other growth states.**

I hope you will keep in mind three critical questions as you restructure the Medicaid program.

- 1. Does the program treat citizens in each of our states fairly with an equitable distribution formula, or does it favor some states over others?**
- 2. Does the program reward those states making a real commitment to reform and improved management, or does it lock in the inefficiencies of the past and turn back the clock on reform? AND**
- 3. Does the program set and maintain an appropriate, basic national standard for the care of children and others in need, or does it establish a new underclass in America?**

We need to be careful not to undo much of the gains we've made. I'm proud of the fact that Florida leads the nation in reforming Medicaid –

- We've cut the rate of growth in half and reduced the cost through managed care of Medicaid;**
- We've imposed stringent price level controls on providers;**
- We've encouraged alternatives to expensive long term care; and**
- We've continued to use conservative standards for eligibility.**

These approaches are creating significant savings today.

Florida already has more than 655,000 people or 40% of Medicaid eligibles enrolled in managed care. By next year we expect to have over one million of the state's 1.6 million eligibles enrolled. Only six other states have a higher percentage of their Medicaid recipients enrolled in managed care.

We also have stringent price level controls on all our providers. The majority of providers receive no price level increases at all. Physicians, home health providers, and therapists are all capped at their current levels of reimbursement.

Similarly, Florida's payment level to hospitals, nursing homes and other institutions is strictly controlled. For our hospital inpatient services, we allow only the Medicare-approved rate of inflation.

We've also maintained a tight rein on eligibility. Our AFDC payment standard is only 31% of the poverty level, ranking us 38th in the nation. We provide few optional services to the standard program.

We have done much to control costs, eligibility, and benefits. And we've saved the state and federal government money while doing so.

From 1991 to 1992, Florida's average spending per recipient actually declined 3% while there was a nearly 8% increase nationally. Our cost per recipient was under \$2,400 in 1993, that ranked us 44th in the nation.

But under the approach offered by some of my colleagues, we get penalized for these cost-savings efforts. Our base year for the block grant reflects the savings we've generated. States that have done NOTHING start out at a higher base. And, as they follow Florida with reforms, they'll get another windfall.

Florida stands ready to share in the cuts -- and we have already gone a long way to reduce our Medicaid costs. But, I will not stand by and let other governors, who are looking to catch a windfall, speak for my state and other growth states.

If they are so intent on having the rest of us sacrifice to balance the budget, let them participate in the sacrifice, too.

If Medicaid needs to be reduced by 20 percent to meet the goals, let every state receive the same level of cut.

Now, I think the overall level of cut is too high. And I think we'll have a disagreement over that. But, if you do need to cut \$185 billion out of this program you should at least do it equitably.

I have a proposal to distribute these cuts fairly. It requires sacrifice for all states -- including the low-growth states. It's a plan that would apply the cut fairly to all states.

For years, Congress has been told by the General Accounting Office that funds in the Medicaid program are not targeted to areas of true need.

The dollars, very simply, should go where the needy live. As the Congress looks at capping the program, it should account for the differences in population growth, poverty, uninsured rates and the percentage of elderly and disabled in each state. I am not alone in sharing that view. Governor Wilson of California, Governor Symington of Arizona and others have expressed strong concerns about a block grant formula that does not take these factors into account.

The United States was founded upon the simple but unwavering belief that "all people are created equal." That basic principle is undermined -- and on the verge of being abandoned -- through a block grant proposal that values people differently.

Let me end by putting it simply: The debate in Congress should not be about developing a Michigan block grant, a Massachusetts block grant or a Florida block grant.

We should be talking, instead, about a true federal-state partnership for health care

With a true federal-state partnership, a child, or a family in Florida, is worth as much as a child and a family anywhere else in the USA.

Any proposal leaving Washington must recognize that truth.

I want a program that enables me to address the particular needs and growth of Florida.

I want a program that allows me to continue the reforms that show great promise for care -- as well as savings.

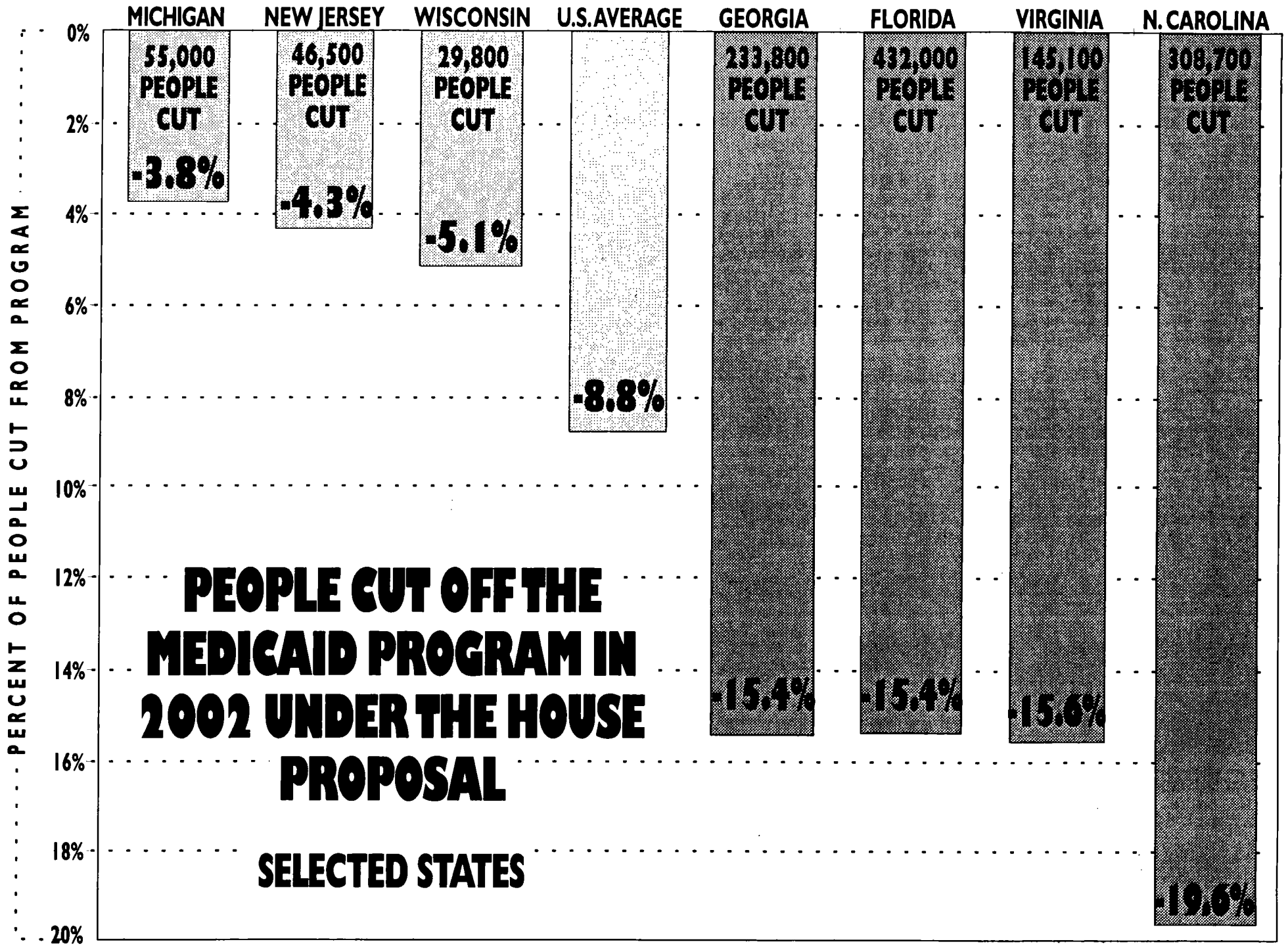
A true federal-state partnership for health care is one that has flexibility -- but it also recognizes the federal government's responsibility.

Richard Nixon championed this approach as much as Ronald Reagan. Both argued that the federal government must share the fiscal burden and ensure equal treatment of those in need.

Florida and other growth states are willing to share the load. But, we want the federal government to cooperate -- the way a partner should.

Thank you.

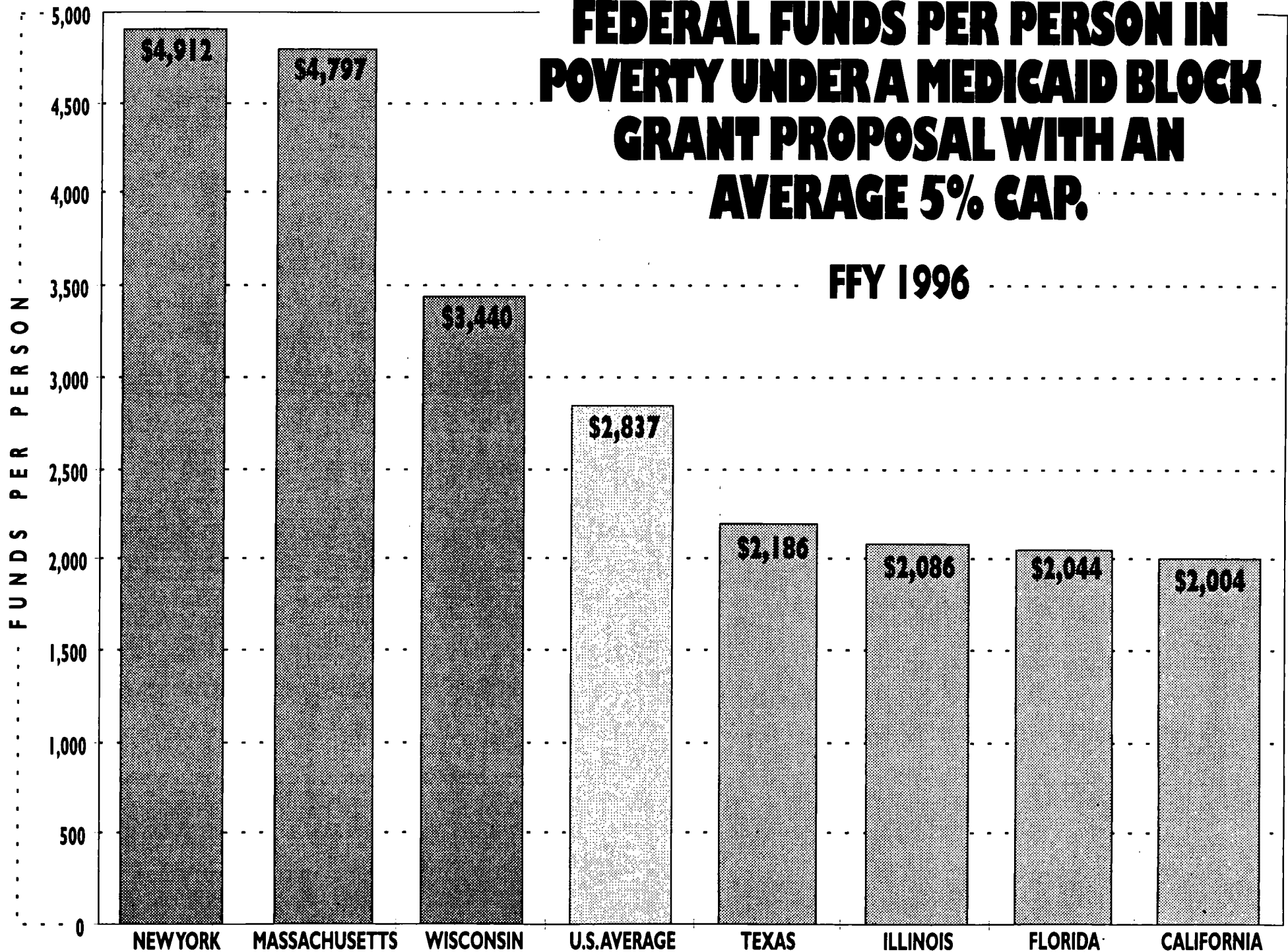
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SOURCE: Kaiser Commission on the Future of Medicaid.

FEDERAL FUNDS PER PERSON IN POVERTY UNDER A MEDICAID BLOCK GRANT PROPOSAL WITH AN AVERAGE 5% CAP.

FFY 1996



SOURCE: Urban Institute.

facsimile

TRANSMITTAL

to: Jennifer Klein
fax #: 456-2078
re:
date:
pages: 8 pages, including cover sheet.

I was able to download testimony from Govs. Chiles, Leavitt, and Engler from Legi-Slate. Missing was Don Sundquist's testimony.

I called the Commerce Committee. The next hearing scheduled on Medicaid is on June 15th at 10:30 a.m. in 2322 RHOB.

From the desk of...

Julie Darnell
Research Associate
Center for Health Policy Research
The George Washington University
2021 K Street, N.W., Suite 800
Washington, D.C. 20006

202/296.6922
Fax: 202/296.0025

LEGI-SLATE Report for the 104th Congress Fri, June 9, 1995 10:31am (EST)

- Thursday, June 8, 1995
House Health & Environment Subcmte Hearing: Governor Lawton Chiles
of Florida - Prepared Remarks
Transcript ID: 1201314 (319 lines)

PREPARED TESTIMONY OF
GOVERNOR LAWTON CHILES,
FLORIDA

BEFORE THE HOUSE COMMERCE SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

RESTRUCTURING MEDICAID

THURSDAY, JUNE 8, 1995

Remarks of
FLORIDA GOVERNOR LAWTON CHILES
House Commerce Subcommittee on Health and the Environment June 8, 1995
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I spent 18 years here as a member of the United States Senate
and I have been involved in my share of budget-balancing fights. I
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So I watched with great interest as I learned that the Congress was looking to provide governors with more flexibility to implement their own solutions to health care problems in their states.

I know that this is only the beginning of the process in designing the new program, but I must say I am very disturbed by what some of my friends, a few governors from other states, have been suggesting.

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I think this next chart [see attached] illustrates that point. Keep in mind these are conservative estimates. If, and it is a very big IF, states could, with all the flexibility that has been promised,

keep spending increases per recipient to no more than the inflation rate, we'd see dramatic reductions in the number of people served for the growth states, while some states would emerge relatively untouched.

Michigan would have to reduce the number of elderly, disabled, pregnant women and kids by less than 4% but, Georgia would have to cut over 15% or 234,000 people off the program.

New Jersey would have to reduce enrollment by a little more than 4%, while North Carolina would have to cut almost 20% off the rolls.

And, Wisconsin would see about a 5% reduction in people served, while Florida's reduction would be over 15% or more than 430,000 of our elderly, disabled, kids and pregnant women.

And as I said, these are conservative estimates. I think the Governor of Wisconsin and Governor Engler (I'll let him speak for himself) expect to get a windfall out of this. That kind of inequity should not be allowed.

We need to look carefully at how this plan impacts the people in states like Florida and other growth states. I know this Committee does not want to endorse a proposal that:

- o Says the elderly in Florida are not valued as much as the elderly in Michigan; or that
Says children in Texas are not worth as much as children in Wisconsin; or that
- o Tells the poor and the sick in Virginia they won't receive the same level of care as the poor and the sick in Massachusetts; or that
- o Says federal support won't accompany the children and families, the elderly, the poor and the sick who move to Florida, or other growth states.

I hope you will keep in mind three critical questions as you restructure the Medicaid program.

1. Does the program treat citizens in each of our states fairly with an equitable distribution formula, or does it favor some states over others?
2. Does the program reward those states making a real commitment to

reform and improved management, or does it lock in the inefficiencies of the past and turn back the clock on reform? AND

3. Does the program set and maintain an appropriate, basic national standard for the care of children and others in need, or does it establish a new underclass in America? We need to be careful not to undo much of the gains we've made. I'm proud of the fact that Florida leads the nation in reforming Medicaid -

- o We've cut the rate of growth in half and reduced the cost through managed care of Medicaid;

We've imposed stringent price level controls on providers;

- o We've encouraged alternatives to expensive long term care; and

We've continued to use conservative standards for eligibility.

These approaches are creating significant savings today.

Florida already has more than 655,000 people or 40% of Medicaid eligibles enrolled in managed care. By next year we expect to have over one million of the state's 1.6 million eligibles enrolled. Only six other states have a higher percentage of their Medicaid recipients enrolled in managed care.

We also have stringent price level controls on all our providers. The majority of providers receive no price level increases at all. Physicians, home health providers, and therapists are all capped at their current levels of reimbursement.

Similarly, Florida's payment level to hospitals, nursing homes and other institutions is strictly controlled. For our hospital inpatient services, we allow only the Medicare-approved rate of inflation.

We've also maintained a tight rein on eligibility. Our AFDC payment standard is only 31% of the poverty level, ranking us 38th in the nation. We provide few optional services to the standard program.

We have done much to control costs, eligibility, and benefits. And we've saved the state and federal government money while doing so. From 1991 to 1992, Florida's average spending per recipient actually declined 3% while there was a nearly 8% increase nationally. Our cost per recipient was under \$2,400 in 1993, that ranked us 44th in the nation.

But under the approach offered by some of my colleagues, we get penalized for these cost-savings efforts. Our base year for the block

grant reflects the savings we've generated. States that have done NOTHING start out at a higher base. And, as they follow Florida with reforms, they'll get another windfall.

Florida stands ready to share in the cuts -- and we have already gone a long way to reduce our Medicaid costs. But, I will not stand by and let other governors, who are looking to catch a windfall, speak for my state and other growth states.

If they are so intent on having the rest of us sacrifice to balance the budget, let them participate in the sacrifice, too.

If Medicaid needs to be reduced by 20 percent to meet the goals, let every state receive the same level of cut.

Now, I think the overall level of cut is too high. And I think we'll have a disagreement over that. But, if you do need to cut \$185 billion out of this program you should at least do it equitably.

I have a proposal to distribute these cuts fairly. It requires sacrifice for all states -- including the low-growth states. It's a plan that would apply the cut fairly to all states.

For years, Congress has been told by the General Accounting Office that funds in the Medicaid program are not targeted to areas of true need. The dollars, very simply, should go where the needy live. As the Congress looks at capping the program, it should account for the differences in population growth, poverty, uninsured rates and the percentage of elderly and disabled in each state. I am not alone in sharing that view. Governor Wilson of California, Governor Symington of Arizona and others have expressed strong concerns about a block grant formula that does not take these factors into account.

The United States was founded upon the simple but unwavering belief that "all people are created equal." That basic principle is undermined -and on the verge of being abandoned - through a block grant proposal that values people differently.

Let me end by putting it simply: The debate in Congress should not be about developing a Michigan block grant, a Massachusetts block grant or a Florida block grant.

We should be talking, instead, about a true federal-state

partnership for health care

With a true federal-state partnership, a child, or a family in Florida, is worth as much as a child and a family anywhere else in the USA. Any proposal leaving Washington must recognize that truth.

I want a program that enables me to address the particular needs and growth of Florida.

I want a program that allows me to continue the reforms that show great promise for Care -- as well as savings.

A true federal-state partnership for health care is one that has flexibility -but it also recognizes the federal government's responsibility. Richard Nixon championed this approach as much as Ronald Reagan. Both argued that the federal government must share the fiscal burden and ensure equal treatment of those in need.

**Florida and other growth states are willing to share the load. But, we want the federal government to cooperate -- the way a partner should.
Thank you.**

END

---No. 2 of 3-----

- Thursday, June 8, 1995

House Health & Environment Subcmte Hearing: Gov. John Engler of

Michigan - Prepared Remarks

Transcript ID: 1201322 (148 lines)

PREPARED TESTIMONY OF
JOHN ENGLER,
GOVERNOR
STATE OF MICHIGAN

BEFORE THE HOUSE COMMERCE COMMITTEE
HEALTH AND ENVIRONMENT SUBCOMMITTEE

THURSDAY, JUNE 8, 1995

Michigan Governor John Engler

Testimony Before the U.S. House Commerce Committee's Subcommittee on

Health & Environment

Chairman Michael Bilirakis (R-FL.)

Thursday, June 8, 1995

Thank you, Mr. Chairman.

I am honored to join my colleagues and to have this opportunity to give you a perspective on Medicaid from Michigan. First, let me say that we in the Great Lakes State are impressed by efforts of the House and Senate leadership to rein in federal spending and balance the budget. It's long overdue and we support that goal.

Runaway spending is not only breaking the federal budget; it is placing an enormous burden on state budgets. This Congress has shown great courage in the face of intense opposition from defenders of the status quo. Every change is subject to attacks and distortion. For example, when the House correctly sought to give states control over programs like school lunches - A decision I strongly support opponents were quick to decry the decision and hold press conferences in school lunchrooms asserting that school kids would go hungry as a result of the action of the House. Certainly, opponents of Medicaid reform will not hesitate to use similar scare tactics. We cannot allow their fog to obscure the objective.

Medicaid, today, is the biggest single burden on our budgets - and I don't think I'm alone in saying that no state can afford it any more - not in its present form. Considered a milestone when it began in the heyday of the Great Society, Medicaid costs are now a millstone. In Michigan, 1 of every 5 dollars in our general fund - 20% - is required to fund Medicaid. And because past Congresses have saddled us with a host of mandates, these costs just keep climbing. And, on top of the mandates, the Health Care Financing Administration (HCFA) keep changing their rules and that means costs just keep climbing even higher. Bottom line: This is one very expensive program.

Let me reiterate: I fully support the need to rein in federal spending. But simply to reduce federal funds, while doing nothing to relieve states of the burden of unfunded mandates and program micromanagement, will hurt our ability to provide the poor with quality health care.

This chart shows just how much direction we already get from Washington it is quite enough, thank you! It is so much direction, in fact, that an average frontline worker spends 80% of his/her time doing paperwork and only 20% solving the family problems that created the dependency in the first place. The most recent GAO report shows that current Medicaid policy is bankrupt - that it's "the sick man" of the federal budget and in need of emergency treatment. Given the budget resolutions passed by the House and Senate, it is clear that the surgery will come this year.

As I see it, you have the opportunity to pursue one of two strategies. One strategy could be to simply reduce federal funding for Medicaid and keep all current rules and regulations. The other strategy would be to fundamentally change the nature of the program by turning it into a block grant. Either strategy will accomplish your goal of reducing the federal budget.

But only the block grant strategy holds any hope that our most vulnerable citizens will continue to receive the health care they need. One thing is absolutely clear: We cannot stay the course.

Creeping micromanagement has entangled us in a briarpatch of perverse incentives that are costing taxpayers dearly. One example - and this is a direct result of the Boren Amendment: In 1989, Michigan Medicaid costs in a nursing facility were \$35 a day. In 1994, they were up to \$57 a day. We are paying a lot more money, but our

patients are not getting a lot more care. I find myself asking: What's wrong with this picture? Can we do no better than this?

The Medicaid program, as it is now structured, will increase by at least 10 percent a year - three times faster than the state revenues that support it and considerably faster than federal revenues, as well. If current trends continued, Medicaid would grow from one-fifth of my state budget today, to one-third by the year 2002. The Michigan budget would be strained to the breaking point by top heavy Medicaid burdens.

I applaud this committee for considering reforms that will change the financing and structure of Medicaid so that states can take full responsibility for, and control of, the program. Speaking for Michigan, I welcome the opportunity to design Medicaid to reflect the values and priorities in our state, and to provide for our most vulnerable citizens who need health care services. However, I am aware that some of the proposals in Congress, aided and abetted by status quo lobby groups, would continue to tie our hands and micromanage Medicaid from inside Washington. I think this would be a serious mistake - for at least two reasons.

First, any provisions that require "set-asides" for specific populations are unnecessary. No child, no elderly person, no individual with disabilities is going to be abandoned when Michigan takes control of its Medicaid program. Second, any financing mechanism that continues a federal matching formula is not acceptable." I repeat: not acceptable. The matching-rate approach will only keep the current system hobbling along and burden state and federal budgets with a host of perverse incentives. We can do better. The type of block grant I am calling for would fix Medicaid and reform the system.

A Medicaid block grant with no strings attached would give states flexibility to be innovative while maintaining necessary services. Flexibility, coupled with growth rates projected in the budget resolutions, create a win-win situation for both beneficiaries and taxpayers. Another benefit of flexibility will be the acceleration of reforms as today's cumbersome waiver process is eliminated.

This committee knows, and I know, that one of the biggest barriers to getting off welfare is access to health care. In March 1994, I submitted a waiver request to HCFA that would guarantee access

to health care for anyone who leaves welfare for a job. Over one year later, I am still waiting for an answer. With block grants, I would have already implemented this proposal, and more people would now be independent.

The only condition that should accompany a block grant is that states use the money to finance health care for low-income citizens. Then I invite the Congress to judge us by the one criterion that counts - performance. Michigan, I should point out, already has a strong track record. Because of our "Healthy Kids" initiative, Medicaid provides one of every four children in Michigan with health care coverage.

Even with today's constraints, our managed care system is a national leader that covers 82 percent of our Medicaid recipients. I'm proud of our achievements, and excited at the prospect of being able to do so much more.

Thank You.

END

-----No. 3 of 3-----

- Thursday, June 8, 1995

House Health & Environment Subcmte Hearing: Governor Michael Leavitt
of Utah - Prepared Remarks

Transcript ID: 1201325 (181 lines)

PREPARED STATEMENT OF
GOVERNOR MICHAEL O. LEAVITT
UTAH

BEFORE THE
HOUSE COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
U.S. HOUSE OF REPRESENTATIVES

ON STATE PERSPECTIVES ON MEDICAID REFORM

THURSDAY, JUNE 8, 1995

-----It is a privilege for me to come before this distinguished body to address two very important questions pertaining to your Medicaid deliberations. First, what is the best strategy for maximizing Medicaid's critical role in providing access to health care? Second, how do we slow the rate of growth in Medicaid expenditures without simply transferring this unsustainable liability to the states?

States have been charged with the primary responsibility to administer Medicaid since its inception in 1965. During the last thirty years, we have moved responsibly to look for ways to achieve both program and administrative cost savings, while assuring delivery of quality health care. While each state has met with varying degrees of success in achieving this goal, the evidence is quite clear that taken as a whole, the states have done a good job of serving the country's poor, unborn, disabled, aged, blind and medically at-risk citizens. This has been done in the face of heavy federal regulation and federal restrictions that have severely hampered state efforts.

In Utah specifically, Medicaid serves 1 out of every 8 Utahns each year. The philosophy of the State has been to foster market place competition and individual recipient financial responsibility to the extent permitted by federal law. This has allowed us to achieve one of

the most efficient and actuarially sound Medicaid systems in the country. In fact, sound management of Medicaid has contributed in large measure to the State being consistently selected as one of America's best managed states by Financial World. Utah has been employed competitive purchasing of major Medicaid services since 1981. We first included HMO products in the Medicaid program in 1982. Along this vein, the State long ago abandoned inflationary cost based reimbursement systems except where still required by present Medicaid federal law.

Shortly after taking office in 1993, I joined with my Utah legislative colleagues in a non-partisan initiative that would span 8 years of comprehensive, incremental health care reform that would ultimately make available affordable health care to all Utahns by the year 2000. This bold yet down to earth strategy is set forth in a document titled **HEALTHPRINT - A BLUEPRINT FOR MARKET BASED REFORM IN UTAH**. A major component of **HEALTHPRINT** is expansion of Medicaid to more Utahns living at or near poverty using no more federal dollars than would actuarially have been spent under the traditional Medicaid program. Under the current system, the Medicaid piece of **HEALTHPRINT** would take the form of an 1115 Waiver. Unfortunately, as a new governor and as a new student navigating the complex Medicaid federal approval processes, I have discovered that this country's governors do not have the authority needed to reinvent how this vital health care program can best meet the needs of its citizenry with the limited federal and state dollars that will be available in the future. Increasingly, federal mandates, court decisions and regulations issued by federal bureaucrats have tied the states' hands when it comes to tailoring a Medicaid program that fits within the budgetary and health care environments of the individual states.

The Medicaid program has evolved into a myriad of sub-programs each with its own set of individual entitlement rules. Administrative flexibility and simplicity has given way to unsurpassed administrative complexity and insensitivity to serving the public efficiently. In addition, federal administration of the Medicaid program through its various regional offices is not proceeding quickly enough to recognize the dramatic changes occurring in our health care markets. As a consequence, states with aggressive health reform efforts are stymied by out-of-date federal regulations and waiver application processes that not only fail to respond to the opportunities presenting themselves to states today, but establish artificial rules and conditions for granting waivers that have absolutely no bearing on the

realities of the market place.

While there are many, many examples of how federal administration of Medicaid has failed to meet the needs of the states, its citizens and this country, I would like to recap just a few. First, we have the outdated Boren requirements that tie state reimbursement systems to obsolete cost-based methodologies rather than the competitive market trends evolving so rapidly in most of our markets. This will continue to cost the states and the federal government billions of dollars each year.

Next, we have the so called list of "optional" services that each state can supposedly add or subtract from its benefit package to stay within budgetary constraints. Unfortunately, federal law and regulation have restricted states from removing optional services from so many special sub-populations of Medicaid, that by the time all these protected eligibility groups are eliminated there is very little cost savings left to realize.

The current system prohibits states willing to make hard choices. An example. Currently, a Medicaid recipient has benefits that are 130% of the average worker in the private sector in our state. After expensive deliberation and discussion with low income advocates, we decided that in Utah we would rather have everybody have basic health care than fewer have the best health plan in the state. We proposed to reduce the benefit level from 130% of the average private sector plan to approximately 118%, using the savings to provide coverage to people who currently have no coverage. What we believe to be a common sense decision, was not allowed under the existing system. There may be those of you who still disagree with our decision, but if we are going to meet our objective of providing access to basic quality health care to all Utahns, we need the ability to make those hard decisions.

Another example, federal law and regulation has so tightly limited the use of copayments and other forms of financial responsibility within the Medicaid population that any strategies to save funds by sensitizing these participants to the consequences of health care utilization decisions is lost. Reasonable cost sharing requirements must be injected into the purchase of health care by a significant part of the Medicaid population, particularly adults, if we hope to gain control of this program and assure its continued availability to future generations.

In the administrative area, the explicit and expensive requirements imposed by federal law and regulation on operation of state Medicaid agencies inhibits redesign of the basic program to transfer greater responsibility to private health plans where they can be more cost-efficiently borne, and the basic responsibilities of states redefined around rate negotiation, health plan enrollment, quality of care monitoring and reporting, and health data collection and analysis.

There will shortly be no need for states to maintain expensive, complex Medicaid Management Information Systems. In fact, the State of Utah is presently operating on a trial basis a single, comprehensive medical billing system that electronically processes claims from all provider types. UHIN, the Utah Health Information Network, collects claims on behalf of all public and private insuring entities in Utah. UHIN is a non-profit organization that was formed voluntarily to address the growing concern around duplicate administrative expenses incurred by multiple insurers. UHIN receives claims either manually or electronically, processes them for payment against the requirements of each liable insurer, handles automatically the coordination of benefits where more than one insurer is involved, applies limitations and other edits against the services received, and directs a payment remittance statement back to the provider advising of the action taken on the claim, and the parties from whom payment will be received. All organizations that came together to form UHIN committed in the articles of incorporation to return all administrative savings that are derived from this public/private venture to the consumer. UHIN is just one example of how the states are moving aggressively to implement real health care reform that will stand the test of time. The time for action is now, and the place for this action is the individual states.

As Congress looks toward limiting the federal funds available to the Medicaid program, it is vital the states be given the tools necessary to craft a program that is not only efficient, but which continues to provide at-risk populations good quality medical care. In my opinion, the most important tool the states must have to accomplish this is flexibility.

Franklin D. Roosevelt said "The future lies with those wise political leaders who realize that the great public is interested more in government than in politics". As the nation's governors, each of us has the first line responsibility to understand our communities needs and the values based on which those needs must be met. I hope we have

the courage and the wisdom to give states the needed flexibility to make critical decisions relative to managing Medicaid within a mutually acceptable funding agreement. This is the only path I see that will enable us to both balance the federal budget and preserve this important program.

Again, it has been my pleasure and privilege to speak to you today, and at this time I would be very happy to speak to any specific questions or concerns you may have.

END
