INTER-GOVERNMENTAL TRANSFERS: VIOLATIONS OF THE FEDERAL-STATE MEDICAID PARTNERSHIP OR LEGITIMATE STATE BUDGET TOOL?

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

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THURSDAY, MARCH 18, 2004

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

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2123, Rayburn House Office building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Hall, Upton, Greenwood, Deal, Burr, Norwood, Shimkus, Wilson, Buyer, Pitts, Barton (ex officio), Brown, Waxman, Pallone, Eshoo, Stupak, Engel, Green, Strickland, Capps, and Rush.

Also present: Representatives Solis and Sullivan.

Staff present: Charles Clapton, majority counsel; Jeremy Allen; health policy coordinator; Eugenia Edwards, legislative clerk; Bridgett Taylor, minority professional staff; Amy Hall, minority professional staff; and Jessica McNiece, minority research assistant.

Mr. NORWOOD [presiding]. We will now call the hearing of the Health Subcommittee to order.

If the witnesses would come on up and get comfortable at the table.

Before I begin with my opening statement, I ask unanimous consent that members who wish to waive their opening statement will be given an additional 3 minutes in questioning. So just let us know, but let's keep in mind we do need to get the witnesses going as soon as possible.

I would like to begin by thanking our witnesses for taking the time to join us and provide their perspectives on an important issue facing the Medicaid program. Today's hearing is the first in a series that will explore different aspects of the Medicaid program and strategies for modernizing this critical component of our health care safety net.

Your testimony on the subject of intergovernmental transfers should prove valuable as the subcommittee moves forward with its work in this particular area.

Medicaid is a joint partnership between the Federal Government and the States. States provide health coverage for eligible beneficiaries and then draw down a specified Federal match to cover

these expenses. The Federal match, which is known as the Federal medical assistant percentage, or FMAP, varies, of course, from State to State.

On average the Federal Government picks up approximately 57 percent of our Nations total Medicaid tab. As we will, no doubt, discuss today, some states have used certain financing mechanisms, including intergovernmental transfers, or IGTs, in an effort to maximize the amount of Federal dollars States are able to draw down.

While I will let our witnesses explain how IGTs work, I want to make two quick points. First, we have numerous examples of cases where States do not expend any of their own funds in securing these Federal payments.

Second, I know that our witnesses will be able to cite specific instances where Federal Medicare payments were not used to pay for Medicaid covered services.

These activities greatly concern us all, as they should and as members of this subcommittee. Inappropriate use of IGTs, while not technically illegal, fly in the face of the Federal-State partnership that was originally envisioned under Medicaid. When States use IGTs to draw down extra Federal funds, they are making a unilateral decision to increase the Federal Government share of their Medicaid programs.

In my opinion, these activities harm States, such as Florida, Mr. Bilirakis' home State, that have not been as aggressive in their use of these tactics.

I hope members use this opportunity to learn more about this complicated subject and do not simply use this hearing as a forum for political grandstanding, they said.

I want to put subcommittees on notice that I intend to hold further hearings on this topics. While members share divergent views regarding Medicaid, I think we should all share the goal of insuring that every single Federal dollar spent on Medicaid goes directly to providing Medicaid services, and that the integrity of the Federal-State partnership is maintained.

I would, again, like to thank our witnesses for taking their time to join us today. I know that we all look forward to your testimony, and we are going to get to it as quickly as we can.

Now, I would like to yield to the ranking member of the subcommittee, the gentleman from Ohio, for a 5-minute opening statement.

Mr. BROWN. Thank you, Mr. Chairman.

Medicaid coverage is at risk for tens of millions of Americans who need Medicaid coverage. What is our response? Rather than focusing on shoring up Medicaid, we focus on ways of cutting more dollars from it.

The President's budget cuts $24 billion from Medicaid over the next 10 years. While the details are sketchy, CMS apparently intends to eliminate certain mechanisms that States use to finance their share of the Medicaid program.

Previous administrations have worked with Congress and with the States to address the misuse of intergovernmental transfers and other financing mechanisms. Because of these changes, the op-

portunity to divert funds from Medicaid has been significantly curtailed.

Let's not fool ourselves. If we cut $24 billion from Medicaid, we won't be cutting dollars from unrelated State programs and State projects. We will be cutting people off from health care. Forty-nine States and the District of Columbia have plans to cut their Medicaid program this year. In my own State, Governor Taft has announced he plans to cut at least $120 million from Medicaid even though there are already waiting lists for critical services.

A little boy in my district recent who tragically has an incurable, severely disabling and terminal illness was placed on a waiting list for care he absolutely and he desperately needed. The hell that he and his parents went through is something we should never again have to witness.

Apparently to this administration that just does not matter. The Bush Administration is resurrecting old skeletons to justify the unjustifiable, to justify starving the Medicaid program instead of saving it. Medicaid is not an extravagance. Medicaid is not an afterthought. Medicaid anchors this Nation's health care system.

Medicaid spending has increased dramatically over the past 4 years not because of fraud, not because of abuse, but because of enrollment increases associated with the economic downturn, 300,000 fewer jobs in my State alone in the last 3 years, of course there is a greater need for Medicaid services, and the increase has been because prescription prices and hospital costs are pushing up spending for public and private insurers alike.

Medicaid is cost efficient. Medicaid provides health care for fewer dollars per enrollee than the private health insurance system.

Not only does Medicaid protect the individuals covered under the program; it plays a major role in financing the health and long-term care sectors of our economy. That means protecting the health professionals who serve all of us, and it means jobs.

The President will not replace the $24 billion he cuts from Medicaid even though Medicaid is the only reason that the uninsurance rate in this country has not exploded under his watch. It is the only reason 1.3 million low income seniors have access to nursing home care. It is the only reason children living in poverty receive care in a doctor's office rather than in an emergency room.

I keep coming back to the same question. What has happened to this Nation's priorities since President Bush took office? Why are the most unfortunate among us the least important people in this country to our government?

The government's role is to assist those in need, not to desert them. Corporate tax loopholes cost the government more than $155 billion each year. Last year corporate ex patriots cost the U.S. Government $70 billion in lost revenue moving offshore to Bermuda and other places.

The Bush Administration, not concerned about that corporate tax cheating, the Bush Administration's decision to withhold Medicare cost estimates from Congress will cost taxpayers $534 billion over the next 10 years. The Bush Administration decision to launch "infomercials" touting the Medicare bill will cost Americans at least $80 million.

But the President and Congress just seem not too concerned about those tax dollars, yet we kick Medicaid when it is down. The President and Congress should be concerned about fraud and abuse, to be sure, but we should be far more concerned with investing the necessary dollars to keep Medicaid afloat. That is what our focus should be today.

This subcommittee has sole jurisdiction over Medicaid. We bear significant responsibility for the formulation of national health care policy. We should not permit, much less help, the Bush Administration to demonize, to destabilize, and ultimately to destroy this essential safety net program.

I yield back my time.

Mr. NORWOOD. Thank you, Mr. Brown, so much for political grandstanding. I tried though.

We are delighted to recognize the chairman of the full Commerce Committee who is with us this morning, Mr. Barton.

Chairman BARTON. Thank you, Mr. Chairman.

I am going to take a point of personal privilege before my statement and announce that Chairman Tauzin was operated on yesterday at Johns Hopkins. It was a lengthy operation, but he came out with flying colors. The doctors indicate that the cancer was localized and that they have removed the tumor, and that it had not spread to any of the other organs in the vicinity. He is going to be in intensive care for a number of days, but will be able to take visitors some time next week.

We have a small card here we are going to be sending around, and we are going to ask all of the members to sign it and say something nice about him in the card, you know, but Billy is doing well and Cecile says he is in good spirits.

As to my opening statement on this hearing, I want to thank Chairman Bilirakis for holding it. I want to thank our witnesses for being here.

The issue of intergovernmental transfers is something that needs to be addressed. In some instances they are legal. It appears in many instances they are abused, and in some instances some of what is being done may be illegal.

Medicaid is a State-Federal partnership, and the partnership does not work when one of the partners tries to game the system, and it certainly appears that in some cases the system is being gamed. So I have a formal statement for the record, which I would ask unanimous consent to put in, but I am looking forward to the hearing, and I again want to thank the witnesses for being here today.

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

Mr. Waxman, you are now recognized for a 3-minute opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman.

Every member of this committee is aware of the critical role the Medicaid program plays in providing health care services to some 50 million Americans, persons who are the most vulnerable and who frequently have the most complex and difficult health care problems.

Further, Medicaid is a program that has always faced severe funding problems largely because it depends on significant State

contributions. This is a true structural problem because at the very time when the economy weakens and people lose their jobs and health care coverage and need Medicaid's help, State revenue bases weaken, as well, making the State contribution doubly difficult.

States and localities have long dealt with the fiscal demands of Medicaid by using a combination of funding sources. Intergovernmental transfers of local funds have been a recognized and explicitly legal source of funding for the program.

In many States, including my own State of California, these funds have been used in conjunction with the DSH Program and upper payment limit rules to support not just critical local public hospitals, but children's hospitals and private institutions which serve large numbers of uninsured patients. They have maintained these institutions and allowed them to provide needed trauma care and community services, especially at a time when they provide so much service to those who have no insurance.

I am sure we will hear about instances where there have been abuses of Medicaid funding, where inappropriate transfers have been used to leverage Federal dollars that have then been used for purposes other than health care. No one condones using scarce Medicaid dollars to build roads.

But action has already been taken to close the loopholes in the law that has led to these abuses. I am not saying all of the problems are solved, but the most egregious abuses will not be permitted under the changes that have already been made in the Medicaid program.

The upper payment limit regulations now being phased in have in effect essentially stopped the ability to use large differentials in payments to draw down Federal dollars for other State budget purposes.

But I want to make one thing clear. I think we have squeezed too much with these regulations, and we cannot afford to do anything more. There was a decision in the last administration to set the limit for public facilities at 150 percent of the Medicare rate, which was more appropriate.

I do not object to maximizing use of Federal dollars to support health care in these vital institutions.

Finally, let me add that as critical as I have sometimes been of States' administration of the program, I think they have a legitimate complaint about the way the Bush Administration continues to lay out one set of financing rules for States to rely upon and then summarily changes them.

State budgets and systems are complex and any Federal proposal to change the law in these areas should be accompanied by notice, opportunity for public comment, and respectful transition periods. No one is helped when the Federal partner makes and unmakes its decisions so suddenly.

I hope if the chairman disagrees with any of my comments he will not claim I am grandstanding. I am submitting these views with all sincerity, and I hope we can discuss it with civility and tolerance for differences.

Yield back the balance of my time.

Mr. NORWOOD. Actually, Mr. Waxman, I thought you did real well, and I know you were sincere.

Ms. Wilson, you are now recognized for 3 minutes.

Mr. WILSON. Thank you, Mr. Chairman.

Medicaid is now the largest health care program in the country. It serves 48 million people and last year had a budget of $280 billion. It is about 7 percent of the Federal budget, and it is close to 15, between 15 and 20 percent of most State budgets.

In my view Rube Goldberg would admire the financing scheme that underpins Medicaid. It is a scheme that is really set up to encourage States to maximize their Federal expenditures with accounting tricks and kickback schemes and to have State Medicaid directors focused on what they can do to get the next percentage of a penny of Federal match rather than focusing on how to improve the health care of the people who depend upon Medicaid.

We know States are using upper payment limits and disproportionate share hospital payments for things other than health care; that they transfer in some cases transfer funds to public hospitals and then require those public hospitals to remit those funds without using them for health care back to State governments.

The Federal match is based on per capita income, and when you have some States pursuing these schemes, that takes dollars from somebody else that needs those dollars to meet their own needs in health care.

Now, there are some circumstances where these intergovernmental transfers are completely legitimate ways of local governments contributing to the State and local match. Every State has a different set-up for how they collect taxes, but there are other circumstances where they are being an abuse of the Medicaid system, and I think we may need to take action to stop it.

I think also though that these tricks are only a symptom of a larger problem. Medicaid's whole financial structure is held together with baling wire and duct tape, and we need to look long term at how we change this structure. We should not be surprised that States play the game. We wrote the rules of the game, and the rules need to be changed so that the States win when the health of low income Americans, children, pregnant women, the adult disabled, and seniors improves.

The system is not set up to improve anybody's health. It is set up to pay claims, and that is a fundamental problem with the financial structure of Medicaid.

This system only continues to function because every State has multiple waivers to do something outside of the rules of the program. Think about that. You need a waiver from the Federal program to focus on improving somebody's health status.

We need to change the rules, and the time is coming to fundamentally change the program so that States do not need these waivers and we have sound financial footing for the Medicaid system.

Thank you, Mr. Chairman, and thank you for holding this hearing.

Mr. NORWOOD. Thank you, Ms. Wilson.

Mr. Pallone, do you wish to have an opening statement?

Mr. PALLONE. Yes, thank you, Mr. Chairman.

Mr. NORWOOD. You are now recognized.

Mr. PALLONE. Mr. Chairman, I am deeply concerned about the impact that the Bush Administration is having on Medicaid. I believe we should be strengthening the program that is the largest source of insurance today in the United States, and instead the President is advocating a radical overhaul of Medicaid.

In his fiscal year 2005 budget, the President cites his legislative goals that essentially destroy Medicaid, that is, turning the program into a allotments or block granting, curbing intergovernmental transfers and increasing audits on States and their financial management of Medicaid.

We have heard that by block granting Medicaid States will have the flexibility necessary for expanding access to health care, but let's be clear. In reality, that is a proposal that simply blackmails the States. The block grant proposal caps the Federal share of Medicaid dollars so that States cannot receive adequate funding as their Medicaid needs rise.

By shifting fiscal responsibility to States, the Medicaid block grant encourages States to limit their liability by capping enrollment, cutting benefits, and increasing cost sharing for millions of low income people.

In addition, any short term relief that States receive up front under the block grant will have to be paid back at the end of the 10 year budget window. If that is not a bribe, then I do not know what is.

Essentially by block granting a large portion of the Medicaid program, the President's proposal simply passes the buck onto hard-pressed States I am also disturbed by the administration's attempt to propose legislation to crack down on intergovernmental transfers, IGTs. When the Medicaid program was created in 1965, the system was financed by State contributions and in an exact match of Federal dollars. States have been using IGTs to increase the amount of matched Federal funds, and these extra dollars are allocated toward the same Medicaid services.

My home State of New Jersey started using IGTs several years ago as a means for funding legitimate Medicaid services, specifically nursing home care. Without IGTs, it is nearly impossible for New Jersey to obtain other funding sources, and this is exacerbated by the fact that New Jersey and every State is facing severe budget shortages.

Medicaid cuts, including a tax on IGTs, will only result in benefit cuts to the elderly, and unfortunately this seems to be the direction that the President desires.

Last, the administration is proposing to spend $20 million to increase the number of State audits. Well, quite frankly, $20 million is valuable and better spent on health care services.

Again, I used my home State of New Jersey as an example. We are experiencing a pending list of over 15 audits by the Department of Health and Human Services. Each case has been examined so far and has had a clean outcome, and I believe our State needs to be afforded the respect it deserves and must be afforded the ability to return to its work of serving its Medicaid beneficiaries and to stop wasting time gathering papers for an increased number of audits.

By cutting Medicaid funding and offering the proposals outlined in his budget, the President is undermining access to care for the poor elderly, sick and disabled and overall the President's proposal weakens the health care safety net and adds to the widening credibility gap that is putting him and the Republicans that support his proposal further out of touch with the American people.

Thank you, Mr. Chairman.

Mr. NORWOOD. Mr. Buyer, you are recognized. You pass? You will be added time in questioning.

I am delighted to recognize Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman, and good morning to everyone. And thank you for holding this important hearing on this important issue.

I think we have before us today an issue that goes really to the heart of one of the most serious problems certainly facing my State, the State of California: insuring that low income families, seniors and people with disabilities have health care coverage.

The Federal-State matching program for Medicaid in my view works. It is a program that really doesn't have the amount of resources that it should have in it, and certainly when our economy is failing and the States are having one of the roughest times in the history of our country, there is a reason why Medicaid is strained. There are more people that are dependent upon it.

I understand that questions are raised about the program's financial management, specially with regard to whether Federal matching funds are being spent appropriately. Questions have been raised primarily about the intergovernmental transfers, and I think that we should have a very healthy discussion about that because if, in fact, dollars are being misused or abused, then that is what we should pursue.

Some States inappropriately inflate the Federal share of Medicaid, but what we should do is go after that. If this is a ruse to really supposedly overhaul the program midstream because there is a misuse of any dollars I think is really unwise because what would be jeopardized is extraordinarily vulnerable both in terms of the people that are dependent upon the funds and certainly the States that are having such a touch time.

IGTs, for everyone on this committee in cases we might be forgetting it during the hearing, are legal and legitimate mechanisms, funding mechanisms for the States. They were put into place by both Democrats and Republicans, and to change this program at a time when many States are in a fiscal crisis, when there is a rising number of Medicaid beneficiaries and uninsured, I think would be reckless.

Mr. Chairman, I just want to point out something that comes with the statement from the National Governors Association that is part of our packet this morning, and it is on page 1. It is under State and local governments, and I am going to quote from it.

"Without the benefit of IGTs, large county-based States, such as New York, California, Wisconsin, and North Carolina, to name just a few, would literally be unable to finance their Medicaid programs, destroying the safety net in many parts of the country and drastically increasing the number of the uninsured."

So I think that every member has got to look to and talk to and work with their Governors regardless of whether it is a Republican Governor or a Democratic government. This is a huge issue for our States, and it certainly is for mine.

IGTs are the funding mechanism for the disproportionate share of the hospital program in my State of California, and these DSH funds are essentially for California's safety net hospitals to be able to provide health care services.

Is my time up?

Mr. NORWOOD. Yes, ma'am.

Ms. ESHOO. My goodness. At any rate, I look forward to nearing from our witnesses, Mr. Chairman, and I think that we need to tread lightly, tread lightly. If we are going to reform something, let's separate the wheat from the chaff, but let's not let anyone fall through that fragile safety net that has been constructed.

Thank you.

Mr. NORWOOD. Thank you, Ms. Eshoo.

I do not know how others feel about it, but I think generally a hearing like this is a learning experience for us all. I do not have an ulterior motive. I just want to hear and learn about what is going on.

With unanimous consent, I would like to refer to the chairman for an introduction.

Chairman BARTON. Thank you, Congressman Norwood.

I do not normally take point of personal privilege twice in one hearing before it even gets started, but the gentleman back to my right was a military fellow for me several years ago. He is a graduate of Texas A&M. Brigadier General Bill Webber, who is one of the two brigadier generals that led the 3rd Infantry Division into Baghdad, part of that time was at the head of the sphere. So I want to welcome him to the Congress and thank him for his fine patriotic work.

Mr. NORWOOD. Thank you, General.

And, Mr. Chairman, I have got it figured out now. He went to A&M. That is what this is all about.

Mr. Shimkus, do you wish to have an opening statement?

Mr. SHIMKUS. Just briefly, Mr. Chairman. Thank you.

Tip of the sphere is the acronym for the infantry, not just the head of the sphere, but the tip of the sphere.

And this IGT thing is an interesting debate, and as governing officials we have to as much as we would not like to shine the light of day on funding, it is really what we have to do.

Now, Illinois is an IGT State. My first really health care battle was with the Clinton administration. It was one of the few times I was in the West Wing with Secretary Shalala on IGT, trying to save the intergovernmental transfer funding stream for Illinois' poor health care facilities that were relying on IGT to make ends meet.

So here we go again, and I think it is a tough issue to debate. It is important, but I think we can't lose sight of how those States who have been using the intergovernmental transfer, at least in the State of Illinois, have gone to help the poor and stressed facilities that are providing needed health care benefits to the poor.

And so I think it is an important hearing, Mr. Chairman, and I thank you for your time. I yield back.

Mr. NORWOOD. Thank you very much, Mr. Shimkus.

And now my good friend, Ms. Capps, would you like to have an opening statement?

Ms. SHIMKUS. No, I will waive.

Mr. NORWOOD. You will waive. Very well.

Let's see. We go to Mr. Stupak. Would you dare to have an opening statement?

Mr. STUPAK. I would prefer to make an opening.

Mr. NORWOOD. You are recognized.

Mr. STUPAK. Thank you, Mr. Chairman.

Welcome to our witnesses.

I would like to open this committee meeting with a reminder that any cut to Medicaid will cause seniors to lose benefits, children of working families to be turned away, and reimbursements of health care professionals to drop again.

In Michigan, Medicaid has been a Godsend for families and seniors, especially during the economic turndown. In the past 4 years, Michigan's program has grown by almost 30 percent, now covering about 1.35 million people.

The President has proposed cutting Michigan's Medicaid budget by $385 million over 10 years. Overall, the President would cut Medicaid nationally by over $23.5 billion over 10 years. How does a State like Michigan whose Medicaid enrollment has increased 30 percent in 4 years fill a $385 million hole? Not easy and with a lot of pain.

Michigan could cut the home and community-based waiver program that allowed people to stay in their homes instead of nursing homes. Michigan could cut 77,000 of Michigan's most vulnerable adults, or Michigan could cut its low prescription drug benefit program for 14,000 low income seniors. This is not acceptable. It is unconscionable.

Today we begin to dissect how States finance their Medicaid programs in an effort to find $23.5 billion in so-called "waste, fraud and abuse." I am for transparency and honest bookkeeping, but I believe the purpose here is dubious. Certainly there are abuses that need to be addressed, but I find it hard to believe that the States are defrauding the government by $23.5 billion.

I have noticed a pattern that every time the majority starts talking about Medicaid reform they are also pushing for more tax cuts. I cannot support cuts to Medicaid when Michigan's unemployment rate is around 7 percent and when we have over 43 million uninsured people nationwide, yet the majority wants another $150 billion in tax cuts. The numbers just don't add up.

I am looking forward to the discussions we are going to have here today and through on this issue, and with that I yield back the balance of my time, Mr. Chairman.

Mr. NORWOOD. Thank you, Mr. Stupak.

Mr. Green, I apologize to you. You were supposed to be next, Mr. Stupak said you did not care. So you are now recognized.

Mr. GREEN. Well, that is the way he plays basketball, too. He's always trying to go around me.

Thank you, Mr. Chairman, and I do have a statement.

I would like to thank you for holding the hearing to discuss the intergovernmental transfers, or IGTs as it is abbreviated, in the Medicaid program. There are few areas of Medicaid that are more arcane and difficult to understand than the IGT, and there are going to be countless acronyms thrown around during the hearing which may leave many of us more confused than enlightened. But being from a State that has a long history of using IGTs to draw down Federal dollars, I would like to take a moment to discuss the importance of the mechanism and advocate for the protection of States that are legitimately using IGTs to provide health care for millions of low income individuals.

My home State of Texas is one of the last in the Nation to have only a Statewide sales tax, no income tax. So a lot of our revenue is generated at the local level. As a result, nine large public hospitals provide the IGTs that equal the State's match portion to draw down Federal Medicaid funding.

This funding helps Texas capture Federal matching funds through the Medicaid disproportionate share program and the upper payment limit. The mechanism enabled Texas to draw down $504.3 million in Federal funds, all of which they have disbursed to public and private DSH hospitals.

Now, I know this sounds complicated, but it is perfectly legal and perfectly legitimate, and nothing about this is shady or underhanded or inappropriate. And our State, county and municipal governments help underwrite our Federal health care programs. Very little State funding. It is how our program is designed by the local government, and that is the way it has worked, not as best as I would like it, but still the Harris County Hospital District, which is a major health provider for low income and Medicaid populations in the city of Houston, uses IGT to drawdown $72.7 million in upper payment limits and $26.6 million DSH funding in 2003.

The revenue stream is a critical component of the District's proposed for fiscal year 2005, $750 million. So you can tell we are talking about, you know, not a small portion of this Harris County Hospital district's budget.

Now, I know that some States have abused the IGT to draw down Federal dollars and have spent them on non-health care related costs, such as roads and bridges, but we have addressed these issues many times to stem the abuses, and while there is still more that we could do, any effort to eliminate IGTs would be detrimental to not only my State but a number of States.

We need to make sure that the Texas program and other programs that follow the rules are protected, and, again, hank you, Mr. Chairman.

And to follow up my colleague, Mr. Shimkus, I was probably only in the West Wing one time under the Clinton administration, too. That was when I told them I would vote against NAFTA.

Mr. NORWOOD. Thank you, mr. Green.

Mr. Burr, do you wish to make an opening statement?

Mr. BURR. Mr. Chairman I would. I'd like to.

Mr. NORWOOD. You are recognized.

Mr. BURR. I would like to thank you for holding this hearing.

I think that it is safe to say that all of us are disgusted at how intergovernmental transfer find their way from the health care

arena to highways and other infrastructure needs, and we want to see that stopped.

I think the one challenge for this committee and this Congress is to make sure that we do not in any way, shape or form change our commitment to the health care needs across this country and at the State levels.

I think that this hearing is important to understand not only why intergovernmental transfers are used, but how we might be able to change it or if we can change it so that if there is a process of flexibility, that it can only go to meet the health care needs; that we cannot have some of the abuses that exist.

I do not think we are as much here today to start a process to find somebody to blame or to hang. We are here to figure out how to make the system better.

I want to thank our witnesses who are willing to come today. I want to challenge the members on this committee that have always displayed a tremendous amount of interest in how to make the system better; to listen very carefully; to ask all of the important questions; to go through the process of multiple hearings and then, in a bipartisan way, try to plug the problems and enforce those things that we produce up here that benefit those human faces that we see at home every week that we go there.

So, Mr. Chairman, I thank you for the committee's willingness to do this. I also understand the importance of what we are now headed into, and I know that every member is committed to make sure that we do this right.

I thank you, and I yield back.

Mr. NORWOOD. Thank you. I appreciate it from the gentleman from North Carolina.

Ms. Solis, do you wish to make an opening statement?

Ms. SOLIS. Yes.

Mr. NORWOOD. You are recognized.

Ms. SOLIS. Thank you very much, Mr. Chairman, and thank you for the opportunity to also be here. I am not officially on this subcommittee, but have a keen interest also.

I represent California. As was mentioned earlier by other members, it is a very important part of this discussion here today.

So I want to, first of all, thank the panelists for being here, and I would like to especially thank our representative and CEO from the Children's Hospital of Los Angeles. For more than 100 years, the Children's Hospital of Los Angeles has been a valuable resource for our children and our families in L.A. county, and I thank you for the diligent work that your staff provides to the many, many youngsters that come from my district, from the 32nd Congressional District.

California's Medicaid program, known as MediCAL provides access and health care to well over 6.5 million low income Californians, including children, working families, pregnant women, immigrants, and the disabled and elderly. California has a history of lawfully using the intergovernmental transfer program to provide crucial help to safety net hospitals. These are hospitals that are integral to our community.

The ones that I represent in my district are the White Memorial Center in East Los Angeles and the Citrus Valley Health partners

in West Covina, and while I share the administration's concern with insuring that Medicaid dollars are used appropriately, I also know that proposals to limit the use of legal, legitimate IGTs, such as California's, could seriously damage our health care safety net.

One out of every six Californians and one out of every four California children are covered by MediCAL. We absolutely must keep in mind as we move forward with these discussions.

I look forward to hearing from the witnesses.

Thank you, Mr. Chairman.

Mr. NORWOOD. Thank you, Ms. Solis.

And, Mr. Greenwood, would you care to make an opening?

Mr. GREENWOOD. I will be very brief, Mr. Chairman.

Mr. NORWOOD. You are recognized.

Mr. GREENWOOD. And I thank Chairman Bilirakis for holding this committee hearing. It is important. We have a lot to learn, and I am among those who is here because I want to learn more about this issue.

But I do think there is a fundamental flaw with the whole notion of intergovernmental transfers, a fundamental flaw, and the fundamental flaw is that this Medicaid system was a system that was designed to be roughly 50-50 split, and there are variations between the States obviously, but it was supposed to be a shared notion that if the State was willing to belly up to the bar and make some sacrifices, tax its citizens, raise some money for health care, that we at the Federal level would be a partner.

And there is obviously a consulting industry that has arisen in this country where individuals who work in the State Medicaid programs figure out how to do this. They go out into the private sector and then they come back and they consult with States, and they have come up with these solutions where essentially the State gets to manipulate the process so that the program is funded essentially 100 percent with Federal dollars.

That is unsustainable. It is not the way the program was designed to be. My State of Pennsylvania is right in the thick of it, doing it with great alacrity, but it is wrong, and you cannot sustain it. It is not the way the system was designed to be worked, and we will never get control of the Medicaid funding problem and the growth rates and make sure that it is really a sustainable program for the long run unless we get real serious and make some difficult choices about IGTs.

Thank you, Mr. Chairman.

Mr. NORWOOD. Mr. Hall, do you care to have an opening statement?

It is of interest to me that there are a number of members of the full Commerce Committee here that are not on the Health Care Committee that are here, and I think that is a very good sign that there is a great deal of interest.

Are there any other members who have not made an opening statement who wish to do so?

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

I now call this hearing of the Health Subcommittee to order. I would like to begin by thanking our witnesses for taking the time to join us and provide their perspec-

tives on an important issue facing the Medicaid program. Today's hearing is the first in a series that will explore different aspects of the Medicaid program and strategies for modernizing this critical component of our healthcare safety net. Your testimony on the subject of intergovernmental transfers should prove valuable as the subcommittee moves forward with its work in this area.

Medicaid is a joint partnership between the federal government and the states. States provide health coverage for eligible beneficiaries, and then draw down a specified federal match to cover these expenses. The federal match, which is known as the federal medical assistance percentage, or "FMAP," varies from state to state. On average, the federal government picks up approximately 57% of our nation's total Medicaid tab.

As we will no doubt discuss today, some states have used certain financing mechanisms, including intergovernmental transfers, or "IGTs," in an effort to maximize the amount of federal dollars states are able to draw down. While I will let our witnesses explain how IGTs work, I want to make two quick points. First, we have numerous examples of cases where states do not expend any of their own funds in securing these federal payments. Second, I know that our witnesses will be able to cite specific instances where federal Medicaid payments were not used to pay for Medicaid-covered services.

These activities greatly concern me, as they should all members of the subcommittee. Inappropriate uses of IGTs, while not technically illegal, fly in the face of the federal state partnership that was originally envisioned under Medicaid. When states use IGTs to draw down extra federal funds, they are making a unilateral decision to increase the federal government's share of their Medicaid programs. In my opinion, these activities harm states, such as Florida, that have not been as aggressive in their uses of these tactics.

I hope members use this opportunity to learn more about this complicated subject and not simply use this hearing as a forum for political grandstanding. That said, I want to put members of the subcommittee on notice that I intend to hold further hearings on this topic. While members share divergent views regarding Medicaid, I think we should all share the goal of ensuring that every single federal dollar spent on Medicaid goes directly to providing Medicaid services and that the integrity of the federal-state partnership is maintained.

I would like to again thank our witnesses for taking the time to join us today—I know we all look forward to your testimony. I now yield to the ranking member of the subcommittee, the gentleman from Ohio, for an opening statement.

PREPARED STATEMENT OF HON. ELIOT ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I am a bit troubled about the tone and the apparent intent of this hearing today. The Administration and this Committee appears to be targeting states that utilize intergovernmental transfers and seeking to cut almost $10 billion in 5 years from critical health care funding. At a time of fiscal crisis, high unemployment, and over 40 million Americans lacking health insurance, I believe it is highly irresponsible to seek further cuts in our nation's fragile health care safety net.

Last week we heard testimony from Secretary Thompson regarding the Presidents budget for health care. In looking over the President's budget I was disappointed to see that there is little in the way of bolstering health care for the uninsured, aside from a modest increase for community health centers. Instead, the Administration's main goal seems to be cutting even further funding for the poorest and frailest Americans in the Medicaid program by what it calls "curbing" the use of intergovernmental transfers. However, the budget is high on rhetoric with little detail into how these cuts are to be implemented.

Mr. Chairman, I and other Members of this Committee fought hard to reach an agreement a few years ago that allowed some states, including New York, that utilize intergovernmental transfers to continue doing so if the revenue generated was used for health care purposes for a transitional time period. New York has always used money generated from intergovernmental transfers to plug holes in the very fragile health care safety net in the state. When I hear that President Bush and my Republican colleagues are trying to save money by cutting health care funding it boggles my mind because in the end we will either pay now or we will pay a much heavier price later. In this case, with a floundering economy and those without jobs and insurance on the rise, we will pay a very heavy price by saving money on the backs of those most in need.

Mr. Chairman, in my limited time I could not begin to talk about all the problems that this country faces in caring for the poor and uninsured. The move to cut $10 billion in Medicaid funding exemplifies what this Administration stands for: an attack on the poor and uninsured and a lack of vision in regards to what our countries needs are.

I want to thank the witness for their time and I yield back.

Mr. NORWOOD. Well, members of the committee and for our guests, I would like to take a minute and introduce our witnesses to us all. First we have Kathryn Allen, who is the Director of Health Care, Medicaid and Private Health Insurance Issues with the GAO.

Ms. Allen, we are delighted you are here. Thank you.

Mr. George Reeb, thank you for being here. Assistant Inspector General for Centers for Medicare and Medicaid Audits, Office of Inspector General with HHS.

And Mr. Walter Noce. Did I say that right? President and Chief Executive Officer of Children's Hospital, Los Angeles.

Ladies and gentlemen, your full statement obviously will be placed into the record, and generally we allow about 5 minutes of oral testimony. I am going to be a little lenient today since we only have three witnesses, and if you run over a little bit, I am going to ignore that, but just keep it within decent bounds.

With that, Ms. Allen, we would love to hear from you now, please.

STATEMENTS OF KATHRYN G. ALLEN, DIRECTOR OF HEALTH CARE, MEDICAID AND PRIVATE HEALTH INSURANCE ISSUES, GOVERNMENT ACCOUNTING OFFICE; GEORGE M. REEB, ASSISTANT INSPECTOR GENERAL FOR CENTERS FOR MEDICARE AND MEDICAID AUDITS, OFFICE OF INSPECTOR GENERAL, HHS; AND WALTER W. NOCE, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, CHILDREN'S HOSPITAL

Ms. ALLEN. Thank you, Mr. Chairman, Mr. Brown, and other members of the subcommittee.

I appreciate the opportunity to be here today to testify as you address these very important issues of States' use of intergovernmental transfers, or IGTs, in the Medicaid program.

As we have already heard this morning, Medicaid fulfills a very crucial national role by financing health services to about 50 million low income Americans. It now finances more individuals than does the Medicare program.

The population served is extremely heterogeneous. Medicaid pays for health care for about one in five of all children nationwide, one in five of individuals with chronic disabilities who live in the community, and two in three of all nursing home residents.

Congress structured the Medicaid program as a shared Federal-State responsibility, as has been pointed out already this morning, with the Federal share of each State's payments determined by a formula which is set in law.

The Federal Government pays for at least half of every State's Medicaid program and up to two-thirds for some States that have less fiscal capacity to finance this care. Through broad Federal guidelines, States have considerable discretion to design and implement their programs. For more than a decade, however, States

have used a number of what we call creative financing schemes to inappropriately increase the Federal share of Medicaid spending.

Now, IGTs is just one of the tools that States have used to do this. In a broad sense, States and local governments use IGTs to carry out important shared functions, such as collecting and redistributing revenues to provide essential government services.

But States have also used IGTs to transfer funds to and from State or local government owned facilities as part of complex schemes that inappropriately boost the Federal share of Medicaid costs.

These financing schemes have taken various forms over the years. Many of us know them as provider taxes and donations, disproportionate share hospital, or DSH payments, and upper payment limit, or UPL schemes. My written statement provides more detail on how each of these works.

While the details differ, they share certain common features. They take advantage of statutory and regulatory loopholes. Some States make large Medicaid payments to certain providers, such as counties that operate nursing homes. These payments typically exceed by far the established Medicaid payment rate for those facilities that receive the payment.

The payment from the State then triggers the Federal match at the State's established matching rate. Such transactions create the illusion of a valid State payment to qualify providers who deliver services to eligible individuals.

In reality, however, this payment is only temporary because it is essentially a round trip transaction. The money does not stay with the provider. Most or all of the payment returns to the State, and once this round trip is completed, the State uses the returned funds to supplant its own share of future Medicaid spending or even uses the funds for non-Medicaid purposes.

Financing schemes such as these undermine the Federal-State partnership in three ways. First, States using these schemes effectively increase the Federal matching rate beyond that which is established in law. It does so by inflating Federal spending while State contributions remain unchanged or in some cases even decline.

Second, there is no assurance that these increased Federal payments are used for valid Medicaid services for eligible individuals on whose behalf the payments are made.

And, third, the schemes enable States to pay a few public providers amounts that grossly exceed the cost of services provided, which is inconsistent with the statutory requirement that Medicaid rates be economical and efficient.

As these questionable practices have come to light over the years, the Congress and the administration have, indeed, acted to curtail them through statutory and regulatory reform. Despite these actions, however, problems persist. For example, as has already been mentioned this morning, the UPL loophole has been reduced, but it has not been eliminated. States can still claim excessive Federal funds for certain classes of facilities, such as county-owned nursing homes. They can still channel all of the funds through one or more facilities in the same round trip transaction as described earlier.

To close this loophole altogether, GAO is suggesting that Congress consider a recommendation that remains open from one of our earlier reports, that is, to prohibit Medicaid payments that exceed actual costs for any government owned facility.

In response to the question that is posed in the title of today's hearing, GAO believes that IGTs can be, they are a legitimate State budget tool when used in the course of fulfilling legitimate governmental functions.

However, IGTs have come to be closely associated with, if not synonymous with, abusive schemes. While the Congress and the administration have acted to address the schemes identified to date, new variations continue to emerge year after year.

Experience shows that some States are likely to continue looking for creative means to supplant State funding, making a compelling case for sustained vigilance. We need to continue to spot and stop the next emergent scheme before it grows to the point of becoming a staple of State funding.

In conclusion, Mr. Chairman, States are, indeed, currently feeling considerable budget pressure as a result of reduced revenues in recent years and increased Medicaid costs. Understandably, many States are quite concerned about the actual or potential loss of Federal Medicaid funding that they have come to rely upon.

The challenge here will be to find the proper balance between States' flexibility to administer their Medicaid programs in accordance with their priorities and the shared Federal-State fiduciary responsibility to manage the program efficiently and economically in a way that ensures the program's fiscal integrity, but also in a way that ensures that public dollars designated for Medicaid beneficiaries are, in fact, spent on their care.

Mr. Chairman, this concludes my prepared statement.

[The prepared statement of Kathryn G. Allen follows:]

PREPARED STATEMENT OF KATHRYN G. ALLEN, DIRECTOR, HEALTH CARE—MEDICAID AND PRIVATE HEALTH INSURANCE ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today as you explore the issue of states' use of intergovernmental transfers in the federal-state Medicaid program. Medicaid finances health care for an estimated 53 million low-income Americans at a cost of $244 billion.[1] Medicaid is the third-largest mandatory spending program in the federal budget and one of the largest components of state budgets, second only to education. The program fulfills a crucial national role by providing health coverage for a variety of vulnerable populations, including low-income families with children and certain people who are elderly, blind, or disabled. Congress has structured Medicaid as a shared responsibility of the federal government and the states, with the federal share of each state's Medicaid payments determined by a formula specified by law. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), is the federal agency responsible for the program, and the states design and administer their programs with considerable discretion and flexibility.

For more than a decade, states have used a number of creative financing schemes to inappropriately increase the federal share of Medicaid expenditures. Intergovernmental transfers, or IGTs, are one of the tools that have enabled them to do so. State and local governments use IGTs to carry out their shared governmental functions, such as collecting and redistributing revenues to provide essential government services. But by using IGTs, states can also transfer funds to or from local-government entities, such as government-owned nursing homes, as part of complex financing schemes that inappropriately boost the federal share of Medicaid costs. In my

[1] Estimated federal-state cost is for fiscal year 2002, the latest year for which data are available.

testimony today, I will (1) describe how some state financing schemes have operated, including the role of IGTs in these schemes; (2) discuss how such financing schemes compromise the federal-state partnership that is the foundation of the Medicaid program; and (3) discuss what can be done to further curtail state financing schemes. My testimony today is based on our prior work assessing state financing schemes and federal oversight of them. We conducted this body of work from June 1993 through January 2004 in accordance with generally accepted government auditing standards.[2]

In summary, for many years states have used varied financing schemes, sometimes involving IGTs, to inappropriately increase federal matching payments. Taking advantage of statutory and regulatory loopholes, some states, for example, have made large Medicaid payments to certain providers, such as nursing homes operated by local governments, which have greatly exceeded the established Medicaid payment rate. These state expenditures would enable states to claim large federal matching payments. Such transactions create the illusion of valid expenditures for services delivered by local-government providers to Medicaid-eligible individuals. In reality, the spending is often only temporary because states require the local governments to return all or most of the money to the states through IGTs. Once states receive the returned funds, they can use them to supplant the states' own share of future Medicaid spending or even use them for non-Medicaid purposes. Because such arrangements effectively increase the federal Medicaid share above what is set under law, they violate the fiscal integrity of Medicaid's federal-state partnership. As new schemes have come to light, Congress and CMS have taken legislative and regulatory actions to curtail them; nonetheless, problems remain. We believe Congress and CMS should continue their efforts to preclude states' ability to claim excessive federal Medicaid payments, and we suggest that Congress consider a recommendation that remains open from our prior work, that is, to prohibit Medicaid payments that exceed actual costs for any government-owned facility.

BACKGROUND

Title XIX of the Social Security Act authorizes federal funding to states for Medicaid, which finances health care services including acute and long-term care for certain low-income, aged, or disabled individuals. States have considerable flexibility in designing and operating their Medicaid programs. Within broad federal requirements, each state determines which services to cover and to what extent, establishes its own eligibility requirements, sets provider payment rates, and develops its own administrative structure. In addition to groups for which federal law requires coverage—such as children and pregnant women at specified income levels and certain persons with disabilities—states may choose to expand eligibility or add benefits that the statute defines as optional.

Medicaid is an open-ended entitlement: states are generally obligated to pay for covered services provided to eligible individuals, and the federal government is obligated to pay its share of a state's expenditures under a CMS-approved state Medicaid plan. The federal share of each state's Medicaid expenditures is based on a statutory formula linked to a state's per capita income in relation to national per capita income. In 2002, the specified federal share of each state's expenditures ranged from 50 percent to 76 percent; in the aggregate, the federal share of total Medicaid expenditures was 57 percent.[3] The Social Security Act provides that up to 60 percent of the state share of Medicaid spending can come from local-government revenues and sources.[4] Some states design their Medicaid programs to require local governments to contribute to the programs' costs.

SOME STATE FINANCING SCHEMES HAVE USED IGTS TO CREATE THE ILLUSION OF VALID MEDICAID EXPENDITURES

For more than a decade, some states have used various financing schemes, some involving IGTs, to create the illusion of a valid state Medicaid expenditure to a health care provider. This payment has enabled states to claim federal matching funds regardless of whether the program services paid for had actually been pro-

[2] See related GAO products at the end of this statement.

[3] In May 2003, Congress passed the Jobs and Growth Tax Relief Reconciliation Act, which appropriated $10 billion for a temporary increase in the federal matching rate for states. This across-the-board increase of 2.95 percent was effective from April 1, 2003, through June 30, 2004.

[4] See 42 U.S.C. § 1396a(a)(2) (2000).

vided. As various schemes have come to light, Congress and CMS[5] have taken actions to curtail them (see table 1). Many of these schemes involve payment arrangements between the state and government-owned or government-operated providers, such as local-government-operated nursing homes.

Table 1: Medicaid Financing Schemes Used to Inappropriately Generate Federal Payments and Federal Actions to Address Them

Financing arrangement	Description	Action taken
Excessive payments to state health facilities.	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration (HCFA) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by states.
Provider taxes and donations ..	Revenues from provider-specific taxes on hospitals and other providers and from provider ''donations'' were matched with federal funds and paid to the providers. These providers could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially barred certain provider donations, placed a series of restrictions on provider taxes, and set other restrictions for state contributions.
Excessive disproportionate share hospital (DSH) payments.	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped both the amount of DSH payments states could make and the amount individual hospitals could receive.
Excessive DSH payments to state mental hospitals.	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to state psychiatric hospitals.
Upper payment limit (UPL) for local government health facilities.	In an effort to ensure that Medicaid payments are reasonable, federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate payment limit for each of several classes of local government health facilities. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.

Source: GAO.

A variant of these creative financing arrangements involves states' exploitation of Medicaid's upper payment limit (UPL) provisions.[6] These schemes share certain characteristics, including IGTS, with other financing schemes from prior years (see table 1). In particular, these arrangements create the illusion that a state has made a large Medicaid payment-separate from and in addition to Medicaid expenditures that providers have already received for covered services-which enables the state to obtain a federal matching payment. In reality, the large payment is temporary,

[5] In June 2001, the Health Care Financing Administration (HCFA) was renamed the Centers for Medicare & Medicaid Services (CMS). We continue to refer to HCFA throughout this testimony where agency actions were taken under its former name.

[6] The UPL sets the ceiling on what the federal government will pay as its share of the Medicaid costs for different classes of covered services and often exceeds what states actually pay providers for Medicaid-covered services. States were able to exploit the UPL loophole by paying nursing homes and hospitals owned by local governments much more than the established Medicaid payment rate and requiring the providers to return, through IGTS, the excess payments to the state.

since the funds essentially make a roundtrip from the state to the Medicaid providers and back to the state. As a result of such round-trip arrangements, states obtain excessive federal Medicaid matching funds while their own state expenditures remain unchanged or even decrease. Figure 1, which is based on our earlier work, illustrates how this mechanism operated in one state (Michigan).[7]

As shown in figure 1, the state made Medicaid payments totaling $277 million to certain county health facilities; the total included $155 million in federal funds and $122 million in state funds (step 1). On the same day that the county health facilities received the funds, they transferred all but $6 million back to the state, which retained $271 million (steps 2 and 3). From this transaction, the state realized a net gain of $149 million over the state's original outlay of $122 million. In cases like this, local-government facilities can use IGTs to easily return the excessive Medicaid payments to the state via electronic wire transfers. We have found that these round-trip transfers can be accomplished in less than 1 hour. The IGT is critical, because if the payment does not go back to the state, the state gains no financial benefit and actually loses from the arrangement because it has simply paid the provider more than its standard Medicaid payment rate for the services. In a variant of this practice, some states require a few counties to initiate the transaction, by taking out bank loans for the total amount the states determined they can pay under the UPL. The counties wire the funds to the states, which then send most or all of the funds back to the counties as Medicaid payments. The counties use these "Medicaid payments" to repay the bank loans. Meanwhile, the states claim federal matching funds on the total amount.

Consistent with past actions, Congress and CMS have taken steps to curtail UPL financing schemes when they have come to light. At the direction of Congress,[8] the agency—then called the Health Care Financing Administration (HCFA)—finalized a regulation in 2001 that significantly narrowed the UPL loophole by limiting the amount of excessive funds states could claim.[9] HCFA estimated that its 2001 regulation would reduce the federal government's financial liability due to inappropriate UPL arrangements by $55 billion over 10 years;[10] a related 2002 regulation was estimated to yield an additional $9 billion over 5 years.[11] CMS recognized that some states had developed a long-standing reliance on these excessive UPL funds, and the law and regulation authorized transition periods of up to 8 years for states to come into compliance with the new requirements.[12] As we recently reported,[13] however, even under the new regulations, states can still aggregate payments to all local-government nursing homes under one UPL to generate excessive federal matching payments beyond their standard Medicaid claims. For example, CMS information about states complying with the new regulation indicates that, through UPL arrangements with public nursing homes and other public facilities, states can still claim about $2.2 billion annually in federal matching funds exceeding their standard Medicaid claims.

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[7] See U.S. General Accounting Office, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government,* GAO/HEHS-94-133 (Washington, D.C.: Aug. 1, 1994), and *Major Management Challenges and Program Risks: Department of health and Human Services, GAO-03-101 (Washington, D.C.: January 2003).*

[8] The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directed HCFA to issue a final regulation to limit states' ability to claim excessive federal matching funds through UPL arrangements. See Pub. L. No. 106-554, App. F, § 705(a), 114 Stat. 2763A-463, 575576 (2000).

[9] Specifically, HCFA eliminated states' ability to combine, or aggregate, LJPLs across private and local-government providers. Before this regulation, a state could claim excessive payments on the basis of the combined amount potentially payable to all private and local-government providers in the state. The regulation established separate UPLs for separate classes of non-state-government facilities (those owned by local governments), including inpatient hospitals, nursing homes, and intermediate care facilities for the mentally retarded, See 66 Fed. Reg. 3148 (2001) (codified at 42 C.F.R. part 447 (2002)).

[10] HCFA's estimate covered UPL arrangements for nursing homes, inpatient hospital services, and outpatient hospital services.

[11] The 2002 regulation reduced the upper limit for local-government hospitals from 150 percent to 100 percent.

[12] The length of a state's transition period was to be based in part on how long the state had had in place a UPL arrangement meeting certain specified criteria. During the assigned transition period—established in 1-, 2-, 5-, or 8-year intervals—excessive UPL payments were to be phased out.

[13] See U.S. General Accounting Office, Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed, GAO-04-228 (Washington D.C.: Feb. 13, 2004).

States' use of these creative financing mechanisms undermines the federal-state Medicaid partnership as well as the program's fiscal integrity in at least three ways.

First, state financing schemes effectively increase the federal matching rate established under federal law by increasing federal expenditures while state contributions remain unchanged or even decrease. For example, for one state we analyzed (Wisconsin), we estimated that by obtaining excessive federal matching payments and using these funds as the state share of other Medicaid expenditures, the state effectively increased the federal matching share of its total Medicaid expenditures from 59 percent to 68 percent in state fiscal year 2001.[14] The state did so by generating nearly $400 million in excessive federal matching funds via round-trip arrangements with three counties. Similarly, the HHS Office of the Inspector General found that a comparably structured arrangement in Pennsylvania effectively increased that state's statutorily determined matching rate from 54 percent to about 65 percent.[15]

Second, CMS has no assurance that these increased federal matching payments are used for Medicaid services. Federal Medicaid matching funds are intended for Medicaid-covered services for the Medicaid-eligible individuals on whose behalf payments are made.[16] Under state financing schemes, however, states can use funds returned to them at their own discretion. We recently examined how six states with large UPL financing schemes involving nursing homes used the federal funds they generated.[17] As in the past, some states in our review deposited excessive funds from UPL arrangements into their general funds, which the states may or may not use for Medicaid purposes. For example, one state (Oregon) has used funds generated by its UPL arrangement to help finance education programs. Table 2 provides further information on how states used their UPL funds in recent years, as reported by the six states we reviewed.

Table 2: Selected States' Use of Funds Generated through UPL Arrangements

State	Use
Michigan	Funds generated by the state's UPL arrangement are deposited in the state's general fund but are tracked separately as a local fund source. These local funds are earmarked for future Medicaid expenses and used as the state match, effectively recycling federal UPL matching funds to generate additional federal Medicaid matching funds.
New York	Funds generated by the state's UPL arrangement are deposited into its Medical Assistance Account. Proceeds from this account are used to pay for the state share of the cost of Medicaid payments, effectively recycling federal funds to generate additional federal Medicaid matching funds.
Oregon	Funds generated by the state's UPL arrangement are being used to help finance education programs and other non-Medicaid health programs. UPL matching funds recouped from providers are deposited into a special UPL fund. Facing a large budget deficit, a February 2002 special session of the Oregon legislature allocated the fund balance, about $131 million, to finance kindergarten to 12th grade education programs. According to state budget documents, the UPL funds are being used to replace financing from the state's general fund.
Pennsylvania	Funds generated by the state's UPL arrangement are used for a number of Medicaid and non-Medicaid purposes, including long-term care and behavioral health services. In state fiscal years 2001-2003, the state generated $2.4 billion in excessive federal matching funds, of which 43 percent was used for the state share of Medicaid expenses (recycled to generate additional federal matching funds), 6 percent was used for non-Medicaid purposes, and 52 percent was unspent and available for non-Medicaid uses. (Percentages do not total 100 percent because of rounding.)
Washington	Funds generated by the state's UPL arrangement are commingled with a number of other revenue sources in a state fund. The fund is used for various state health programs, including a state-funded basic health plan, public health programs, and health benefits for home care workers. A portion of the fund is also transferred to the state's general fund. The fund is also used for selected Medicaid services and the State Children's Health Insurance Program, which effectively recycles the federal funds to generate additional federal Medicaid matching funds.

[14] U.S. General Accounting Office, Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes, GAO-02-147 (Washington D.C.: Oct. 30, 2001), and GAO-04-228.

[15] U.S. Department of Health and Human Services, Office of the Inspector General, Review of the Commonwealth of Pennsylvania's Use of Intergovernmental Transfers to Finance Medicaid Supplementation Payments to County Nursing Facilities, A-03-00-00203 (Washington, D.C.: 2001).

[16] See 42 U.S.C. § 1396 and § 1396d(a).

[17] GAO-04-228.

Table 2: Selected States' Use of Funds Generated through UPL Arrangements—Continued

State	Use
Wisconsin	Funds generated by the state's UPL arrangement are deposited in a state fund, which is used to pay for Medicaid-covered services in both public and private nursing homes. Because the state uses these payments as the state share, the federal funds are effectively recycled to generate additional federal Medicaid matching funds.

Source: GAO.

Third, these state financing schemes undermine the fiscal integrity of the Medicaid program because they enable states to make to providers payments that significantly exceed their costs. In our view, this practice is inconsistent with the statutory requirement that states ensure that Medicaid payments are economical and efficient.[18] Under UPL financing arrangements, some states pay a few public providers excessive amounts, well beyond the cost of services provided. We found, for example, that Virginia's proposed arrangement would allow the state to pay six local-government nursing homes, on average, $670 in federal funds per Medicaid nursing home resident per day—more than 12 times the $53 daily federal payment these nursing homes normally received, on average, per Medicaid resident.[19]

FURTHER FEDERAL ACTION WOULD HELP ADDRESS CONTINUING CONCERNS WITH STATE FINANCING SCHEMES

Although CMS and the Congress have often acted to curtail states' financing schemes, problems persist. Improved CMS oversight and additional congressional action could help address continuing concerns with UPL financing schemes and other inappropriate arrangements.

We recently reported that CMS has taken several actions to improve its oversight of state UPL arrangements, including forming a team to coordinate its review of states' proposed and continuing arrangements, drafting internal guidelines for reviewing state methods for calculating UPL amounts, and conducting financial reviews that have identified hundreds of millions of dollars in improper claims.[20] Starting in August 2003, when considering states' proposals to change how they would pay nursing homes or other institutions, CMS also began to ask states to provide previously unrequested information. The information includes sources of state matching funds for supplemental payments to Medicaid providers, the extent to which total payments would exceed providers' costs, how a state would use the additional funds, and whether a state required providers to return payments (and, if so, how the state planned to spend such funds). As of October 2003, CMS indicated that it had asked 30 states with proposed state Medicaid plan amendments to provide additional information, and the agency was in the process of receiving and reviewing states' initial responses.

We also reported, however, that CMS's efforts do not go far enough to ensure that states' UPL claims are for Medicaid-covered services provided to eligible beneficiaries. Moreover, we remain concerned that in carrying out its oversight responsibilities, CMS at times takes actions inconsistent with its stated goals for limiting states' use of these arrangements. For example, we previously reported that while the agency was attempting to narrow the glaring UPL loophole in 2001, it was allowing additional states to engage in the very schemes it was trying to shut down, at a substantial cost to the federal government.[21] More recently, we reported that CMS's granting two states the longest available transition period of 8 years, for phasing out excessive claims under their UPL arrangements, was not consistent with the agency's stated goals. We estimated that, as a result of these decisions, these two states can claim about $633 million more in federal matching funds under their 8-year transition periods than they could have claimed under shorter transition periods consistent with CMS's stated policies and goals.[22]

In our view, additional congressional action also could help address continuing concerns about Medicaid financing schemes. Although Congress and CMS have taken significant steps to help curb inappropriate UPL arrangements and other financing schemes, states can still claim federal matching funds for more than a public provider's actual costs of providing Medicaid-covered services. As long as states are allowed to make payments exceeding a facility's actual costs, the loophole re-

[18] See 42 U.S.C. § 1396a(a)(30)(A).
[19] GAO-02-147.
[20] GAO-04-228.
[21] GAO-02-147.
[22] GAO-04-228.

mains. A recommendation open from one of our earlier reports would, if implemented, close the existing loophole and thus mitigate these continuing concerns. We previously recommended that Congress consider prohibiting Medicaid payments that exceed actual costs for any government-owned facility.[23] If this recommendation were implemented, a facility's payment would be limited to the reasonable costs of covered services it actually provides to eligible beneficiaries, thus eliminating the possibility of the exorbitant payments that are now passed through individual facilities to states. The Administration appears to support such legislative action; the President's budget for fiscal year 2005 sets forth a legislative proposal to cap Medicaid payments to government providers (such as public hospitals or county-owned nursing homes) to the actual cost of providing services to Medicaid beneficiaries.[24]

CONCLUSIONS

The term "IGTs" has come to be closely associated—if not synonymous—with the abusive financing schemes undertaken by some states in connection with illusory payments for Medicaid services to claim excessive federal matching funds. IGTs are a legitimate state budget tool and not problematic in themselves. But when they are used to carry out questionable financial transactions that inappropriately shift state Medicaid costs to the federal government, they become problematic.

We believe the problem goes beyond IGTs. An observation we made in our first report on this issue in 1994 is as valid today as it was then: in our view, the Medicaid program should not allow states to benefit from arrangements where federal funds purported to benefit providers are given to providers with one hand, only to be taken back with the other.[25] State financing schemes, variants of which have been applied for a decade or longer, circumvent the federal and state funding balance set under law. They have also resulted in the diversion of federal funds intended to pay for covered services for Medicaid-eligible individuals to whatever purpose a state chooses.

Although Congress and CMS have often acted to address Medicaid financing schemes once they become apparent, new variations continue to emerge. Experience shows that some states are likely to continue looking for creative means to supplant state financing, making a compelling case for the Congress and CMS to sustain vigilance over federal Medicaid payments. Understandably, states that have relied on federal funding as a staple for their own share of Medicaid spending are feeling the budgetary pressure from the actual or potential loss of these funds. The continuing challenge remains to find the proper balance between states' flexibility to administer their Medicaid programs and the shared federal-state fiduciary responsibility to manage program finances efficiently and economically in a way that ensures the program's fiscal integrity.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee may have.

Mr. NORWOOD. Thank you very much, Ms. Allen.

Mr. Reeb, you are now recognized for 5 minutes.

STATEMENT OF GEORGE M. REEB

Mr. REEB. Thank you.

Good morning, Mr. chairman and members of the committee. I am here today to discuss intergovernmental transfers of Medicaid funds. We have found that current policies and practices involving intergovernmental transfers severely limit the ability of policymakers to manage, account for, and assess the benefits of Medicaid dollars. These complex fund transfers and financing mechanisms were in some cases designed solely to maximize Federal reimbursements to the States.

Although action has been taken to curb the effect of such practices, significant vulnerabilities remain. States first use provider tax and donation programs to increase Federal Medicaid matching

[23] U.S. General Accounting Office, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government,* GAO/HEHS-94-133 (Washington D.C.: Aug. 1, 1994).

[24] U.S. Department of Health and Human Services, *Budget in Brief FY 2005* (Washington, D.C.: Mar. 1, 2004), http://www.hhs.gov/budget/docbudget.htm (downloaded Mar. 15, 2004).

[25] GAO/HEHS-133.

funds while at the same time reducing the use of State resources in the Medicaid program. The present use of intergovernmental transfers in areas such as nursing homes and hospital upper payment limits and disproportionate share hospital payments have opened new venues for States to employ creative financing mechanisms.

But the consequences of the use of some intergovernmental transfers is the same as the use of tax and donation programs. States' share of cost of their Medicaid programs declines, and the increased Federal Medicaid funding derived from these financing mechanisms is often diverted to commingled accounts where it can be used for purposes unrelated to Medicaid.

Let me first explain programs we noted where the Medicaid regulations allow State Medicaid agencies to pay different rates to the same class of providers as long as the payments in the aggregate do not exceed what Medicare would pay for the services. As you know, this is known as the upper payment limit.

Based on audits in six States that we have reviewed, we have found payments were not related to cost. The facilities surrendered the upper payment limit dollars back to the States. Medicaid dollars were available for use for non-Medicaid expenditures, and Federal funds were used for State matching payments.

In an effort to curb these abuses and insure the State Medicaid payment systems promote economy and efficiency, CMS issued a final rule in 2001 that modified the upper payment limit regulations. These changes have been a positive step, and, when fully implemented, will dramatically limit, though not eliminate, a State's manipulation of the Medicaid program because the regulation still does not require that the enhanced funds be retained by the targeted facilities to provide medical services to Medicaid beneficiaries.

Another source of both benefit and abuse is the Medicaid disproportionate share payments made to financially assist hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients. Our work has shown that some States have diverted these funds by requiring public hospitals to return large portions, upwards of 80 to 90 percent of the payments back to the State Medicaid agencies through intergovernmental transfers.

We believe that return of these funds contradicts the stated purpose of assisting these public safety net hospitals to pay for uncompensated care cost. In some States, the use of the enhanced payments under the upper payment limit regulations and the disproportionate share of program are combined as a method to increase Federal reimbursements.

The possibility exists that all public provider types, especially those who are paid funds above their cost, could be used by States to maximize Federal revenues without insuring that the integrity of the basic Federal-State sharing of Medicaid cost is met.

Three such areas that we presently have under review concern the potential use of intergovernmental transfers in school-based health services, payments to State employed physicians, and hospital graduate medical education programs. Our concern is that these payment types can be used in financing mechanisms which return a portion of the Federal funds back to the State, resulting

in a net gain for the State government while inflating the Federal share above statutory matching percentages.

The administration's fiscal year 2005 budget proposes two actions that would help improve the program integrity. The budget proposes to restrict the use of intergovernmental transfers, and it proposes to limit the Medicaid payments to individual public providers to no more than the cost of providing services to Medicaid beneficiaries.

We have not yet had a chance to discuss these proposals with our Department, but we welcome their efforts to ensure better control over the benefit.

We continue to recommend from our prior reports that the transition periods included in the upper payment limit regulation be shortened, that annual audits be performed by the State's upper payment limit calculations; that facility specific limits be used that are based on the cost of providing services to the Medicaid beneficiaries; that States be required to allow the public facilities to retain the upper payment limit funds that they receive; and that Medicaid payments that are merely returned to the public providers, after and within sometimes the same day, be declared a refund of those payments so that they can be back within the State pool of funds that could be used for true Medicaid services directly.

Our overarching concern is to insure that Federal matching payments are in the proper proportion to State shares and that the funds are used to provide the intended health care services in the intended facility to the intended beneficiaries.

This concludes my testimony. I would be happy to answer any questions.

[The prepared statement of George M. Reeb follows:]

PREPARED STATEMENT OF GEORGE M. REEB, ASSISTANT INSPECTOR GENERAL, CENTERS FOR MEDICARE AND MEDICAID AUDITS

Good morning Mr. Chairman and Members of the Committee. I am here today to discuss intergovernmental transfers of Medicaid funds. We have found that current policies and practices severely limit the ability of the Congress, the Department of Health and Human Services, and State and local governments to manage, account for, and assess the benefits of Medicaid dollars. Some fund transfers and financing mechanisms are designed solely to maximize Federal reimbursements to States and serve to obfuscate the source and final use of both Federal and State funds. Action by the Congress and the Centers for Medicare and Medicaid Services (CMS), through issuance of revised regulations in 2001, has helped to curb the effect of such practices, but significant vulnerabilities remain.

First, I will describe the Federal/State Medicaid partnership and accountability principles. Then, based on audits we have completed over the years, I will summarize some serious problems we uncovered with respect to taxes and donations, enhanced payments to certain health care providers, and disproportionate share hospital payments. I will specifically describe how States use intergovernmental transfers to divert funds away from their agreed upon purpose once the Federal share is received. Finally, I will discuss some newer concerns arising from our most recent work related to school based health services, state-employed physicians, and hospital graduate medical education payments.

THE MEDICAID FEDERAL/STATE PARTNERSHIP

The Social Security Act authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Since the inception of the Medicaid program, the Federal Government, through CMS, and the States have shared in the cost of the program. Each State Medicaid program is administered by the State in accordance with an approved State plan. While the States have considerable flexibility in designing their State plans and operating their Medicaid pro-

grams, they must comply with broad Federal requirements. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid-eligible individuals. The Federal Government pays its share of medical assistance expenditures to the States according to a defined formula, which yields the Federal medical assistance percentage. This percentage ranges from 50 percent to 83 percent, depending on each State's relative per capita income. My testimony deals with practices that distort these Federal/State matching requirements and cause the Federal Government to pay disproportionately more, without a corresponding benefit to the intended beneficiaries.

ACCOUNTABILITY OF MEDICAID FUNDS

Effective use of State and Federal Medicaid funds depends on the consistent application of the following widely-accepted accountability principles:

- There should be assurance that the funds paid are actually used for the intended purposes. For example, if disproportionate share payments (payments to hospitals that provide care to large numbers of Medicaid and uninsured patients) are made, they must be used to reimburse hospitals for their uncompensated care costs.
- The management oversight structure should be adequate to ensure that Medicaid funds are paid only for health care services and products that are appropriate and necessary.
- There should be a clear trail of responsibility within the State as to who is accountable for the proper expenditure of Medicaid funds.
- The State Medicaid agency must ensure that quality and timely healthcare services are being delivered to properly eligible beneficiaries.

Our studies raise serious concerns that some or all of these aspects of accountability are lacking in some State Medicaid programs.

STATE ABUSES OF MEDICAID PAYMENT SYSTEMS

The Office of Inspector General (OIG) has focused considerable audit resources over the last several years on enhanced Medicaid payments made to hospitals and nursing facilities. Although these have proven to be troublesome areas, they are but a continuation of creative financing mechanisms that States began to use extensively starting over 15 years ago.

States first used provider donation and tax programs to increase Federal Medicaid matching funds while at the same time reducing the use of State resources in the Medicaid program. States would either arrange for providers to donate funds to the Medicaid program or certain provider groups would be levied special taxes. States were allowed by Federal regulations to use these funding sources as the State share of Medicaid expenditures. These collected funds were then repaid to the providers by increasing the total Medicaid reimbursement. As the reimbursements were raised, the providers recouped their donations or taxes, and the State could then use the Federal matching funds for whatever purpose it decided. The provider tax and donation programs were generally not about increasing services to Medicaid beneficiaries, nor about improving the quality of care provided to these beneficiaries. Rather, they were carefully crafted financing techniques that allowed States to reduce their share of Medicaid costs and force the Federal Government to pay significantly more.

While both congressional and regulatory action has curtailed most of these problems with taxes and donations, the new uses of intergovernmental transfers in areas such as upper payment limits and disproportionate share hospital payments have opened new venues for States to employ creative financing mechanisms. States' use of intergovernmental transfers in certain ways has the same consequences as the old taxes and donations schemes: a State's share of the cost of its Medicaid program declines; Federal taxpayers in other States pay more than their share of Medicaid; and the increased Federal Medicaid funding derived from these financing mechanisms is often diverted to commingled accounts, where it can be used for purposes unrelated to Medicaid.

I will discuss upper payment limits first.

Enhanced Payments Available under Upper Payment Limits.

The Medicaid regulations allow State Medicaid agencies to pay different rates to the same class of providers as long as the payments, in aggregate, do not exceed what Medicare would pay for the services. This is known as the "upper payment limit." Federal regulations in effect before March 13, 2001, established two separate aggregate limits within a State applicable to each group of health care facilities (i.e., nursing facilities, hospitals, and intermediate care facilities for the mentally re-

tarded). For each group, the first limit applied to all providers in the State (private, State operated, and city or county operated). The second limit applied to only State-operated facilities. There was no separate aggregate limit that applied to non-State-owned public providers, such as city- and county-owned facilities. Therefore, State Medicaid agencies were able to calculate the total enhanced payment (the difference between the regular Medicaid payment and the Medicare payment amount for a similar service) amount to those providers on the basis of all private, State operated, and city or county operated facilities. The entire amount could then be distributed to only city- and county-owned facilities.

Based on audit results in six States, we found that:

- Payments were not related to costs. In general, enhanced payments to city- and county-owned providers were not based on the actual cost of providing services to Medicaid beneficiaries or were without a specific intent to increase the quality of care provided by the public facilities that received the enhanced payments.
- Facilities surrendered upper payment limit dollars to the State. City and county nursing homes and hospitals did not always retain all the enhanced payments that were intended for them. Instead, billions of Federal Medicaid dollars were returned by these providers to the States through intergovernmental transfers.
- Medicaid funds were used for non-Medicaid expenditures. Some of the money sent back to the State governments through use of intergovernmental transfers were deposited in the general fund or earmarked for use in health-related service areas, but not necessarily for the Medicaid services approved in the State plan.
- Federal funds were used for State matching payments. Those funds that were used for Medicaid purposes were used as the States' share to match more Federal funds. That is, Federal funds were diverted from their intended purpose to generate still more Federal funds.

In short, the States' use of intergovernmental transfers as part of the enhanced payment program was only a financing mechanism designed to maximize the Federal share of Medicaid while effectively avoiding the Federal/State matching requirements.

An example of how a State used the upper payment limit rules, in conjunction with intergovernmental transfers, to their advantage is as follows:

> The State creates a State-maintained funding pool to increase reimbursement to county government-owned nursing homes. The State calculates the funding pool by determining the difference between the upper payment limit (based on Medicare payment principles) and the regular allowable Medicaid payments made to all these facilities. The combined total of the differences for all facilities in the State represents the funding pool. The initial source of the State's share of the funding pool is the State's general fund. With the State's share available, Federal matching funds are claimed. The funds in the pool, including Federal and State share, are then transferred to the county providers as a Medicaid enhanced payment. Within a short time frame, using intergovernmental transfers, the nursing facilities return the majority of the enhanced payment to the State.
>
> Little or none of the funds are retained by the nursing facilities for the benefit of their Medicaid residents. The gain from this financing mechanism accrues to the State government, not the Medicaid facilities or beneficiaries. The State commingles the Federal matching funds generated by these enhanced payments with its general fund, in effect making them available for any purpose, including the State share of payments needed to obtain additional Federal funds.

CMS's Actions to Curb Upper Payment Limit Abuses

In an effort to curb these abuses and ensure that State Medicaid payment systems promote economy and efficiency, CMS issued a final rule in 2001 which modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory action created three aggregate upper payment limits—one each for private, State, and non-State government-operated facilities. The creation of a separate aggregate payment limit for non-State government-owned facilities effectively reduces the amount of funds that States can gain by requiring public providers to return Medicaid payments through intergovernmental transfers. The new regulations will be gradually phased in and become fully effective on October 1, 2008.

We commend CMS for changing the upper payment limit regulations. The CMS projected that these revisions would save $55 billion in Federal Medicaid funds over a 10-year period. However, as part of the regulatory changes, CMS increased the enhanced payments that States may pay public hospitals from 100 percent to 150 percent of the amount that would be paid under Medicare payment principles. We

had recommended that the payments continue to be limited to 100 percent, and CMS subsequently took that action at an additional savings of $24.3 billion over 10 years.

These regulatory changes have been a positive step in controlling the States' ability to use financing mechanisms that violate the Federal/State Medicaid partnership agreement. When fully implemented, these changes will dramatically limit, though not entirely eliminate, State manipulation of the Medicaid program because the regulation still does not require that the enhanced funds be retained by the targeted facilities to provide medical services to Medicaid beneficiaries. Thus, Federal funds continue to be vulnerable to diversion, especially through the use of intergovernmental transfers.

OIG's Additional Planned Work Involving Upper Payment Limits

We are continuing our work in the area of States' use of upper payment limit regulations as a financing mechanism to increase Federal reimbursement. Our work is focused on three areas:

- States' adherence to the transition periods under the new regulations.
- Application of the new aggregate limits by States that have just begun to use the upper payment limit funding mechanisms.
- The possible impact on public nursing homes if the funds paid as part of the upper payment limit regulations were left at the facilities rather than being sent back to the States as part of an intergovernmental transfer transaction.

For example, we are currently performing audit work at a county nursing facility in a State that makes enhanced payments to public nursing facilities. During our three-year audit period, $132 million in Medicaid payments was directed to the nursing facility from the Federal Government, the county, and the State, using the upper payment limit provision. The county and State purported to contribute $66 million, generating a matching Federal share of $66 million (the State and Federal matching rate in 50%/50%).

Preliminary work indicates, however, that of the $132 million, the nursing facility retained only $50 million. The remaining $82 million was returned to the county and State through intergovernmental transfers for discretionary use.

Government Payer	Total Payment to Nursing Facility (A)	Amount of Payment Returned to Payer by Nursing Facility (B)	Net Payment (A-B)
Federal	$66 million	$0	$66 million
County	$50 million	$46 million	$ 4 million
State	$16 million	$36 million	($20 million) Gain
Total	$132 million	$82 million	$50 million

As summarized in the table above, the Federal Government contributed $66 million and the County government contributed $4 million towards the care of residents of the nursing facility, while the State was able to make a profit of $20 million.

The nursing facility returned $82 million of the $132 million to the county and State through the use of intergovernmental transfers, despite the fact that during our audit period State surveyors had rated the nursing facility as in immediate jeopardy for a pattern of deficiencies and substandard care that constituted actual harm and required significant corrections. If the nursing home had retained more of its upper payment limit funding, it might have provided better quality of care.

We plan to review additional individual nursing homes as part of our continuing work in the upper payment limit area.

Disproportionate Share Hospital Program

Another financial mechanism that can be the source of both benefit and abuse is known as Medicaid disproportionate share hospital payments. Under this program, enhanced payments are made to financially assist hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients. These payments are important because public "safety net" hospitals face special circumstances and play a critical role in providing care to vulnerable populations.

Our work has shown that the States can divert these funds in ways similar to upper payment limit funds. Audits in two States show that public hospitals, that received disproportionate share hospital payments, returned large portions (80 to 90 percent) of the payments back to State Medicaid agencies through intergovernmental transfers. Here is an example of one of those States:

- During fiscal years 1999 and 2000, the State made disproportionate share hospital payments of approximately $738 million to acute care hospitals.
- Approximately $632 million of the $738 million was transferred back to the State.
- The result was that approximately 86 percent of the total disproportionate share hospital payments were returned to the State via an intergovernmental transfer.

Once payments were returned, the States were able to use the funds for any purpose deemed appropriate. We believe the return of these funds contradicts the stated purpose of assisting these public safety-net hospitals to pay for uncompensated care costs.

In many States, the use of enhanced payments under the upper payment limit regulations and disproportionate share program are combined to increase Federal reimbursements. The financial relationship involves some States allowing hospitals to retain upper payment limit funds but requiring the return of disproportionate share hospital funds through intergovernmental transfers. In other cases, the reverse occurs—hospitals retain disproportionate share hospital funds but return upper payment limit funds.

EMERGING VULNERABILITIES

The concerns we have had with States' use of intergovernmental transfers involving upper payment limit rules and disproportionate share payments extend beyond these areas. We foresee the possibility that all public provider types could be used by States to maximize Federal revenues without ensuring that the integrity of the basic Federal/State sharing of Medicaid costs is met. We are finding areas where States can manipulate Federal financing sources and neglect accountability over the payment of Medicaid funds. One of these areas concerns school based health services.

States are permitted to use their Medicaid programs to help pay for certain health care services delivered to children in schools, such as physical and speech therapy services. Schools may also receive Medicaid reimbursement for the costs of administrative activities, such as Medicaid outreach activities, application assistance, and coordination and monitoring of health services.

We have identified instances where States require the school districts to return a portion of the Federal funds back to the State through intergovernmental transfers, thus resulting in a net gain for the State government.

In addition, we are beginning audit work involving States' potential use of intergovernmental transfers in two additional areas: state-employed physicians and hospital graduate medical education payments. Both of these provider types could be paid an enhanced payment that could serve as a mechanism for inflating the Federal share of payments for Medicaid services above the statutory Federal matching percentage. The additional payment amount made to public providers could then be returned to the State in a mechanism similar to what we have observed in the upper payment limit process at hospitals and nursing homes. Our concern is that any payment above a public provider's cost could become a part of a financing mechanism that would not ensure that the funds were used for the medical care to which they were intended. We have not yet issued any audit reports on these payment areas, but increasingly we are focusing on them.

ENSURING THAT MEDICAID FUNDS ARE USED FOR MEDICAID SERVICES

We are continuing our work in the areas noted above and plan to provide CMS with additional recommendations on how to help ensure that Medicaid expenditures are in fact used for medical care to Medicaid beneficiaries.

The Administration's fiscal year 2005 proposed budget includes two actions that should help improve the integrity of the Medicaid program. First, the budget proposes to restrict the use of certain intergovernmental transfers that are in place solely to undermine the statutorily determined Federal matching rate. Second, the budget proposes to cap Medicaid payments to individual State and local government providers to no more than the cost of providing services to Medicaid beneficiaries. We have not yet had a chance to discuss these proposals with the Department but welcome their efforts to ensure better control of the benefit.

In addition, some recommendations from our prior work involving upper payment limits and disproportionate share hospital payments have not yet been implemented. We believe they should be. Here is a summary of them.

Upper payment limits. The following additional steps are important because the total number of States now making enhanced payments as part of the upper payment limit process has increased in recent years. We have and continue to recommend that:

1. The transitions periods included in the final upper payment limit regulation be shortened since the controls are not in place to ensure that these added funds are actually used for Medicaid health care services.
2. Annual audits be performed of the States' upper payment limit calculations to ensure compliance with the upper limits.
3. Facility-specific limits be used that are based on the cost of providing services to Medicaid beneficiaries.
4. States be required to allow public facilities to retain upper payment limit funding to provide health care services to Medicaid beneficiaries.
5. Medicaid payments returned by public providers to the State be declared a refund of those payments and used to offset the Federal financial participation generated by the original payment.

Disproportionate share hospital payments. We continue to recommend that steps be taken to ensure that disproportionate share hospital funds remain at the hospitals to provide care to vulnerable populations, rather than being returned to the States through intergovernmental transfers. We believe that any Medicaid payment returned by a provider to the State should be treated as a credit applicable to the Medicaid program.

Disproportionate share hospital payments serve an important purpose in trying to help hospitals cover their uncompensated care costs. But, without States being required to leave the funds at the hospitals, there is no assurance that the intended purposes of disproportionate share payments is being met.

CONCLUSION

Our overarching concern is to ensure that Federal matching payments are in the proper proportion to States' shares and that the funds are used to provide the intended health care services in the intended facility to the intended beneficiaries. Changes are still needed to enable the Congress and the Department to be responsible stewards of Federal funds and measure the true cost and benefits of the Medicaid program.

Mr. NORWOOD. Thank you very much, Mr. Reeb.

Mr. Noce, you are now recognized for 5 minutes.

STATEMENT OF WALTER W. NOCE, JR.

Mr. NOCE. Thank you, Mr. Chairman and members of——

Mr. NORWOOD. Turn your mic on, please, or pull it closer.

Mr. NOCE. Thank you, Mr. Chairman, members of the committee, and a particular thanks to Congresswoman Solis for her acknowledgement of the fine work of the caregivers of my institution.

In my remarks today I want to underscore four points. No one has a greater stake in the financial integrity of Medicaid than the providers of the patients assisted by the Medicaid program.

At the same time, no one would be more affected by changes in the Medicaid financing than the enrollees and providers, including the poor children who rely on Medicaid for their coverage and other seriously ill children who rely on Children's Hospitals for their care.

In California, at least, local financing of Medicaid is a longstanding part of the program, and although there are many State and Federal issues that may be discussed around the legitimate ways States reach their Federal match, in the end adequate funding for the program must be provided.

We ask that, as this committee considers possible changes that might experiment with the State or Federal Medicaid matching, it must be balanced with the need for stabilized funding for the providers and enrollees who serve and depend on this program, particularly in these challenging financial times.

A few facts about children's health care. Medicaid is by far the Nation's largest payer of health care for children, despite the fact

that they account for less than 25 percent of all Medicaid spending. More than half of all Medicaid enrollees are children; three-quarters are children and their mothers.

Medicaid pays for the health care of one out of every children, one in every three infants, and one in every three children without special health care needs. Children's hospitals are only 3 percent of all hospitals, but we provide 40 percent of all hospital care for the children in the United States.

We are an indispensable part of the health care for every child, and our ability to deliver these services depends on the Medicaid program. We are major providers of both in-patient and out-patient services. For example, my own hospital provides 85,000 days of in-patient care and more than 285,000 out-patient visits a year. Children's hospitals nationally provide more than 80 percent of hospital care for all children with serious conditions, such as cancer and heart disease.

We train most of the Nation's pediatricians and pediatric specialists and house the leading pediatric research centers. We are major safety net providers for the children in our communities.

At my hospital we are doctor and clinic, dentist, hospital for low income children. We work hand in glove with other community health centers in our area providing staff and taking referrals for children needing specialty care.

Medicaid is by far Children's Hospital's largest payer, but it doesn't come close to reimbursing us for the cost of that care. On average, Children's Hospitals devote nearly 50 percent of their patient care to children assisted by Medicaid. My own hospital has historically been 70 percent, and for this fiscal year we were at 75 percent.

On average, Medicaid pays for less than 80 percent of the cost of patient care provided by a Children's Hospital. At my own hospital, the base Medicaid program pays for less than 70 percent of the cost of in-patient care. This is even worse for out-patient and physician care. We receive slightly over $20 for a clinic visit regardless of the primary care or specialty care that is provided and often mandated by State law.

Disproportionate share payments, DSH payments, which have been at least partially funded through IGTs in States such as mine, have made a vital difference, but we are still underpaid. Even with DSH payments, Medicaid pays Children's Hospitals on average only 84 percent of the costs of the care of the patients that they care for. Without IGTs, the services to children in my State would be dramatically impaired.

In conclusion, please consider that the vulnerable population that Medicaid serves, particularly children and the providers who serve them, when you consider changes in allowable State Medicaid financing, reductions in Federal Medicaid dollars to States inevitably translates into less money for those of us on the front lines, the safety net providers and the vulnerable populations that we serve.

We welcome Federal oversight from Medicaid not only in terms of the integrity of its financing, but also in terms of the adequacy of its payments for providers and its ability to reach the populations it is intended to cover. Providers are already seriously underpaid, and eligible children remain unenrolled. The number of

uninsured children could be reduced by more than two-thirds if all eligible children were just enrolled in the Medicaid and SCHIP programs.

Every year my fellow hospital COs and I face legislative proposals in our States to cut payment rates, eligibility, and benefits for children, and months of uncertainty ensue about the outcome of those proposals. Yet with children representing less than 25 percent of Medicaid spending, and in my State only 17 percent of Medicaid spending, cuts for children's services produce really very little savings.

There may be a number of policy issues around State financing mechanisms, such as IGTs and differences in ways to resolve them, but in the end I would implore you not to make changes that have the unintended consequence of taking dollars away from safety net providers, such as my hospital, and the children who depend on them.

Thank you, Mr. Chairman.

[The prepared statement of Walter W. Noce, Jr. follows:]

PREPARED STATEMENT OF WALTER W. NOCE, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, CHILDRENS HOSPITAL LOS ANGELES, CHAIR, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS

Mr. Chairman, thank you for the opportunity to testify before you today on Medicaid and its financing.

My name is Bill Noce, and I am the president and chief executive officer of Childrens Hospital Los Angeles (CHLA). I also chair the board of trustees of the National Association of Children's Hospitals (N.A.C.H.) in Alexandria, VA.

Founded in 1995, N.A.C.H. is the public policy affiliate of the National Association of Children's Hospitals and Related Institutions (NACHRI). N.A.C.H. represents more than 120 children's hospitals nationwide, including independent acute care children's hospitals, children's hospitals within larger hospitals, and children's specialty and rehabilitation hospitals. N.A.C.H. assists them in fulfilling their missions of clinical care, education, research, and advocacy devoted to children's unique health needs.

Founded more than 100 years ago, CHLA is a not-for-profit pediatric academic medical center. We provide nearly 300 beds for inpatient care, 30 clinics, one of the nation's largest pediatric residency training programs, and one of the leading pediatric research centers to meet children's unique health care needs. We are a regional and national pediatric center for all children and our ability to do all of this depends on the performance of Medicaid.

I am not an expert in designing different ways for states to achieve Medicaid matching dollars. Nor is CHLA, as a not-for-profit private institution, a transferring financing entity. I am, however, an expert in running a hospital staffed by dedicated physicians and other professionals whose sole mission is to provide health care to the sickest children. Unfortunately this has made me an expert in the challenges all children's hospitals face because of the lack of financial stability in the Medicaid program.

Overview: Three Main Points

In my remarks, I would like to underscore three points.

- No one has a more vested interest in the financial integrity and strength of Medicaid than the providers devoted to patients assisted by Medicaid.
- No one will be hurt more by changes in the financing of Medicaid than enrollees and providers, including children's hospitals and the poor children who rely on Medicaid for their health coverage.
- Experimenting with state/federal Medicaid financing must be balanced with the need for stabilized funding for Medicaid and its multiple missions, particularly in challenging fiscal times.

Children's Hospitals Are Indispensable to Children's Health Care

I would like to begin with a quick snapshot of children's hospitals, which illustrates the roles they play in children's health care.

Children's health services, particularly specialty care, are concentrated in relatively few institutions. Only three percent of all hospitals, children's hospitals provide 40 percent of all hospital care for children in this country.

- Children's hospitals are the major providers of both inpatient and outpatient services. For example, CHLA provides more than 85,000 days of inpatient care and more than 285,000 outpatient visits a year.
- Nationally, children's hospitals provide more than 80 percent of the hospital care required by children with serious illnesses, such as cancer or heart disease.
- We train the majority of the nation's pediatricians, virtually all of its pediatric subspecialists, and the majority of our pediatric research scientists.
- We house the nation's leading pediatric biomedical and health services research centers. More than a third of all of the National Institutes of Health's pediatric research funding supports the pediatric research in children's hospitals.
- We are also major safety net providers for the children in our communities. At CHLA, for example, we are doctor, clinic, dentist and hospital for low-income children. We work hand in glove with the community health centers in our area, providing staff and taking referrals for children needing specialty care

Children's Hospitals and Their Services Depend on Medicaid

Medicaid is by far the largest payer of patient care provided by children's hospitals.

On average, children's hospitals devote nearly 50% of their patient care to children assisted by Medicaid. My own hospital devotes 70% of our patient care to patients covered by MediCal—the California Medicaid program.

Every year most of my children's hospital colleagues and I, along with pediatricians, struggle in our states to avoid Medicaid provider cuts or cuts in children's coverage.

Medicaid currently does not come close to paying the cost of the care required for the children it covers. On average, Medicaid pays for 76 percent of the cost of patient care provided by a children's hospital. In my own hospital, Medicaid pays for less than 70 percent of the cost of care. For outpatient primary and specialty care, as well as physician care, the picture is even worse.

Disproportionate share hospital payments, which have been at least partially funded through intergovernmental transfers (IGTs) from public hospitals or hospital districts in some states such as mine, have made an important difference. Even with DSH payments, Medicaid still pays an average of only 84 percent of the cost of care. Without IGTs, I don't know that we would receive even that level of payment.

Children's Coverage Depends on Medicaid

Medicaid serves many missions in the preserving the nation's health care safety net. One mission that is not always recognized is that Medicaid is by far the nation's largest payer of health care for children, particularly very ill children. Children are half of all Medicaid beneficiaries, yet they account for less than 25 percent of all Medicaid spending. On the other hand, two-thirds of Medicaid spending goes to provide services to the elderly and the disable, including very expensive long-term care services.

Mr. Chairman, and other members of the Subcommittee, please keep this is mind as you evaluate the significance and effectiveness of Medicaid spending.

- Children account for more than half of all Medicaid recipients. Three quarters are children and their mothers.
- Medicaid covers one in four children, one in three infants, and one in three children with special health care needs.
- In the most recent economic downturn, two million additional children would have been added to the ranks of the uninsured if it were not for Medicaid.

Why Changes in Medicaid Financing Affect All Children

N.A.C.H. and I want to ensure that all Medicaid dollars are spent on Medicaid-related services and that its financing is sound. But, we urge you to consider any changes in legitimate Medicaid financing in light of those of us "on the frontlines," who will most directly feel the impact of reduced funds.

Medicaid plays such a large role in financing children's hospitals that reductions in Medicaid spending would seriously damage our ability to serve all children, not just children of low-income families, as well as add to the numbers of uninsured children. For example:

- Reductions in Medicaid mean children's hospitals may have to look at longer waiting times for visits to our clinics and emergency departments, as well as potential clinic closings.

- They mean children's hospitals may have to look at the sustainability of highly subsidized services, such as transport services, pediatric dental services, or child abuse prevention and treatment services.
- They mean children's hospitals may have to look at delaying service expansions at a time when the demand for our services is greater than ever.

Conclusion: Work on Medicaid as If It Matters to All Children

In conclusion, I want to emphasize that we welcome your oversight of Medicaid not only in terms of the integrity of its financing but also, hopefully, in terms of its performance for providers and the vulnerable populations who depend on it.

Medicaid's fiscal challenges are, in many ways, directly related to its success in addressing many disparate health care needs in this country. Yet, much remains to be done. In many cases, providers are seriously underpaid. And, we could reduce the number of uninsured children by more than two-thirds thereby insuring almost all children—if all children eligible for Medicaid and the State Children's Health Insurance Program were simply enrolled.

Local funding has had a longstanding role in Medicaid financing in many parts of the country. There may be a number of policy issues around IGTs and federal/state differences in ways to resolve them. But in the end, please don't make changes that have the unintended consequences of removing dollars from the safety net providers that depend on them. Reducing federal Medicaid funds that flow to states will ultimately be felt by providers and enrollees alike.

Although federal oversight of the program is an integral element in the integrity of the financing of Medicaid, it is not time to reduce funding for Medicaid. Remember, fiscally responsible federal oversight and reducing funding for the program are two very different legislative exercises. As with past Congresses, we know you will approach your oversight of Medicaid guided by the needs of its vulnerable populations and the providers who serve them. It will affect the future of health care for every child in this country.

Thank you for the opportunity to testify today.

Mr. NORWOOD. Thank you very much, Mr. Noce.

And I will recognize myself for a couple of questions.

Ms. Allen you made a statement a minute ago that went something like this: prohibit Medicaid payments that exceed cost. That was a recommendation that you had made that is not in place.

Whose cost?

Ms. ALLEN. It would be the facility's cost to provide care, whether it be a nursing home or a hospital.

Mr. NORWOOD. So are you suggesting that the hospital should reimburse for just what it costs the hospital to render the service and not make anything on it?

Ms. ALLEN. We all know that there are different bases for costs, and what is important is that for some public programs, Medicare as well as Medicaid, there are other important public policy objectives that are achieved through the financing of these programs. For example, graduate medical education and safety net hospitals represent additional costs that are important public policy objectives. In both of the current programs, Medicaid and Medicare, those types of costs are considered to be legitimate and valid costs and can become part of the cost basis.

So in this recommendation that we are making, we think that there is still room to consider those other public policy goals and to factor that into the base of cost.

Mr. NORWOOD. If we were to do that, does that put an incentive out there for people to make sure their cost is higher?

Ms. ALLEN. There needs to be a sense of what are reasonable costs, and the factor that is used now in the Medicaid program is that reasonable costs are tied to Medicare payments.

Medicare, as you know, is regulated more at the Federal level than Medicaid is, and so there are certain cost limits in Medicare.

Those limits are used and considered to be reasonable for Medicaid. So in implementing this recommendation, if there were to be reasonable costs established, it needs to be based on a test that is not yet perhaps established.

Mr. NORWOOD. Mr. Noce, is your reimbursement rate in Medicaid anywhere close to Medicare?

Mr. NOCE. No.

Mr. NORWOOD. So Medicaid is a already reimbursing under the top limit of Medicare.

In my practice of dentistry, I see Medicaid patients. Who is going to best determine my cost, me or you?

Ms. ALLEN. A combination, sir. GAO actually looked at exactly that issue a few years ago. In looking at access to dental services, we found that one of the primary barriers to providing care to Medicaid beneficiaries was the payment rate, and what we found was that the closer——

Mr. NORWOOD. Which was determined by the State.

Ms. ALLEN. Which is determined by the State, absolutely. The closer that the Medicaid rate can get to usual, customary, reasonable cost, the higher the provider participation rate will be.

Mr. NORWOOD. I hear what you were suggesting in your statement, and I will not do it here, but all kind of little bells go off in my head if we were to allow you to have that provision that you are suggesting. My observation of it over the years has been simply that there is a whole lot less cheating out there than you think. The problem is that the State and the government reimbursement rates are so low people are just really trying to get by, to make it work so that they can continue to serve that particular patient.

General Reeb, in your testimony, you cited the example of a nursing home that was providing substandard care to beneficiaries, yet the State required the home to pay over $80 million back to the State's IGT. Would this money have been better used to insure that these beneficiaries received adequate care instead of enriching the State budget?

Mr. REEB. Absolutely. What we found was that if the money had remained at the nursing home, the total payments would have exceeded their total costs for that year for all patient types. That is how high the payment amount that was paid to them initially was. It actually exceeded costs for all paying patients, whether it be Medicaid, private patients or whatever.

But the requirement up front was that as soon as they received the money, they had to transfer the bulk of it back, and the money from the Medicaid perspective that remained at the home was Federal money. There was only $4 million out of the $50 million that remained that was actually from county funds. No State funds actually stayed at that nursing home.

Mr. NORWOOD. My time is almost up, but do we do annual audits of every State?

Mr. REEB. As a gross entity? No. The reviews are by a Medicaid agency within CMS that does financial analyses of specific aspects. From an OIG perspective, we audit certain topics like upper payment limits or disproportionate share.

Mr. NORWOOD. So you spot it around to do audits to check things.

Mr. REEB. Yes, sir. There are State audit groups within each State who audit the Medicaid program within the context of the single audit program.

Mr. NORWOOD. When my turn comes up again, I am going to go right back to that. I am curious about how much money out of the system goes into that versus the treatment or care of patients.

Mr. Brown, you are now recognized.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Noce, thank you for being here and for the work you do.

We all hear obviously frequently about State budget problems in your State and my State and pretty much every State in between, and we also hear about the threats to health coverage under CHIP, under Medicaid, other health programs. Talk to us, if you would; give us a little more detail of what this means in California in terms of perhaps caps in enrollment, in terms of cutting coverage. Give us a better understanding of the threats in your State to its health care system.

Mr. NOCE. Well, I think the fiscal problems of our State have been pretty well publicized. We just passed a bond issue to make up for a past deficit, and we hope to work our way out of that. Our legislature has just convened and is starting to debate this next year's budget, and there are several proposals on the table, including cutting provider rates, including putting enrollment caps into the SCHIP program, in terms of caps on Healthy Families. That is our SCHIP. The California Children's Services, which is a State funded program related to children with special needs; capping many optional benefits under Medicaid; certainly cutting physician rates in the States, which of course has the effect of not having people get care because most of the physicians now will not accept Medicaid patients.

We had a study done in my orthopedic department where only one in 50 orthopedists in L.A. County would accept within 2 months' period of time a Medicaid child with a broken arm, but we recalled those same offices with private insurance, and every office could see them within 2 weeks, and that is really the environment that the patients that we serve are dealing with every day.

As the chairman noticed, most of the significant Medicaid providers are simply struggling to get by. I mean, literally every day is figuring out how are we going to meet the demand for our services with the available resources that we have.

Mr. BROWN. Okay. Thank you.

Mr. Reeb, the examples you gave showing billions of Federal dollars in excessive payments going into State coffers has to do with the State following laws and regulations in place before the administration's 2001 regulations. If a State were to follow the current law, the pot of money would be significantly smaller; is that correct?

Mr. REEB. Yes, sir. That is the plan.

Mr. BROWN. So can you tell me under current UPL and IGT law, so not including the payments being made under the transition rules, how much of total UPL money going to facilities is being returned to the State level as opposed to being kept by the facilities?

Mr. REEB. Well, we do not know yet. We asked CMS that question, as a matter of fact, about their tracking of the upper payment

limits under the new regulations. GAO, I believe, in their report tried to make an estimate of how much at the end of the transition period that there might be that is remaining within the upper payment limit process, if you will.

It is going to be an appreciable drop. There has been a $77 billion scoring by CBO of the savings from the 2001 regulation, and then there are various States that are in the 5 year, the 2 year, the 8 year phase-in period. New States are coming in.

The difficulty that we have is in 2008 when they are fully transitioned, the behavior is unknown as to whether a State that presently has a nursing home upper payment limit program could institute a hospital upper payment program. You can have such programs for nursing homes, hospitals, and intermediate care for mentally retarded patients.

So there are State behavior patterns evolving, and we do not know what will happen in several years from now. In present terms, we do not have a number. I defer to GAO, if I read their report properly, as to what it might be in 2008.

Mr. BROWN. Okay. Thank you.

Mr. NORWOOD. Thank you, Mr. Brown.

Ms. Wilson, you are now recognized for questions.

Ms. WILSON. Thank you, Mr. Chairman.

And I appreciate the testimony of the panelists that we have had here today.

Director Allen, you made some comments about diversion or some examples of diversion of funds that were obtained through financing schemes to pay for education expenses in your testimony. Are you aware of other examples and can you be more specific about some of the things you have found where Medicaid dollars through these financing schemes have been used for things other than health care?

Ms. ALLEN. Yes. In our most recent report, which we just released 2 days ago, we were looking at a variety of States, and in this case we looked at six States in terms of how they were using the funds.

The example that you mentioned was from one State that spent about $130 million of its UPL funds to help fund its K through 12 education program, as well as its higher education program. They came down to the end of their budget year, they were out of money, they were looking for additional sources of money, and so they took the Medicaid UPL money to help pay for those functions.

Ms. WILSON. Which State was that?

Ms. ALLEN. That was the State of Oregon.

Another State that we identified a couple of years ago NSO services as an example, although it should have been phased out by now. You see, what States do is they go in with a proposed methodology that explicitly says in this case we are going to pay nursing homes this amount of money. So in this case this State proposed such a methodology. CMS approved it. CMS had no reason to suspect that it was not going to be used for that purpose.

The State then put that money into what it called a senior living trust fund that they wanted to use to help keep seniors out of nursing homes to help them enjoy community-based care and to provide some other services.

These are very laudable goals. However, it was not for the purpose for which it was applied for, which was nursing home payment. That money went into the trust fund and has drawn interest over time. This is not something we have followed up on in an auditing capacity, but it has been reported in the media that in this last budget year that the State borrowed all of that trust fund balance to help balance the State budget.

Now, the State said it will pay it back at some time, but we do not know if that will ever happen.

Ms. WILSON. Which State was that?

Ms. ALLEN. That was the State of Iowa.

In our most recent report though what we saw more commonly was simply recycling of funds; that is, the funds would go back into the State general fund or into a specified Medicaid fund so that it would then supplant the State share of Medicaid spending.

What that does then is to free up State funds for other purposes, and for those we do not have specifics on what those other purposes may be.

Ms. WILSON. Mr. Reeb, you mentioned in your testimony some actions that could be taken to provide greater assurances that Medicaid dollars are used for their intended purpose, and you briefly touched on them in your oral testimony, but I wonder if you could expand on them and which ones you think are most important so that we can make sure that the money gets to health care providers.

And I have tremendous sympathy, particular, Mr. Noce, for your situation, and I have seen it in my State where the providers facing State legislatures are under the gun. I mean, you have very little negotiating power when the Governor or the State legislature says, "We are going to maximize Federal funds, and we are going to come up with a new scheme, and we are going to give you some money, but then you have to give us back some of it."

You do not have a lot of leverage in that situation. You have got to deal with what you have got to deal with, but I see that as really hurting the providers as well, and I am very concerned about it. And you cannot really squeal on it because, you know, they make the rules. They write the bills.

So I have a lot of sympathy for that situation, but again, back to what we can do about it, what are the most important things we could do to make sure that the money for Medicaid gets to health care from your perspective?

Mr. REEB. The way we have come about this is once we looked at the upper payment limit process and the amount of money that becomes available for drawing Federal participation, the difficulty we had was that there was no assurance that the money ultimately is used in health care, or Medicaid especially. That is what it is being paid for. The information needed to be accurate so that you and other policymakers can, in fact, understand the amount actually going to care for the Medicaid population.

So the most important thing to us is, when they say they are going to pay for a particular service to a particular provider for the Medicaid beneficiary, that the money stays there. If the money would stay there, this ties into Ms. Allen's point about cost. We are not looking to lower the cost. Whatever the cost may be, in our

opinion, if you are going to pay the upper payment limit, pay up to that amount; keep it there. But, we found the added money that goes out, the enhanced payment, the profits that could be made, in effect is what then becomes available for the recycling back to the State through the IGT process.

So the important thing to us is to make the money have a trail to it. That, in fact, it stays at the provider level at the point of service, whether it be the Children's Hospital in California or a doctor servicing someone Texas; that it stays there and is used for that intended purpose.

Ms. WILSON. Thank you, Mr. Chairman.

Mr. BROWN. Mr. Chairman, can I ask a clarification on Ms. Allen's response to Ms. Wilson?

Mr. NORWOOD. Will you yield to Mr. Brown?

Mr. BROWN. Just for one short question.

Mr. NORWOOD. Well, you do not have any time.

Unanimous consent for Mr. Brown?

Mr. BROWN. Thank you.

Ms. Allen, the examples you gave, are they still going on or are they generally addressed by the 2001 regulations?

Ms. ALLEN. The Oregon example is a current example. It just happened in the most recent budget year. The example from Iowa should be phased out because they had a 2-year transition period, and that has now expired.

Mr. NORWOOD. Ms. Eshoo, you are now recognized.

Ms. ESHOO. Thank you, Mr. Chairman.

I want to pick up on States being audited. How many have been audited so far?

Mr. REEB. From an IG perspective, we audited initially the upper payment limit process. We audited initially six States. Then, based on that, the information was used as part of the regulation changes. Subsequent to the regulation in 2001, CMS asked us to look at 10 additional States to determine if the transition periods are accurately being carried out. We are in the middle, almost at the end, of doing those reviews. We are looking at six additional States that are brand new States to see whether or not the upper payment limit and intergovernmental transfer processes are improved or are similar to what we found in our original six.

Ms. ESHOO. Now, that is what, 22, 22 States, just a little less than half of the country? What is the plan? Are all going to be audited before changes are made?

Mr. REEB. Not all of the States I do not believe have an upper payment limit process in place.

Ms. ESHOO. How many States?

Mr. REEB. CMS was a little sketchy when we asked them the question. They did not have the data together, but I think it is around 40. That is the impression I have. I am not sure. Perhaps GAO knows better, but not every State has implemented this particular program.

Ms. ESHOO. I do not really know who to direct this question to because there is not anyone from the administration testifying today.

There are two things. It is how the monies are used, but at the other end of this is the administration has proposed $23 billion in

cuts. Now, is there a plan for this? I mean, what is behind the cut? I sit a guesstimate as to what the audits are going to find? I mean, it seems to me that we are trying to back into something having made up our minds what the end result of the problem is.

So have you given any estimates in terms of what can be saved relative to the audits and the misuse of funds?

Mr. REEB. No, ma'am.

Ms. ESHOO. Do we know how each State will be affected with the cuts?

Mr. REEB. I do not have the details and have not been a part of that particular——

Ms. ESHOO. Have you been consulted about any of it, about the $23 billion?

Mr. REEB. Only to the extent that we are aware of the CMS plan to try to increase the oversight in program integrity within Medicaid. They do plan or hope to hire additional financial analysts. What they're trying to do, I believe, as a part of their new initiative is look at the plan amendments that come in from the States in advance, rather than at the back end try to determine what went on. They're trying to scrutinize better up front.

Ms. ESHOO. But does the $23 billion have any relevance to the audits and what you have described?

Mr. REEB. I do not know.

Ms. ESHOO. You do not know.

Mr. REEB. But there are two separate functions of audit work, if you will. We within the OIG are looking at fraud, waste, and abuse. Within the program itself, within CMS they have folks they call——

Ms. ESHOO. Well, I appreciate that. I appreciate that. Given the scarcity of dollars or the strain, which was described so well by Mr. Noce, is that, you know, every dollar counts. We have a shortage of dollars in the system given the needs. Now we're looking for how we can make better use of the dollars because we do not want any of them wasted or abused or to plug up other holes in State budgets. This is for health care.

But we also have a proposal from the administration for $23 billion in cuts. That is why I am asking the question. Is there a nexus between your work in the audits and what you believe can be saved, given what this testimony is about?

Mr. REEB. We do not——

Ms. ESHOO. Is there a relationship between the two? Have you given any estimates to the administration or been asked to do that?

Mr. REEB. No, ma'am. No, we have not.

Ms. ESHOO. So we do not know how it is going to affect the States. We do not know where the $23 billion has come from. it does not seem to be tied to the whole issue that we are here for today, which is a legitimate one.

I am very resentful of any State that would abuse the funds because in California we have done, excuse the expression, a damned good job with the dollars. We have done it honestly and we take very good care of people.

Mr. Chairman, I think that this points to something, and that is that we need to have yet another hearing on this, and we need to have the administration here to give testimony as to, you know,

what the plan is in writing relative to the $23 billion proposed cut, and if, in fact, there is a nexus to what the issue of this hearing is about today.

Mr. NORWOOD. Ms. Eshoo, I think that is a great idea. We will do that in 3 weeks.

Mr. Buyer, you are now recognized.

Mr. BUYER. Mr. Reeb, I would like to know whether or not there are any examples, or to any of the witnesses, examples of substandard care to patient beneficiaries by these State schemes to enrich their budgets. Did you find any examples to any particular nursing homes or hospitals?

Mr. REEB. Yes, sir. Within the OIG work, we had the example of the nursing home that, in fact, received sufficient funds from Medicaid that would have covered their total cost to operate the home. However, the money that they were required to transfer back to both their county and to the State dropped them below the amount of money that they needed to cover their cost. In fact, the home had been cited in the most severe category for bad care. It seemed to us that the budget for nursing care, the number of nurses in that particular home, had they been able to keep the funds, at least they would have had money available to perhaps increase the on board strength of nurses up to the level that they wanted to budget.

Mr. BUYER. Mr. Reeb, with regard to DSH, Congress created these payments to assist the safety net hospitals with the paying of cost for uncompensated care. You cited an example of a State where hospitals are required to pay 86 percent of the total DSH payment back to the State.

Doesn't this type of kickback directly contradict and undermine the intent of Congress in creating these types of payments?

Mr. REEB. It is definitely a problem. The DSH payments are supposed to be related to the cost of the uncompensated care. We have performed audits where we have found both the individual providers and the States have paid monies above the cost for the individual providers, and at the same time others where the money went out that equaled the uncompensated care costs, but they were required to intergovernmental transfer it back. So the purpose of the DSH funds to actually be at the point of service for uncompensated care is a mixed bag as to how well is it working.

Mr. BUYER. In Indiana I am aware that when DSH payments go back to the State, they sit down and they negotiate then what percentage will be identified as administrative costs, and some of the percentage can be very high. So the actual dollars that end up going to help hospitals is shocking.

Do you find that other States are not passing these DSH payments on to the hospitals?

Mr. REEB. Well, they have to be paid initially in order to be able to bill CMS for the Federal participation amount. Once the funds are returned, anything can be done with them; and, regarding the basis of cost, it is not outlined as to how much administrative cost is allowed.

Mr. BUYER. Let me ask you this. What if Congress proposes to say that no State can withhold DSH payments, say, only 5 percent for administrative costs? I mean if we actually came in and said

it and began to hammer the States, does that make a little more sense?

Mr. REEB. Well, I think so as an auditor, from the standpoint that you are trying to separate the cost to try to get better accountability and better control to know what is going on.

We have made similar recommendations in managed care programs, for instance, in Medicare, setting a limit for how much administrative costs could be. I am not aware, at least in the Medicaid program, where any such limits are mandated, but it would be an improvement.

Mr. BUYER. It would be prudent for Congress to consider setting a percentage for which a cost for administrative expenses for a State. It is worthy of our discussion.

Mr. REEB. Yes, sir.

Mr. BUYER. You concur.

Mr. REEB. Yes, sir.

Mr. BUYER. Let me ask Mr. Noce. The GAO gave this recommendation that Congress consider to prohibit Medicaid payments that exceed actual cost to any government owned facility. Do you think that is a good idea?

Mr. NOCE. I think it is a question of the accounting rules for what accounts for costs, as we were talking about before. I think if we are talking about providing cost of care, I, for one, would vote for having a mandate that all Medicaid providers have to have their costs reimbursed.

Mr. BUYER. Boy, this is a really simple statement. Let me see. To prohibit Medicaid payments that exceed actual cost to any government owned facility. Do you have a problem with that?

Mr. NOCE. Well, in all honesty, I am not in a government owned facility, but my——

Mr. BUYER. But I am asking for your opinion. You have come here as a witness.

Mr. NOCE. My understanding is that there are some accounting rules that move money back in and out. So they have to count for revenue that really is not on their cost. I am most familiar with Los Angeles County, and I know the net dollars that they receive is not anywhere close to their cost either.

And I can only speak for the experience in my State, but the public facilities——

Mr. BUYER. You have never been an administrator of a publicly owned facility?

Mr. NOCE. I have not.

Mr. BUYER. All right. Thank you.

Mr. NOCE. But I observe the one in my county, and I can assure you that they are not getting net Medicaid costs above their real costs of providing care for the patients that they serve.

Mr. BUYER. Ms. Allen, have you examined Indiana?

Ms. ALLEN. No, sir, we have not.

Mr. BUYER. All right. I look forward to having a sidebar conversation with you. Okay?

I yield back my time.

Mr. NORWOOD. Is the gentleman yielding back?

Mr. Waxman is recognized for 5 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman.

I am going to ask Ms. Allen. There seems to be general agreement that when the upper payment limit regulations are fully implemented that most of the identified problems with drawing down excess funds will be eliminated. I recognize that during the transition period this will not be fully assured.

However, I think most of us remember there was a good reason to have a transition period. If States had used a system that relied on such payments for a long period of time to support critical health care services, it was recognized that changing the rules overnight would cause a great deal of disruption and, indeed, loss of services by some very vulnerable people.

The Inspector General recommends in their testimony that the transition periods be eliminated. Do you agree with that?

Ms. ALLEN. Mr. Waxman, I think the GAO would agree with the points that you just laid out, that we do believe that those States that have incurred costs over a long period of time, those that have developed a longstanding budgetary reliance do deserve the opportunity to phase that out over time. It is important so that that will not be detrimental to the beneficiaries being served.

Now, that is assuming that the money is going to the beneficiaries. At the same time, however, even if the States were using those funds to supplant State funding for other important State activities, I don't think that it would be prudent to create immediate harm to those either. So we would endorse transition periods.

Having said that, in the report that we just issued 2 days ago, we did make a recommendation to CMS that for two States that were given an 8-year transition period we saw no basis for that, and recommended that those be reduced to something that would be more in keeping with when they, in fact, did establish their mechanisms because they had not established long-standing budgetary reliance.

Mr. WAXMAN. The original concept behind the transition period was to give a longer period to States that had the system in effect for years and years. To me that makes a lot of practical sense, especially since this was part of the negotiation with them.

I was interested in your conclusion that in certain cases the program of intergovernmental transfers was approved almost simultaneously with the new regulations, and yet an 8-year transition was granted. I believe that was the case in Wisconsin.

Will you tell us a little bit more about what happened there?

Ms. ALLEN. Yes. Actually there were two States that were very similar in terms of the timing. Those two States were Wisconsin and Virginia.

HCFA, the predecessor to CMS, had been notifying the States for some time, beginning in the year 2000, that they were going to bring a halt to these practices. A letter had gone out in the summer of 2000 announcing this and suggesting that States not put forth anymore proposals.

There was a proposed rulemaking in the fall of 2000 in which the Congress acted through BIPA, the Benefits Improvement and Protection Act, to compel CMS to finalize that regulation and put it in place.

HCFA did implement the regulation in January 2001. The regulation was to take effect in mid-March. I think it was about March 13.

In February of that same year, Wisconsin came in with a proposal that was much larger than anything it had in place before, and CMS ultimately approved that because it concluded that it was linked to a payment mechanism that had been in place many years prior.

Our conclusion, though, was that these were two very different proposals that really were not similar to each other, and we concluded that approving that was really not justified.

Mr. WAXMAN. As I understand it, the additional Federal funds drawn down from intergovernmental transfers from county owned nursing homes in Wisconsin are used both to pay the bad debt in public nursing homes and also provide more community care for people with disabilities as an alternative to nursing homes.

I think the same is true in Iowa, and it is also my understanding that such community care expansion is an explicit provision in the Louisiana UPL State plan amendments. If all money paid to nursing homes was required to be retained by the nursing homes, what would become of the community care programs?

Ms. ALLEN. There could be an impact. If that money now is being diverted to community based care, there could be an impact, and that would be unfortunate because many people are trying to increase the supply of community based services.

But from a purist point of view and from where we sit at the General Accounting Office, we believe that the purposes for which the money is approved and designated should be the purpose for what it is used. If there is a desire on the part of States to use it for a different purpose, let's be straightforward and do it that way.

Mr. WAXMAN. Thank you.

Thank you very much, Mr. Chairman.

Mr. BILIRAKIS. All right. What is the gentleman's pleasure? Would you like to get a comment from one of the others?

Mr. WAXMAN. If anybody else wants to comment, that is certainly fine. I had another question, but I also have no more time.

Mr. BILIRAKIS. All right. Thank you.

Mr. WAXMAN. But if anybody wants to comment further on the questions that I asked.

I do want to welcome Mr. Noce.

Mr. NOCE. Thank you, sir.

Mr. WAXMAN. He has been a long time leader in health care in Los Angeles and is very eloquent about why we have to be concerned about what the impact will be on public and Children's Hospitals.

Mr. BILIRAKIS. Thank you, Mr. Waxman.

Mr. Greenwood is recognized for 5 minutes.

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

Ms. Allen, in your document, there is a headline "State Abuses of Medicaid Payment Services," and under that category do you have an order of magnitude of what you think the Federal overpayments to those States who are abusing the Medicaid payment system is or are?

Ms. ALLEN. We have relied on CMS' estimate by closing the loophole, the upper payment limit loophole in the year 2001.

Mr. GREENWOOD. That is $55 billion over 10 years.?

Ms. ALLEN. That is the $55 billion over 10 years.

Mr. GREENWOOD. But that is just one form of abuse.

Ms. ALLEN. That is correct. The one that we have also talked about today, DSH, and I think Mr. Reeb would agree with this, has greatly diminished because part of the reforms to DSH back in the 1990's was to also institute facility specific caps, and I believe that the work that the IG has done would show that less of the money is going back to the State. More is staying with the hospitals, which is another endorsement of the proposal to consider having facility specific caps.

But in direct answer to your question, we do not have an estimate of——

Mr. GREENWOOD. Because there are certainly other mechanisms besides UPL and DSH. There is the whole notion of provider specific taxes or contributions——

Ms. ALLEN. Yes.

Mr. GREENWOOD. [continuing] held up as a match and then returned to the provider. Do you have any estimate of how big a problem that is?

Ms. ALLEN. Not on that yet, sir. We know that that is a growing practice. We know that more and more States are submitting applications. We are beginning to get phone calls from States and from other representatives who are concerned about it, but we have not yet devoted any work effort to that.

Mr. GREENWOOD. Mr. Reeb, do you have any ballpark figures on these numbers?

Mr. REEB. No. I agree with Ms. Allen. We have also been receiving the calls. There seems to be congressional staff interest in taxes and donations.

Mr. GREENWOOD. How about the trend rates? You make reference, Ms. Allen, to the last 15 years, I think. Is this a growing problem?

You say the DSH is diminishing, but do you have a sense as to whether the excess payments to States or the abuses is a growing phenomena?

Ms. ALLEN. I would say that it goes in cycles. When the pattern began with provider taxes and donations in the early 1990's, that grew exponentially, and then it was capped. Then it was DSH. It grew exponentially. Between 1990 and 1992, DSH grew from about $1 billion to $17 billion in 2 years.

Through UPL, which has been in recent years, again, it took off, but that has been diminished. You bring up the issues of provider taxes and donations. That could be one of the next ones. We believe that CMS is keeping an eye on it, but we do not yet know exactly the details of how that is progressing or not.

Mr. GREENWOOD. You talked about the idea of payments exceeding costs and the recommendations to make sure that doesn't happen. Could you just give us a specific example of how that could happen?

How does payment for a particular service come to exceed the actual cost?

Ms. ALLEN. I will give you a very specific example. One or two States went in for approval, again, for a very clear methodology about how they wanted to reimburse nursing homes, laid it out. Essentially it said, "We would like to pay our nursing homes up to what Medicare would pay." CMS approved that.

What a couple of the States did then was to funnel all of that money just through 5 or 6 nursing homes. We have two examples. In one State the Federal payment per day for six nursing homes went from $53 a day——

Mr. GREENWOOD. Six hundred and seventy, right?

Ms. ALLEN. Six hundred and seventy.

Mr. GREENWOOD. I read your testimony.

Ms. ALLEN. Exactly. But that money did not stay there. It was returned.

In another case, it went——

Mr. GREENWOOD. So let me understand that. Why did they do that? Why did they just do that with 6 or 7 facilities?

Ms. ALLEN. Because those are the counties that agreed to participate in that scheme. You know, it is very interesting. It is my home State of Virginia, and I was very aware at the time of things that were going on in Richmond about this. The State had a very difficult time getting any county or municipality to participate. They were practically begging, and only one or two counties ultimately would agree to do it, and then there are only so many county nursing homes.

So they chose that as the conduit for channeling the money that then just went back to the State.

Mr. GREENWOOD. What would be the methodology if we were to enact that recommendation to determine what the costs actually are? Do you use Medicare? I mean, is that the standard that you recommend?

Ms. ALLEN. That could be one basis, but as we also talked about, there are other policy goals that we might want to make sure that are included as part of the costs in terms of safety net hospitals that might have additional costs, GME costs, for example.

I think it would require some work to develop that.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Ms. Capps for 8 minutes.

Ms. CAPPS. Thank you, Mr. Chairman.

Mr. Noce, I have a question to ask you, but since I did not make an opening statement, I want to make a couple of remarks that I wanted to make just to set the stage for that. It has often been remarked that the measure of a civilization can be determined by its desire and its ability to care for its most vulnerable people. Surely if there is any population that fits that category it would be the Medicaid population.

Now, our President's budget cuts $23.5 billion over the next 10 years in health care. These are to be authorized by this committee, and I'm a member of the budget committee as well, and it was acknowledged by the administration in setting the case for their budget that it would be expected that these cuts would come from Medicaid.

As we prepared our budget for consideration by the full House yesterday, I introduced an amendment to eliminate these cuts in Medicaid to offset them with cutting in half the tax cut to the millionaires. I appreciated the support of many professional groups, provider groups, Governors, some groups that are represented here in our audience today, a wide range, not just Children's Hospitals. Believe me, it's a cross-section of those who provide services to the Medicaid population.

My goal in listening to you all and in coming to terms with what the desires are with the intergovernmental transfer situation is that we be careful not to throw the baby out with the bath water.

But I want to, Mr. Noce, give you a chance to comment further. As you were making your presentation I was rather nostalgic for a former budget chair, a member of the House from Ohio, Mr. Ocasek, who was considered a budget hawk, but when his twin babies were born prematurely, he had first hand experience with the Children's Hospital, and he authored legislation, which I was happy and honored to co-author with him and co-sponsor to substantially increase the funding base for Children's Hospital. He felt that they were so disproportionately or under funded in all the ways that they provide services in the high percentage of their patients who are Medicaid patients.

Now, I know that California hospitals depend on this money to support the health care system, and I was hoping you would be able to kind of look into the future if we do make these drastic cuts in this time of economic disparity. Can you foresee how you will continue, not you personally as much as those you represent here on our panel today?

What would it be like to have to really drastically scale down both for your providers and also particularly for those who are recipients of the care?

Mr. NOCE. Well, first I would need to say that our experience in California is that we do not participate in any of these types of programs that we have just heard about.

Ms. CAPPS. I see.

Mr. NOCE. But what our concern is is that regulation sometimes is a shotgun rather than a rifle, and if the consequence of that was intergovernmental transfers in its entirety were eliminated and, therefore, the funds that currently flow into California were eliminated, it would have—and I am not really saying this for dramatic effect for this committee—but for my hospital I already project because of some unique mandates in California, government rights to seismic safety and minimum nurse-staff ratios and other things. We are looking at a projected $25 to $30 million loss for the next several years.

I get $35 million from these intergovernmental transfer type funding vehicles.

Ms. CAPPS. Now, can I jump in?

Mr. NOCE. Sure.

Ms. CAPPS. This loss that you are projecting, is that before we get to something that we might do in the future?

Mr. NOCE. Yes, that is with that included. The loss would jump to $60 to $70 million. We cannot cut or scale down. We have actually had discussions with my Board leaders. We do not believe that

we could survive as an institution, and although we have not made a decision on this because nobody wants to face up to it, if I am interpreting the discussion, we would, in effect, close our hospital. We would become a pediatric research facility, and we would offer to lease the hospital to a public entity to wanted to run it because as a private hospital, we cannot sustain losses of $60 to $70 million. We would run through our cash in a couple of years.

And, you know, that is obviously an assumption that that money is not replaced from some other source, but we do worry about that from a regulatory point of view. By the time the consequences are actually known through the process, it is too late for any individual provider.

Ms. CAPPS. And you had mentioned in one of your responses that a pediatric orthopedic patient who is receiving Medicaid sometimes waits how long?

Mr. NOCE. Well, essentially they do not get care at all.

Ms. CAPPS. We are talking about the United States of America.

Mr. NOCE. In some specialties, except for community clinics, a few safety net providers, the physician's offices do not take them. I mean the payment rate in California is 50 percent to 60 percent of Medicaid rates, and if the State, as is proposed now, is cutting them even more, it just simply will not take Medicaid patients into their practices.

Ms. CAPPS. What would a young person, a child with an orthopedic problem, a Medicaid patient, what would that family do in Los Angeles?

Mr. NOCE. They come to an emergency room of a safety net provider, Los Angeles County, my hospital, a couple of the others that were mentioned, White, California Hospital.

Ms. CAPPS. But if they have some congenital deformity or some kind of spina bifida or something that really needs specialized care over a long period of time, what is the outlook?

Mr. NOCE. Well, then you are looking at two or three of us who have the capability to do that, and that is, frankly, our concern about some of this discussion, is you do not have to make very many changes. There are so few providers who provide for some of these populations that if the effect is to damage those few providers, and that is way downstream from what you were talking about in this committee, we literally would have no providers left to care for those types of patients.

Ms. CAPPS. And some of these projected cuts you are seeing even without what we are anticipating doing here. Just given the situation both in California, but also with our economy and with some other hardships or difficulties that many providers are experiencing with some of our government programs.

Mr. NOCE. Yes, even with this funding flow, our State is currently considering enrollment caps on various programs, cutting physician rates. So this population is already at increased risk without this discussion.

Ms. CAPPS. I am almost out of time. I wondered if either of the other two would want to comment on this.

Mr. REEB. We happen to have done an audit of the DSH program in California, and the difficulty that we had was that, in rough numbers, about $2.5 billion was paid, and $549 million went to pri-

vate hospitals, such as Dr. Noce's, and the money that went to the public hospitals was intergovernmental transferred back to the counties. In net, just using mathematics of the total amount of money, the only money that stayed at public hospitals and private hospitals was Federal money. The State's share was coming back to the County.

So that Federal net amount went out. If, in fact, the hospitals that handle the indigent care patients need more funds, from our reviews of California, there is an opportunity there for the State funds to remain at the provider level as well.

Mr. BILIRAKIS. The gentlelady's time has expired.

The Chair recognizes himself in spite of the fact that the staff here did not want me to.

Mr. Green, I want you to know he favors you. He wanted me to go to you rather than to myself.

Mr. GREEN. Well, thank you, Mr. Chairman, but I will be glad to wait my turn.

Mr. BILIRAKIS. Mr. Noce; is that correct, Noce?

Mr. NOCE. That is correct.

Mr. BILIRAKIS. Of course, you would prefer that all of the Medicaid dollars that are intended to go for Medicaid treatment for patients go for that purpose, would you not?

Mr. NOCE. Yes.

Mr. BILIRAKIS. And you have heard some of the schemes here, and God knows over the years, and it is not just Medicaid dollars, but DSH dollars. We have had over a period of time hearings on, if you will, the diversion of a lot of DSH dollars to highway projects and States and whatnot.

So you would prefer all of those dollars to go the way they are intended to go; isn't that correct?

Mr. NOCE. Yes.

Mr. BILIRAKIS. All right. The President, in the process of, as Ms. Capps says, reducing Medicaid funding, is concerned about the intergovernmental transfers. We, of course, are the ones who determine what the ultimate budget is going to be here. It is recommendations made from every White House, and we will determine. I would like to think that hopefully some way that the Medicaid collars are intended to go to the States for our use for those particular purposes rather than turn out some of these schemes that they place, and I might add, even though it is not the subject of this hearing, the DSH dollars, because that has concerned me over the years.

So would you agree with me that some of these schemes that we are talking about do endanger Medicaid beneficiaries by taking millions of dollars away from providers that are financially vulnerable and some that are already providing substandard care?

Mr. NOCE. If you mean by schemes that are taking and building roads and those types of things.

Mr. BILIRAKIS. Exactly.

Mr. NOCE. I absolutely would agree with that.

Mr. BILIRAKIS. Absolutely. Well, I think that is really our purpose here now more than anything else. You know, I do not disagree with Ms. Capps or others in this regard, but I think that for us to be encouraging, I hate to use the word when we are talking

about vulnerable beneficiaries, but cheating here is a terrible way to go.

If California, Florida, et cetera, et cetera, does not have enough Medicaid dollars, I think we should address those situations and do it in a legal way where we change the formulas or whatever the case might be there rather than to encourage intergovernmental transfers so that they are getting additional dollars, whether it be used for Medicaid or whether it be used for other purposes, you know, in a way that it was not intended.

The existing Federal-State Medicaid partnership is a good one. Should, in fact, that be breached by virtue of allowing schemes to take place so that people can get, you know, additional dollars, I think we ought to look at it straight, just there are not enough dollars going to these particular things. It is a change of proportion, I guess is what I am saying, because the proportions vary, as you know. They vary, California, Florida, from West Virginia and so many of these other poorer States.

So we are all agreed that many millions are diverted from Medicaid use, correct, Ms. Allen?

Ms. ALLEN. Yes, that is correct.

Mr. BILIRAKIS. Correct Mr. Reeb?

Mr. REEB. Yes.

Mr. BILIRAKIS. And we are all agreed, are we, that these schemes disadvantage States if played by the rules and who consequently pay a greater share of Medicaid expenses? They are disadvantaged, are they not?

Mr. NOCE. Yes, sir.

Mr. BILIRAKIS. What should we do about it, if anything? Mr. Noce, what should we do about it? Should we just leave things as they are?

Mr. NOCE. Well, I would be in support of very targeted regulations that would make sure that those abuses do not occur. I mean, the caution that I would raise would be I have seen regulation that is so broad that it has the effect of unintended consequences where there is no abuse and takes money away from those that really need it.

Mr. BILIRAKIS. Amen to that.

Mr. NOCE. But I would be very much in favor of targeted regulation to prevent taking Medicaid dollars that are in too short supply and filling other needs of a State such as building roads.

Mr. BILIRAKIS. Wouldn't you feel better about getting the dollars that you fill your hospital needs in a way that is the result of an existing Federal-State Medicaid partnership in terms of the proportion of dollars that come from the Federal Government to the State and whatnot, rather than depending upon, you know, some intergovernmental transfer type schemes that get you additional dollars? Wouldn't you be more comfortable with that?

Mr. NOCE. Well, at least——

Mr. BILIRAKIS. Or would you rather have the money no matter how you get it?

Mr. NOCE. You know, in the end that is the bottom line.

Mr. BILIRAKIS. That is the bottom line.

Mr. NOCE. But I would certainly be in favor of something that is stable and predictable. That is part of the problem with Med-

icaid, is that it is, from a provider point of view, it is very unpredictable about how much you are actually going to get. At least in our State, we do have a tradition of local and State sharing for some of our health care programs of long standing, but I certainly would be in favor of a simplified, predictable funding scheme that providers knew how much it was going to be and we could rely on it.

Mr. BILIRAKIS. Yes, and you would not have to depend upon some sort of a creative way to get those needed dollars, correct?

Mr. NOCE. Well, I am on the receiving end.

Mr. BILIRAKIS. Well, you would rather not have to depend upon that.

Mr. NOCE. You are exactly right. I would prefer not to come back and have to talk with you about 16 different ways that the program could be funded.

Mr. BILIRAKIS. Ms. Allen, any comments?

Ms. ALLEN. In response to your question about what can we do, I will come back to the recommendation that has been open for a while. We believe that if we were to focus on what facilities' costs are and reimburse them on a fair and reasonable basis, that will largely take care of that, of the problem we are talking about today.

As long as States are able to aggregate pools of money across facilities and channel them through a few facilities, we will continue to have this abuse, but if you try to pay for services in individual facilities who are caring for individuals, then everyone should come out ahead.

Mr. BILIRAKIS. Mr. Reeb.

Mr. REEB. Yes, we look for accountability. The present process allows for a distortion of how much really is going to serve Medicaid beneficiaries. So, if you could get a direct link and an audit trail, whether you want to have audits performed or not, someone can, in fact, track the fact that you paid for a Medicaid beneficiary for a particular service at a particular provider, and the money stayed there for that service.

Mr. BILIRAKIS. Well, thank you, Mr. Reeb.

I was not here at the outset of the hearing. I do want to welcome you and to thank you for taking time to be here at our invitation. I was tied up on a State Department matter, if you can believe it, but in any case, I do welcome you and thank you.

And I would now recognize Mr. Green for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. Reeb, in my opening statement I referenced nine urban hospitals throughout Texas, through IGTs provide the State portion of the Medicaid funding for the disproportional share allotment. Using IGTs, Texas is able to draw down the additional $504 million in Federal funds for a total of $840 million.

These funds are then redistributed back to these nine public hospitals, but also to 87 rural hospitals, 64 other urban hospitals, and seven Children's Hospitals. One hundred percent of the funds are returned to these hospitals to assist them with their uncompensated care cost.

Is there anything you could see that could be illegal or troubling to you about this arrangement?

Mr. REEB. No, we would not have a problem. In fact, we audited the disproportionate share of payments in Texas a couple of years ago. We do not have a problem with the fact that the State's share is funded through a relationship with a county. That is certainly up to the State and local governments to work that out.

It is only on the back end, after payments are made. If the funds do not remain at the provider level where the services are being rendered, the distortion that is then created by sending that money back to the general funds is what we have a problem with.

Mr. GREEN. Okay. So you do not have a problem with that. In all honesty I disagree philosophically, but having served 20 years in the legislature before I got here, we beat our head against the wall there to try and get additional State money, but it is the system that we have developed, and like a lot of urban areas and rural areas that need assistance, it is one that is at least providing it.

Does CMS advocate that IGTs should be eliminated altogether?

Mr. REEB. I would not want to speak for them.

Mr. GREEN. You do not know.

Mr. REEB. No, sir, I do not know.

Mr. GREEN. And I appreciate your comment about the auditing, and again, if there is a problem of IGTs and it is broken, let's fix the problem instead of just throwing out the whole issue.

Ms. Allen, the question of block granting is the solution to the fraud problem I have is that block granting would not eliminate problems that I think identify. Many of us are concerned about proposals coming out of the administration for block granting Medicaid programs and capping Federal funding for Medicaid which shifts the burden of the program onto the States who could not possibly absorb such a cost shift.

And, again, using my own example in Texas, the State provides very little in funding for it, and yet we are going to give elected officials the authority to decide on it. I would seem like it would be much better to change and instead of changing the fundamental nature, it would jeopardize coverage for a lot of folks.

And I have heard people suggest that these problems being discussed today show that the Medicaid program is out of control and must be curbed. Therefore, we need to block grant it to insure the integrity. I am concerned about block granting because I know over the years if your goal is to insure integrity, that may not be the best way to do it. You are transferring the authority to elected officials who may not have the tax or the funding or the dollars that they are using.

Can you comment on the block grant as the solution to the States' activities we are hearing about today?

Ms. ALLEN. Yes. Block grants have been discussed recently, and they are not new. I mean, 10 years or so ago there was a similar discussion.

We think that in terms of considering financing the program differently, there are certain fundamentals that always have to be considered. One is that any financing mechanism or approach is vulnerable to abuses. Every system needs to have internal controls to make sure that you can follow the money, to make sure that it is being spent on eligible beneficiaries.

For block grants, if they were to be considered more seriously, we would need to make sure that type of accountability is included. On the other hand, for block grants, the advantage could be that they can provide a little bit more budget certainty from the Federal point of view.

The question though is that that's a different approach from how the Medicaid program has been designed from its outset. From the outset it has been designed to be sensitive to changes in economic conditions, countercyclical so that when economic conditions worsen, the formula will adjust to help States with their share of program costs.

So if a block grant were to consider the economic cycles, that would be important. I would say though finally on this point, and I would be happy to continue the conversation if you'd like, but if you think about something like block grants, the question is: what is the basis for individual States' program spending? Where do you start?

As you have already heard today, there are some States that have unduly maximized the Federal funding. How can that be balanced against other States that have played by the rules and would be disadvantaged if a baseline for future Federal funding was based on actual funding to date?

So there are a number of things to consider in going to any type of different financing approach.

Mr. GREEN. Well, I guess, Mr. Chairman, I do not have any seconds left, but there is a saying that I have heard in Texas for years about you do not throw the baby out with the bath water. If you have a system that is working and, again, subject to audit obviously, because we want to know where funding our tax dollars go to, then why eliminate a system that may be working in some States. Let's address the problem and not throw it all out.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Stupak for 5 minutes.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. Noce, if I may, you said something to the chairman that I sort of wanted to follow up on. You said to Mr. Bilirakis that you would support a targeted approach, but if that targeted approach actually takes money out of the system, wouldn't you agree that we need to replace that money to make sure that providers and beneficiaries are provided for and do not get hurt?

Mr. NOCE. Yes. My comments about the targeted approach was on those schemes that divert the money from the program to such things as building roads, but if any money is removed from the Medicaid system as a result of this, we are going to damage the providers and the beneficiaries unless there is some other revenue stream that backfills the money lost.

Mr. STUPAK. Okay. Thanks for that clarification.

Ms. Allen, on a clarification, if I may, in your discussion with Mr. Greenwood, you mentioned Virginia nursing homes and you had trouble trying to get people to participate. Was that because of reimbursements from Medicaid or was it because of the scheme that was being used?

I was unclear if it was the scheme or Medicaid.

Ms. ALLEN. County officials recognized it for the scheme it was and said they did not want to participate.

Mr. STUPAK. Okay. So they saw the sham.

Ms. ALLEN. Yes, exactly.

Mr. STUPAK. Okay. You know, in my opening I mentioned the budget pressure States are having and my State of Michigan is having a difficult time right now with unemployment, which as unemployment goes up more and more beneficiaries come into the system, and are driving States to either increase the cost to beneficiaries or else just cut people out of the program.

And if we are looking at $23.5 billion proposed cut by the President, how are States going to pick up that difference? And I understand that is $23.5 billion over 10 years, but for Michigan it is about $30-some million a year.

How would States pick that up?

Ms. ALLEN. States would have to face very difficult choices, and I can think of at least three choices they would have to make. With less Federal funding, they would have to think about whether they would choose to cut the number of beneficiaries they serve or cut the level of services or type of services that they provide, or perhaps whether they would need to cut provider payment rates.

All of those are very difficult decisions, but they would really have no other recourse.

Mr. STUPAK. You said in earlier testimony that when you were talking about the block grant system with Mr. Green that the Medicaid system was set up to be sensitive to changes in economics and States' budgets, things like this, and I think we would all say right now that most States are struggling right now.

So how is the President's proposal then to make the cut sensitive or in keeping with the spirit of the Medicaid program?

Ms. ALLEN. It might appear to be inconsistent on its face. I think an earlier question had to do with the details of the program, and I would just like to comment, too, that I have not seen any of the details of the cut, how it would be administered, what it consists of, and I think that it is important to see those details before we know what impact there will be.

Mr. STUPAK. Sure. In generalities, as you said, there are only three ways to do it. Either cut the providers or cut the beneficiaries or cut the benefits. There is no other way.

Okay. Is Medicaid reimbursement basically to providers about half of what it is for Medicaid, roughly?

Ms. ALLEN. Yes, maybe half to two-thirds, but it is low, yes.

Mr. STUPAK. Okay. Because I was reading this report here, and I am sorry Mr. Waxman is gone, but in California GAO found that physician fees were about 42 to 55 percent for Medicaid, and in New York it was even worse than that. Again, under Medicaid physician payment was like 29 to 39 percent.

Since the report, and this was a 2001 report, State fiscal situations have worsen, both California and New York and Michigan, Oregon; name them. So if Congress was to implement the President's cuts of $23.5 billion, the States would almost have to go back to a provider type cut, would they not?

Ms. ALLEN. A provider cut could be one of the alternatives, one of the options considered.

Mr. STUPAK. Okay. In Michigan, one of the proposals they have been talking about is the $900 flat fee so that if you come into the hospital in an in-patient stay, it would be $900 no matter what it is. If it was open heart surgery or if it was a hip replacement, it is $900.

Would that be legal underneath the Medicaid system or is the reimbursement tied into the service performed, or can a State just put a flat rate no matter what the hospital stay is and for that stay pay the provider, in this case the hospital, 900 bucks? Is that appropriate underneath the Medicaid system?

Ms. ALLEN. The statutory requirement for Medicaid payment is that the fee be consistent with economy, efficiency, and quality care. I do not know that that provision would meet those criteria, particularly if it is a very expensive procedure, like a bypass.

Mr. STUPAK. Hip replacement or bypass.

Ms. ALLEN. Exactly. I do not know that that would be appropriate for that level of care, quite frankly.

Mr. NOCE. If I may, Mr. Congressman, that is exactly how we are paid in California.

Mr. STUPAK. Just a flat rate no matter what the service is?

Mr. NOCE. Yes.

Mr. BILIRAKIS. Please respond to the question briefly if you can. I did not mean to cut you off completely, but your time is up.

Mr. STUPAK. Thank you.

Mr. BILIRAKIS. Would someone want to respond?

Mr. STUPAK. I think they both did. Thank you.

Mr. BILIRAKIS. Thank you.

Mr. Rush is recognized for 8 minutes.

Mr. RUSH. Thank you, Mr. Chairman.

I want to welcome the witnesses, and your comments have been fairly interesting, those that I was able to hear.

Excuse me, Mr. Chairman. I have got to cut this thing off.

Mr. BILIRAKIS. That is okay. Your time is running.

Mr. RUSH. All right. I am somewhat baffled because it seems to me like for the purposes of justifying cuts by the administration, it seems as though there is an effort to demonize States, including my State, so that it would seem the cuts would be justified. And there seems to be just a simple issue here, and the issue is whether or not funds are being diverted, Medicaid Federal dollars are being diverted away from the services by the IGTs, and if that is the case, then why couldn't we come up with another simple solution as opposed to just resorting to what some might consider draconian efforts?

If you have cases in States where the funds are being diverted and used for other than health related services, other purposes, then why couldn't we just deal with that issue? Can anybody respond to that?

Ms. ALLEN. I would be happy to. CMS is stepping up its efforts to do exactly that now. They recognize that there have been a lot of abuses. They are taking a much more proactive stance in terms of asking States ahead of time, before they approve their budgets, what they are going to be using their money for, what are the sources, and how they plan to use it and whether they plan to turn any money back to the States.

CMS has just begun to collect all of that information. Our work shows that as of last fall they had begun to collect that from about 30 States and analyze it.

I will say though that a number of States are very concerned about this new policy because they are concerned about how CMS is using the information and whether it is being done clearly and consistently in a way that is transparent to all.

Mr. RUSH. Thank you.

Mr. Reeb, in the Office of Inspector General's report, the OIG contends that with regard to the revenue that Cook County in the State of Illinois returned to the State. We could not confirm the contention that the Illinois Department of Public Aid used the funds for health related services.

However, according to the IDPA, the State of Illinois has increased funding for Medicare by a total of $27 billion from 1992 to 2003, and over that same period, IGT funds a total of $5.2 billion. So Illinois has increased funding for Medicaid by a much bigger sum than the IGT funds that it receives.

And aside from the technical accounting arguments with regard to the fungibility of money in the general fund, why does the OIG insist on stating that it cannot confirm that IGT funds were used for health care purposes?

Mr. REEB. Because we were not able to track the money that actually came back from the Cook County providers into the general fund. I mean, you can make the assumption as you are alluding to that, in fact, because total expenditures are up, those funds obviously must have been used. But we could not make that connection.

In Illinois, the interesting wrinkle was that, if I remember right, the Cook County homes were keeping the upper payment limit funds, or a percentage of them, a large percentage, but they were not being paid any disproportionate share payments.

When you get the combination of disproportionate share with upper payment limit with intergovernmental transfers, you have lost the flow of accountability. Total numbers may give you a comfort level to feel that, in fact, the funds must have been used for Medicaid, but you cannot really track it as such.

Mr. RUSH. Okay. Well, do you see any variable that, say, for instance, in Illinois 1.8 million individuals are now covered and over a million children? That has been an increase. If you increase the number of individuals who are covered, then of course your expenditures have to be commensurate with that, should reflect that in some kind of way; is that correct?

Mr. REEB. Yes, sir. I understand. I understand your point.

Mr. RUSH. So did the OIG look at that at all and make any—did you look at anything? Let me ask you this. Did you look at anything? Did you try at all to figure out whether or not Illinois was actually diverting IGT funds from health related services to other uses?

Did you look at anything to——

Mr. REEB. No, sir. We do not try to go into the general accounts and try to determine the use. It loses its identity. The Medicaid funds that were returned lost their identity when they go into the general Treasury. So to audit the entire State's expenditures, No.

1, it is not within our responsibility and purview, but it also would be fruitless.

Mr. RUSH. So is there any other means and methodology that you could have used other than looking at the entire general budget for the State? Is there any other methodology that you could have utilized that would have given you a better idea about what the State of Illinois was doing and was using their monies for?

Mr. REEB. Well, I think the comments from the State, that is why we put auditee comments into the reports, to make sure that we have the balance of both the auditor and the auditee and their comments, in return, said, in effect, "I am using the funds for the purposes of health care because look at my expansion in Medicaid."

Mr. RUSH. Thank you.

I want to ask anybody on the panel in the few seconds that I have. In Illinois, the IGT revenue has been used exclusively to add funds to the State Medicaid program. IGT revenue has funded approximately 10 percent of the overall Medicaid program base, and not one dime of IGT money has gone to anything else but Medicaid services or care for the poor.

Over 1.8 million individuals and 1 million children have been added to the Medicaid program. Is there anything wrong with this in terms of the increase, using the monies to increase the number of participants in the Medicaid program? Is there anything wrong with that?

Mr. BILIRAKIS. Brief responses, please, to that.

Ms. ALLEN. I am afraid I cannot comment on that because we have not looked at Illinois in the case of our work.

Mr. REEB. To the extent that we looked at it, as we have discussed, I can see your point that that is where the mathematics takes you. We have nothing to refute where you are going.

Mr. RUSH. Would you care to respond to that? Is anything wrong with it?

Mr. NOCE. The numbers are perfectly logical. If the number of beneficiaries go up, the expenditures in the program are going to go up.

Mr. BILIRAKIS. The gentlemen's time has expired. Mr. Engel is recognized for 5 minutes.

Mr. ENGEL. Thank you, Mr. Chairman.

Mr. Reeb, I am curious about the move to curb, as the President's budget says, intergovernmental transfers. I know we have been talking about this obviously here this morning, but States that use these intergovernmental transfers, have their Medicaid plans approved by CMS, and those plans included intergovernmental transfer provisions.

Now we hear, of course, that these legally approved funding mechanisms are accounting schemes. Why would CMS approve intergovernmental transfers in the past if they are accounting schemes?

Mr. REEB. Well, in and of themselves, intergovernmental transfers are not necessarily accounting schemes. So when CMS receives a State plan amendment, they approve it based on what is printed on the paper as to what the plan is for a State, how they are going to calculate the funding pool, how they are going to, in fact, use the funds.

Some say, in effect, they are going to set up a separate health fund. Some say, they are going to expand into other areas. That kind of a thing.

That is why CMS in 1999 asked us to look at it. Because of the growth in the State plan amendments for upper payment limit programs, CMS asked us to take a look at those initial six States, because they did not know whether or not it was playing out the way it was planned or not.

Mr. ENGEL. Well, 3 years ago I and other members of this committee hammered out an agreement, as you know, that included a transitional period for States using IGTs so that their Medicaid and other critical health care safety net programs were not severely cut.

Obviously, since then States have fallen even further into fiscal crisis, and obviously simply cannot afford to absorb a $10 billion cut in Medicaid funding without cutting critical health benefits to the frailest and poorest of Americans.

Now, my home State of New York is one of the States in the transitional period and has always used revenue from IGTs to shore up its health care safety net. Are you or CMS or you advocating eliminating this transitional period which we thought was a compromise and worked so hard to hammer out? And it would essentially undermine this agreement which we reached in 2001 that allowed for the transitional period.

Mr. REEB. Our recommendations back when we first looked at the initial six States was that we felt the transition period should be shortened from what was planned. In some cases there was an 8-year transition for States that had already used upper payment limits, over $8 billion I believe, and the lack of accountability of where the funds were being used once they were being returned is what concerned us.

So our interest in reducing the transition was to try to bring accountability into the mix as opposed to saying because they have been doing this for so many years, we will just let them do this for X number of years again.

We were not a part of any deliberation that Congress had with individual States or the administration. We were just viewing it as an objective reviewer of what we were seeing in States that we were reviewing.

Mr. ENGEL. Well, what bothers me about this is because obviously to me this is changing the rules in the middle of the game. If States are doing it and using it and anticipate it, you obviously know the hardship that it imposes on these States by changing the rules. If we hammer out what we thought was a compromise, we weren't totally happy wit it, but we felt this transitional period was a compromise and now there's an attempt to change it once again. So what bothers me, Mr. Reeb, is States like mine are being demonized for attempting to care for the poorest and the frailest across the country.

You know, we hear about States trying to look for creative ways to game the system, but I think States like New York are looking for ways to care for the uninsured, which continues to grow. It is over 40 million Americans. We have obviously unemployment ris-

ing and more people are losing health insurance and seeking public assistance.

So as the economy is failing, to do something like this is really counterproductive because more and more people need the health benefits, and you are making it harder for the States to provide them.

Mr. REEB. Well, we share the concern of the States in having adequate money to pay for health care. Our concern was that because of the lack of accountability, there is no assurance that, in fact, the funds are being used for health care. We try to match up the actual services to the actual provider being paid. Then, when making a decision or making an arrangement with the State and the Federal Government, accurate information is used.

Mr. ENGEL. Well, I just think that cutting Medicaid is a mistake, and I think that we should stop some of these huge tax breaks for the rich so that we have money to provide adequate health care for our people who really need it.

Ms. Allen, let me just ask you——

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. ENGEL. Okay. I will submit the questions.

Mr. BILIRAKIS. Please. We are all going to do that.

Mr. ENGEL. Okay.

Mr. BILIRAKIS. Mr. Strickland is recognized for 5 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman, and I apologize. I have had three subcommittees meeting at the same time this morning. So I am sorry that I arrived so late.

And right in my office now I am missing an appointment with the Children's Hospitals of Ohio, as a matter of fact, Mr. Noce. So I have a question for you.

You are not a government facility; is that correct?

Mr. NOCE. I am not.

Mr. STRICKLAND. Now, you obviously cannot make or receive intergovernmental transfers, but your facility, I would assume, benefits from the upper payment limit and the intergovernmental transfer arrangement in California.

Can you describe to the committee what kinds of payments your hospital gets and what these payments are for?

Mr. NOCE. We get two primary revenue streams related to intergovernmental transfers. One is the disproportionate share hospital program, and the other is a program that I am not sure how it works in the Federal-State, but within our State we call it the 1255, and it is a grant program administered by a rate setting commission in our State that is given to certain hospitals who operate emergency departments and who also provide services to a high percentage of uninsured or MediCAL patients, and that is what we use the money for.

I mean, I reported earlier that my hospital had 70 percent MediCAL. So that is where the money goes.

Mr. STRICKLAND. So what would happen to your facility and other facilities throughout your State if the system were to be stopped?

Mr. NOCE. If that money was not backfilled, my facility would have to think seriously, of closing because we are already pro-

jecting an operating loss of about $25 million a year, and adding on another $35 million, we could not survive that.

Mr. STRICKLAND. So assuming the States did not replace whatever you lost, and given the current fiscal situation that you face, you may close?

Mr. NOCE. Our board would have to seriously look at that. We would be looking at $60 to $70 million losses on a $290 million expense base. You cannot——

Mr. STRICKLAND. Can you tell me how many children you may serve a year?

Mr. NOCE. We serve 85,000 in-patient days and 285,000 out-patient visits a year.

Mr. STRICKLAND. And what percent of that would be children that would be Medicaid?

Mr. NOCE. Historically it is 70 percent; the first 6 months of this fiscal year it is 75 percent.

Mr. STRICKLAND. Where would those children go for care?

Mr. NOCE. Well, in our community, numbers of that magnitude could not go anywhere else. I am the largest provider by far in Los Angeles County for specialty Children's Hospitals.

Mr. STRICKLAND. So we would be talking about thousands of children who may go without needed medical care.

Mr. NOCE. Yes, unless somebody who is not doing pediatrics now stepped up, and I do not see that happening.

Mr. STRICKLAND. Thank you, sir.

Ms. Allen, as States respond to the budget pressures, which I come from Ohio, and so anyone who knows anything about Ohio understands that we are in a critical situation. I just share with you.

We have heard of a man in Oregon who could not afford the copayment for his seizure medication. He stopped taking it, and he died thereafter.

In Arizona, a 59 year old woman with ovarian cancer was living on her disability payment of only $173 a month. Her medicines, 15 medicines each month cost her $80, leaving her $93 for everything else, food, rent, electricity, and other needs.

Given these examples, don't you think that this Congress should be working to protect and shore up Medicaid rather than cut it?

Given the number of uninsured which is escalating in our country, doesn't it make sense to protect the program that serves these most vulnerable Americans?

Ms. ALLEN. Yes, it does make sense to protect the program. I believe the CMS Office of the Actuary has estimated over the past couple of years that over 5 million new beneficiaries have become eligible for Medicaid primarily for two reasons, but the predominant reason is because of the economic downturn.

More people have less income, less insurance, and Medicaid has helped to pick up that slack.

Mr. STRICKLAND. So the need is increasing.

Ms. ALLEN. Yes.

Mr. STRICKLAND. More poor people are looking to this program for the help they need, and we are actually thinking about reducing the budget by $23 billion?

Ms. ALLEN. That is correct.

Mr. STRICKLAND. Those are the cold, hard facts.

I want to thank you, Mr. Chairman, and I want to thank the witnesses.

Mr. BILIRAKIS. I thank the gentleman.

Ms. Allen, let me ask you very quickly. Are there ways to be able to determine how many of these dollars and to whom they are diverted for purposes other than Medicaid, you know, these schemes that we are talking about here?

Are there ways to do that? I mean, can we, if we want to focus on something like that, can we do it?

Ms. ALLEN. Yes, I believe we could do that. It would take some good, hard auditing, a lot of resources, but, yes, I believe we could.

Mr. BILIRAKIS. Well, as we customarily do, we say to you fine panelists that we will submit questions to you and ask you to respond to them in a timely manner. That certainly would be one to Ms. Allen.

And to those of any of you. I mean, Mr. Noce, if you have any ideas in that regard to help us out here, that would be helpful. I am not asking for, you know, the total dollars in intergovernmental transfers. I am talking about those that are misused for purposes other than Medicaid, Mr. Reeb.

I thank all three of you for taking time to be here. You have been very patient. Well, we have had longer hearings, but we appreciate it very much.

Thank you so much for your help.

The hearing in adjourned.

[Whereupon, at 12:07 p.m., the subcommittee hearing was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN HEALTH CARE ASSOCIATION

As the nation's largest publicly-funded health insurance program, Medicaid provides health and long term care coverage to over 1 million seniors and persons with disabilities daily, and serves almost 70 percent of the nation's elderly and disabled patients residing in nursing homes.

With a program of this scope and import, we thank Energy and Commerce Subcommittee Chairman Bilirakis, Ranking Member Brown and members of the Subcommittee for providing us the opportunity to discuss the importance of ensuring America's Medicaid-dependent population receives quality, compassionate care in the face of state and federal budgetary challenges of historic proportions.

In the context of the topic of this hearing, Mr. Chairman, we want to say at the outset that states are not just struggling to stay afloat when it comes to caring for those most in need of help, they are drowning in a swirling sea of red ink caused by what we all have acknowledged is the worst collective state fiscal crisis since World War II.

Granted, federal fiscal relief has helped states place a temporary finger in the dike—but the relief expires on June 30th, and it must not be forgotten that a recent Kaiser Commission survey found that, for many states, FY2004 marked the third consecutive year they were forced to take new actions to reduce spending growth in their Medicaid programs. This has resulted in provider reimbursement freezes and new coverage limitations on a number of vulnerable populations.

According to Kaiser, states have also exhausted many one-time measures they have used to balance their budgets, and Medicaid budget shortfalls are likely in a majority of states for the foreseeable future. Continued expectations of low revenue growth as the economy remains sluggish combined with the growth in demand for Medicaid services means that states will continue to look for ways to cut programs, and limit coverage and benefits.

Results from the Kaiser survey show that reimbursement rates for nursing home care in fiscal year 2003 were cut or frozen in 17 states. For FY 2004, 19 states ei-

ther cut or froze rates for nursing home care; 33 states were able to increase rates for nursing home care in FY 2003; 29 states were able to do so in FY 2004.

It is important to note that the increase or decrease of reimbursement rates is not a true barometer of whether Medicaid is effectively and efficiently paying for quality nursing home care; the key factor is determining whether reimbursement rates are keeping up with the real costs in the health care marketplace to provide those services.

To identify and specifically quantify the shortfall between the Medicaid reimbursement rates and allowable costs of nursing homes in individual states, AHCA engaged BDO Seidman, LLP, an independent accounting firm.

For the third consecutive year, BDO Seidman reviewed the extent to which reimbursement rates have kept pace with the costs to provide care. Using a database of Medicaid rates and cost report information, comparisons of Medicaid rates and allowable costs from 2001 (the most recent audited or desk-reviewed cost report data available) were derived for 37 states—representing almost 88% of all Medicaid patient days in the country.

Results indicate that nationwide, the average shortfall in Medicaid reimbursement was $11.55 per day for every Medicaid patient. In 2001, un-reimbursed Medicaid-allowable costs exceeded $3.6 billion for these 37 states, and exceeded $4.1 billion when the results are extrapolated to all 50 states. Rate increases in fiscal 2003 were, in many states, far less than the higher costs of providing quality care. In still other states, rates were either frozen or reduced—falling even farther below costs.

At the same time, state legislators are facing growing political pressures to expand their programs to cover more populations—especially during these challenging economic times. And not surprisingly, states struggle to find more resources for their Medicaid programs, and often utilize programs that include upper payment limits and intergovernmental transfers. The fact that states cannot rely on current funding to fund their programs is a symptom of a broken system. Our broken system must be reformed so that states have adequate dollars to fund needed Medicaid beneficiary services.

As the Administration and Congress will correctly continue to debate Medicaid reform efforts throughout this year, it is essential to factor into any proposals the fact payment rates are simply not coming close to covering the true costs of providing quality care. If the states continue to fall short with their obligation to adequately fund Medicaid, the federal government, we maintain, has a statutory obligation to ensure continued access to quality care for our frail, elderly and disabled. The question is how we go about doing so.

Congress has previously passed legislation that that altered federal law as it relates to intergovernmental transfers, and established several transition periods to ease states' reliance upon these funds. Implementing regulations from the Centers for Medicare and Medicaid Services (CMS) qualified states for necessary transition periods, and, logically, the longer a state has relied upon these funds, the longer they have to phase out their use.

This is logical, but our concern and worry is that President Bush's proposed FY 2005 budget targets those funds necessary to ensure many of our states' frail, elderly and disabled continue receiving the Medicaid benefits and services that are a literal lifeline.

Despite what some believe to be the case, these additional resources help make the difference between accessing necessary Medicaid services and not—and there will be a stark and consequential negative impact resulting from an potential abrupt policy about-face. A fair, reasonable transition period is necessary. We would oppose any rapid termination of states' ability to access funds to care for their most vulnerable.

Any new federal policy directive must be implemented in a manner that is fair to all states, that provides states with a clear, unambiguous understanding of any new policy and any subsequent changes they are expected to make. Most important, changes of this magnitude impacting populations as vulnerable as those we represent must be made in an open, public and gradual process.

PREPARED STATEMENT OF AMERICAN HOSPITAL ASSOCIATION

On behalf of our nearly 5,000 hospital, health care system, network and other health care provider members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record on the Medicaid program. The AHA shares the committee's concern that the Medicaid program must be strong in order to continue meeting the health care needs of our most vulnerable

people. Nearly 50 million poor, disabled and elderly people rely on Medicaid for their care. Over its nearly 40-year history, Medicaid truly has become the nation's health care safety net.

The importance of this role has never been more critical than today. In the current economy, many Americans remain out of work, pushing them and their families into the ranks of the uninsured. Medicaid has historically served as a buffer to the perils of an uncertain economy by providing access to health care services for those who cannot afford it. Yet, the states still are experiencing serious fiscal crises. In the past two years nearly all states imposed Medicaid cutbacks in some form to fill budget gaps, or used up all of their specials funds to prevent direct cuts in Medicaid eligibility or key services. The vast majority of states expect to consider proposals to cut Medicaid eligibility, health services and payments to health care providers. It is imperative that any federal action to address the current crisis, and any federal efforts to change the current structure of the Medicaid program, must not put further financial pressure on the states nor diminish the guarantee of coverage for our most vulnerable Americans.

Provide Fiscal Relief—The AHA believes that the current fiscal crisis faced by states demands immediate and meaningful federal support. That support could be in the form of an extension of last year's increase in Medicaid's federal matching percentage or other relief that would allow states to use such funds to help support their Medicaid programs. States should not be forced to radically transform their programs to receive such fiscal relief.

Protect the Vulnerable—The AHA believes that this nation has an obligation to care for the neediest of our society. A federally enforced entitlement to a set of meaningful benefits for this population must be maintained. We must not erode the guarantee to coverage for that has long been a fundamental feature of the Medicaid program. We should take no action that would exacerbate the swelling of the ranks of the uninsured.

Maintain Financial Integrity—The AHA believes that the federal and state governments have an obligation and responsibility to maintain their financial commitment to the program. We ask Members of the Committee to work with us to eliminate any provisions in the Fiscal Year (FY) 2005 Budget Resolution currently pending before the House Budget Committee that would reduce funding to the Medicaid program. Such cuts would be a devastating blow to hospitals and to the poor and uninsured patients they serve. Many of these hospitals are in financial jeopardy; many are the sole source of care in their communities. Their failure would put communities at risk, because without them, medical services, social services and important jobs would disappear.

Protect Access to Care—The AHA believes that adequate provider payment is critical to ensuring that Medicaid beneficiaries have access to needed services by making certain there are providers of health care services available. Current Medicaid law has minimal protections that are mostly geared to making the payment rate-setting process more public. The AHA advocates that these current protections should be expanded and strengthened.

The AHA also believes that federal oversight of state Medicaid programs serves as an important tool in protecting access to health care services for vulnerable people. The federal government oversight role ranges from overseeing Medicaid managed care plans to make certain enrollees have access to quality health care providers, to assuring the financial integrity of the program by making certain states spend their Medicaid funds on health care. The Administration already has the authority to protect the Medicaid program and therefore legislative remedies are not required.

The Medicaid program has played a vital role in providing access to health care services to millions of Americans over its 40-year history. The bottom line is that if the Medicaid program did not provide this coverage, tens of millions would be added to the ranks of the uninsured. Disparate emergency-room visits are a poor substitute for health care coverage. America must do better. The AHA stands ready to assist the committee in any way as it tries to meet its many challenges.

PREPARED STATEMENT OF LARRY S. GAGE, PRESIDENT, THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

The National Association of Public Hospitals and Health Systems (NAPH) appreciates this opportunity to submit a statement for the record of the hearing of the Subcommittee on Health on the subject of intergovernmental transfers (IGTs) and state Medicaid financing. Medicaid provides critical support to its eligible recipients as well as to the safety net providers who serve the nation's rising numbers of unin-

sured. Concerns about Medicaid financing are especially relevant now, as tight state budgets increasingly jeopardize the ability of states to fully support the Medicaid program and as the Congress and the Administration consider ways to curtail Medicaid spending.

NAPH does not condone the misuse of federal Medicaid funds and supports valid efforts to ensure that federal funds are used appropriately. However, we are opposed to any efforts that would deprive safety net hospitals of legal and appropriate sources of funding for their vital missions and services. The Congress should carefully weigh the potential impact that any effort to curtail Medicaid spending will have on safety net providers.

NAPH represents more than 100 of America's metropolitan area safety net hospitals and health systems. The mission of NAPH members is to provide health care services to all individuals, regardless of insurance status or ability to pay. Medicaid provides essential support for safety net health care providers who provide access to care for millions of Medicaid and uninsured individuals, train many of our nation's physicians, nurses, and other health care professionals, and provide community-wide services like trauma care, burn care, and emergency preparedness in communities across the country.

Approximately 58 percent of the patients served by NAPH members are either Medicaid recipients or patients without insurance. Medicare covers another 21 percent of the patients of NAPH members. Our members thus rely on governmental sources of financing to cover over three-quarters of their costs. NAPH members provide over 25 percent of the nation's uncompensated hospital care while representing only two percent of acute care hospitals in the country. Medicaid is a major source of essential financing for America's institutional health safety net—38 percent of the net revenues of NAPH member hospitals are Medicaid revenues. Without adequate Medicaid support, most NAPH members simply would not survive.

Medicaid DSH payments are the primary federal mechanism for providing additional support to hospitals that serve large volumes of Medicaid recipients and persons without insurance. These payments are essential to the nation's health care safety net. In addition to the 51 million people currently covered by Medicaid, the number of uninsured Americans has risen to 44 million. Recognizing the demands that these rising numbers of Medicaid and uninsured patients place on safety net providers, last year Congress restored significant amounts of Medicaid Disproportionate Share Hospital (DSH) funding as part of the Medicare Prescription Drug, Improvement and Modernization Act (MMA). It is important to note that Medicaid DSH payments are specifically intended to "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs."[1] This includes the unreimbursed costs of serving Medicaid as well as uninsured patients.[2]

In 2001 (the latest year for which data are available), Medicaid DSH payments covered 25 percent of the otherwise unreimbursed costs incurred by NAPH member systems, despite the fact that DSH payments constituted less than 6 percent of overall Medicaid spending. The recent restoration of DSH funding will help relieve some strain on public hospitals by helping hospitals cover a greater portion of the costs of Medicaid and uncompensated care. However, current attempts to limit IGTs would limit many states' ability to access this critical funding and would have a deleterious impact on safety net providers.

Consistent with Medicaid law, many states use IGTs to help finance essential support payments for safety net providers. For example, a county-owned hospital may transfer public funds to the state Medicaid agency to support the non-federal share of Medicaid DSH payments. This is not abusive; it is a legitimate reallocation of responsibility for covering the non-federal share of Medicaid payments from the state to a local government. Such sharing of the financial burden between states and local governments is often critical to enabling states to provide DSH and other forms of critical support to safety net providers. Recent proposals to severely restrict IGTs would have a crippling impact, particularly on the safety net.

The use of local as well as state funds for the non-federal share of Medicaid expenditures has been a fundamental part of the Medicaid program since its inception. Efforts to reform IGTs should respect the existing and historical local role in financing the Medicaid program. Medicaid is a partnership between the federal government, states and localities. The Medicaid statute has always referred to the "federal" and "non-federal" share, not the state share. Federal Medicaid law and regulations explicitly *permit* entities other than states to

[1] 42 U.S.C. §§ 1396a(a)(13)(A)(iv), 1396r-4(a).
[2] 42 U.S.C. § 1396r-4(g)(1)(A).

contribute some portion of the non-federal share of Medicaid payments through IGTs. Existing federal law allows states to fund *up to 60%* of the non-federal share of Medicaid costs through such expenditures.[3] The Medicaid statute explicitly permits not only local governments but also local government health care providers to contribute the non-federal share.

Over the last several years, legislative and regulatory changes have addressed Medicaid financing abuses. Although some states have historically taken advantage of IGTs by using them to finance excessive payments to public providers which were subsequently returned to the state, Congress and the Centers for Medicare and Medicaid Services (CMS) have effectively curtailed the opportunity for such abuse by placing strict limits on payment amounts. Congress has imposed limits on statewide Disproportionate Share allotments, has capped DSH payments to individual hospitals based on unreimbursed costs and has mandated changes to upper payment limit (UPL) regulations to prevent abuse. The UPL changes alone have reduced federal payments by an estimated $85 billion.

There is no evidence of abuse under these strict new limits. The prepared statements of the governmental witnesses testifying today do not adequately acknowledge the extent to which the potential for abusive IGTs has already been limited. Many of the examples provided by both the U.S. General Accounting Office (GAO) and the Office of the Inspector General (OIG) in their testimony relate to arrangements that could not be established today under current regulations. The recent regulatory changes have not yet been fully evaluated, and adopting even more stringent restrictions would, at this point, be premature.

Any "fat" in the system from IGT abuses has already been cut; further reductions will materially jeopardize access to care for Medicaid and low income patients. Regulatory changes have already removed $85 billion from the Medicaid program. Additional reforms in the name of reducing waste, fraud and abuse will primarily result in reduced payments to providers serving the neediest patients. Restrictions on the use of local funds will, in many states, eliminate the supplemental Medicaid payments—including DSH—that enable NAPH hospitals and other safety net providers to sustain their missions. Congress should avoid adopting broad changes without considering the consequences and the harm to the very patients Medicaid is supposed to help.

NAPH appreciates the opportunity to share our observations about critical Medicaid financing issues. As the number of Americans living in poverty rises, strengthening the Medicaid program is critically important and any policy changes must take into consideration the potential impact on safety net providers who shoulder the burden of caring for our nation's poor and uninsured. We look forward to working with the Committee to develop solutions to the problems confronting our nation's poor and uninsured and the safety net providers that serve them.

PREPARED STATEMENT OF THE NATIONAL GOVERNORS ASSOCIATION

INTRODUCTION

The Medicaid program is the largest and most important health care program in the country. It currently provides $300 billion per year in critical health care and long term care services to more than 50 million low-income children, working families, frail seniors, and people with disabilities. It is a lifeline and a safety net for the most vulnerable members of our society.

Medicaid is actually 56 separate programs and is administered by the states and territories and jointly financed by the states and the federal government. The percentage of the state's share varies depending on several factors, but averages about 57% federal and 43% state. The "non-federal" share can be financed entirely through state funds, but states also have the option to require local governments to share the costs. Of this "non-federal" share, up to 60% can be financed by local contributions. These contributions, or intergovernmental transfers (IGTs), were designed by Congress and are in the Medicaid statute, have been authorized by federal regulations, have been approved by HHS for many years, and are a legitimate mechanism that many states rely on to finance the Medicaid program.

Intergovernmental Transfers

Section 1902(a)(2) of the Medicaid statute codifies this arrangement by requiring states to "provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan . . ."

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[3] 42 U.S.C. § 1396a(a)(2).

Furthermore, Section 1903(w)(6)(A) states, "Notwithstanding the provisions of this subsection, the Secretary may not restrict States" use of funds where such funds are derived from state or local taxes (or funds appropriated to state university teaching hospitals) transferred from or certified by units of government within a state as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider . . ."

Finally, this is also recognized in federal regulations, which authorize the use of public funds as the state share of Medicaid spending if the funds are "transferred from other public agencies (including Indian tribes) to the state or local (Medicaid) agency and under its administrative control . . ." (42 C.F.R. 433.51(b)).

State and Local Governments

The funding of Medicaid follows two broad models: centralized, where the state is responsible for raising revenue and distributing to the local level; and decentralized, where the local entities have much greater authority to raise and spend revenue on their own. IGTs, in part, recognize that state-raised revenue and county-based revenue are essentially equal in the eyes of the law and therefore, neither should be discriminated against.

Without the benefit of IGTs, large county-based states, such as New York, California, Wisconsin and North Carolina to name just a few, would literally be unable to finance their Medicaid programs, destroying the safety net in many parts of the country and drastically increasing the numbers of the uninsured.

Therefore, attacks on the very existence of IGTs would fundamentally threaten the decentralized form of government that these states have chosen and would represent an attempt by the federal government to statutorily favor state governments that are centralized and do not rely on the ability of counties to raise revenue.

We remain hopeful that this is not the intended result of any congressional or administrative actions.

Federal Concerns

The Administration and some members of Congress have accused states of manipulating Medicaid financing mechanisms in inappropriate ways. States have been accused of misusing IGTs in association with Disproportionate Share Hospital (DSH) payments, Upper Payment Limits, and Provider Taxes. These claims are not new, and have resulted in the past in federal action clarifying what is appropriate.

If there continue to be concerns about how states are financing Medicaid, we would recommend that discussions be had that are open, exhaustive, and include all impacted stakeholders. These discussions should at least acknowledge that not only are the state actions in question legal, but have been approved by HHS, and in many cases encouraged by them in the past.

Financing Mechanisms Encouraged by HHS

An excellent example of how states and the federal government worked together is in Nebraska. The state, with the full support and blessing of both HHS central office and regional offices, developed a plan to increase reimbursement to nursing homes to the federal maximum. They then utilized an intergovernmental transfer and dedicated the extra money into a trust fund that would be used solely to assist nursing homes in a physical conversion to assisted living facilities. Everyone benefited. Nursing homes were able to embrace the economics and demand of the 21st century—the increasing preference of seniors to reside at home or in community settings. The state was able to transform its long-term care infrastructure to assisted living facilities—which are much cheaper to maintain than nursing homes. The federal government also benefited by saving money in the long run, and by working with the state to meet the shared goal of decreasing reliance on institutional care.

Do Not Change the Rules Midstream

Regardless of what changes Congress may consider, it is critical that the financing rules of Medicaid not be changed midstream. States have acted within the parameters of the law and the regulations when negotiating budgets—and all financing mechanisms are both legal and approved by HHS. For these rules to be changed midstream, without notification or Congressional directive, would be a presumption of guilt that is inappropriate in a state-federal partnership. In addition, such changes may well constitute an illegal impoundment of funds and violate other bedrock provisions of the Medicaid program.

It is therefore inappropriate for HHS, without legislation approved by Congress, to move forward with changing these rules and policies. We are finding that such a practice is occurring with increasing frequency, much to the concern of our members and their Congressional delegations. I would like to submit for the record a recent letter signed on behalf of the entire Iowa delegation, including Senate Finance

Committee Chairman Grassley and House Budget Committee Chairman Nussle, expressing their concerns that HHS is moving forward with unilateral policy changes that could have significant impacts on Medicaid and the populations it serves.

States who have already received federal approval for this funding have designated the money to go towards such important goals as financing expansions of home and community-based long term care, increasing physician reimbursements so that access to care is not jeopardized, ensuring that tier one trauma centers keep their doors open, and in many states, ensuring that small rural hospitals aren't forced to close or otherwise jeopardize patient care.

States Can Not Continue to Finance Medicaid and the Needs of the Dual Eligibles

Medicaid currently accounts for roughly 20% of any given state's budget, making it the second largest expenditure next to education. The Medicaid program is also growing at almost double digit rates, due to significant pressures in prescription drug costs and long-term care. Growth that large in a program Medicaid's size is unsustainable even in a good economy. Unfortunately, states are not in good fiscal standing. The combination of Medicaid growth and lower than projected revenue has created a situation where Medicaid costs are eating up every dollar of state revenue, leaving no room for increased funding for education or other key priorities.

This unfortunate situation is exacerbated by the difficulty states have had in dealing with unfunded federal mandates and by the fact that increasing amounts of the Medicaid budget (and also state funded programs) are devoted to filling holes in the federal commitment to Medicare beneficiaries:

Forty-two percent of the entire Medicaid budget is spent on services for elderly and disabled Medicare beneficiaries, the so-called "dual eligibles". This is a shocking number when you consider that they comprise only twelve percent of the total number of people served by Medicaid and that they are all fully covered by the entire Medicare benefits package. Medicaid's responsibility includes acute care services beyond Medicare's limitations, prescription drug coverage which Medicare does not yet provide in any comprehensive fashion, payment of expensive co-pays, premiums, and deductibles, and most importantly, long-term care services.

It is critical to be mindful that the Medicaid program is essentially the only funding source for long-term care services in the nation, paying approximately five times what Medicare does in total. Medicaid is responsible for more than sixty percent of all nursing home care in this country. As the baby boom demographic starts to reach Medicare eligibility within the next decade, these trends will worsen substantially unless common-sense reforms are enacted.

Congress first attempted to address prescription drug coverage in the Medicare Catastrophic Act of 1988. This legislation created a drug benefit for seniors and required the Medicaid program to pay significant amounts of cost sharing for low-income seniors through the creation of the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs. Congress quickly repealed the drug benefit, but left intact the Medicaid requirement to cover Medicare cost-sharing. Consequently for the past thirteen years, states have borne billions in increasing costs for the QMB and SLMB programs, and tens of billions in providing prescription drugs for low-income Medicare beneficiaries.

We were strongly encouraged by Congress' recent effort to enact a comprehensive Medicare prescription drug benefit into law, and appreciate the decision to qualify the dual eligibles for the Medicare benefit. However, states will still be required to finance the vast majority of these costs, through the "clawback" effect. This will create an unprecedented reverse block grant of funds from states to the federal government, one in which states will have no control over how the money is spent.

States have never been in a position to welcome these burdens on behalf of the federal government. Strong state revenue growth in the mid 1990s helped mask an unsustainable load that has now become unbearable. Without additional federal help, states will be unable to afford current Medicaid commitments, let alone ponder the significant expansions that would be needed to address the growing problem of the uninsured.

States are spending significantly more money on the Medicaid program now than they were 10 years ago, despite the increased financing through Upper Payment Limit mechanisms. The state share of Medicaid in 2000 was $94 billion, as compared to only $50 billion in 1992, and $70 billion in 1997. This demonstrates state commitment to funding the program and proves that the increases in the Medicaid budgets are not being financed overwhelmingly by federal funds.

Finally, the temporary state fiscal relief will end in fiscal 2004. Because of this, and because of the continued growth of Medicaid overall, the total amount of state dollars in Medicaid will increase by 15 to 20 percent from fiscal 2004 to fiscal 2005.

This will create a fiscal situation ill-suited to absorb additional reductions in the federal commitment to Medicaid funds.

Conclusion

The Governors oppose any reductions in Medicaid spending as well as changes to the current policy that would jeopardize funding for underserved populations. The current policy represents a well thought-out balance that seeks both accountability and sufficient funding for the health care safety net. Changing the policy now could have disastrous consequences for public hospitals and the individuals they serve.

INTER-GOVERNMENTAL TRANSFERS: VIOLATIONS OF THE FEDERAL-STATE MEDICAID PARTNERSHIP OR LEGITIMATE STATE BUDGET TOOL?

THURSDAY, APRIL 1, 2004

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

The subcommittee met, pursuant to notice, at 2:26 p.m. , in room 2322, Rayburn House Office Building, Hon. Charlie Norwood (vice chairman of the subcommittee) presiding.

Members present: Representatives Deal, Whitfield, Norwood, Wilson, Barton (ex officio), Brown, Waxman, Stupak, Green, Strickland, Capps, John, and Rush.

Staff present: Chuck Clapton, majority counsel; Jeremy Allen, health policy coordinator; Eugenia Edwards, legislative clerk; Bridgett Taylor, minority professional staff; Amy Hall, minority professional staff; Purvee Kempf, minority professional staff; and David Vogel, minority staff assistant.

Mr. NORWOOD. The committee will come to order. I now call this hearing of the Health Subcommittee to order.

This is the second hearing the subcommittee has had on the subject of State uses of intergovernmental transfers to finance their share of their State's Medicaid program. While the Federal Government has taken steps to limit the use of these mechanisms, there is evidence to suggest that States are still able to draw down Federal Medicaid payments when no State expenditure has been made.

Today, we will hear from two witnesses who will discuss this issue further, Dennis Smith, the Director of the Center of Medicaid and State Operations at the Centers for Medicare and Medicaid Services.

Mr. Smith, you are most welcome.

And he will discuss the Federal Government's effort to ensure the integrity of the Medicaid program and the administration's proposal to save $9.6 billion over 5 years by curbing IGTs that are in place solely to undermine the statutory determination of the Federal matching rate We will also hear from Barbara Edwards, the Deputy Director for Ohio's Office of Medicaid.

Welcome, Ms. Edwards.

Ms. Edwards is testifying on behalf of the National Governors Association and will provide a different perspective on State uses of IGTs.

Thank you both for taking time to join us today. It is my sincere hope that this afternoon's hearing will help us move closer to answering two important questions: How widespread is the use of these questionable financing mechanisms; and how can we effectively balance the need to ensure that the fiscal integrity of the program is maintained without, at the same time, harming the millions of Americans who rely on this critical component of our health care system?

I would like to close by stating for the record that today's hearing is not about cutting Medicaid programs. It is about making sure that Federal taxpayer dollars earmarked for Medicaid are actually used for that purpose. It is incumbent upon us to preserve the Federal-State partnership that is a hallmark of the Medicaid program.

I would like to again thank our witnesses for joining us this afternoon, and with that, I would yield to the ranking member who is not here.

Would you like me to yield to Mr. Waxman first?

I would like to now——

Mr. WAXMAN. Are you yielding to me?

Mr. NORWOOD. I am asking since Mr. Brown is not here, the ranking member, we normally would go to him first. I will go to you first.

Mr. WAXMAN. Thank you, Mr. Chairman, for going to me. You shouldn't go to me till third, because under the rules I came in third, but I am just going to reserve my opening statement and add some time on for the questions, but thank you very much for calling on me.

Mr. NORWOOD. Mr. Deal, you are now recognized for an opening statement.

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

Mr. NORWOOD. Mrs. Capps, you reserve your time?

Mrs. CAPPS. I welcome our guests and witnesses and reserve my time for additional questioning.

Mr. NORWOOD. Mr. Green, you are recognized, but before you are, it is appropriate, I think, that this subcommittee make mention that this is the last hearing one of your staffers will be attending.

Mr. GREEN. Mr. Chairman, I was going to mention that and put my statement into the record, although this is our second hearing on this issue in 2 weeks and this is the last hearing for my Legislative Director, Sharon Scribner, who will be leaving and, as we say in DC, "going downtown." But Sharon has done a great job not only as Legislative Director, but on this subcommittee. She knows the priority I place on it and we have shared that priority. I know we will miss her, and so will a lot of folks who work with her.

Thank you, Sharon.

Thank you, Mr. Chairman, for that.

Mr. NORWOOD. Mr. Waxman, you are recognized.

Mr. WAXMAN. Mr. Chairman, I understand that Sherrod Brown is the ranking member of this subcommittee. He is on his way here, and I would just hope that we would wait a minute or 2 for him.

Mr. NORWOOD. Why don't we begin on our witnesses and then we will—I wasn't going to do that. I was going to let the witnesses

make their statements, and if he walks in during, then we will—we are not trying to cut him off, but we also don't want him to hold up the hearing. Everybody is busy and these people are, too.

Mr. WAXMAN. It is usually a courtesy that is given.

Mr. NORWOOD. Well, there are two courtesies, one of which is to be on time and the other is to give courtesy to the ranking member, so we have two things going on here.

Mr. WAXMAN. Well, maybe if I could just talk a second more, it appeared we were scheduled for 2 o'clock, and then we had a vote, so that sort of confused people, although we are all here, but I am sure he is just probably, from some old wound in his younger days——

Mr. NORWOOD. Mr. Waxman, you are being very kind. Your time has expired, and I do appreciate where you are coming from.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

I now call this hearing of the Health Subcommittee to order. This is the second hearing the Health Subcommittee has held regarding the Medicaid program and, more specifically, state uses of intergovernmental transfers. In our hearing on March 18th, we heard testimony from the Office of Inspector General at the Department of Health and Human Services and the General Accounting Office describing how states are able to use certain financing mechanisms, including intergovernmental transfers, to draw down federal Medicaid payments without actually spending their own funds. The result is that in some cases, the federal government is contributing more to a state's Medicaid program then it should under federal law.

Today we will explore this topic further and hear two more perspectives on this issue. Dennis Smith, the director of the Center for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, will discuss the federal government's efforts to ensure the integrity of the Medicaid program and the administration's proposal to save $9.6 billion over five years by "curbing IGTs that are in place solely to undermine the statutorily determined federal matching rate."

We will also hear from Barbara Edwards, the deputy director for Ohio's Office of Medicaid. Ms. Edwards is testifying on behalf of the National Governors Association and will provide a different perspective on state uses of IGTs. Thank you both for taking the time to join us today.

Regardless of the fact that today is April Fool's Day, this is a very serious topic. In my mind it is our responsibility to ensure that federal Medicaid payments to states go towards reimbursing providers who provide services to Medicaid beneficiaries and not for other, non-Medicaid purposes. No matter what your views on the Medicaid program might be, I find it baffling that some would resist efforts to protect the fiscal integrity of this program. I have no interest in "cutting Medicaid." I do, however, have a strong interest in ensuring that the integrity of the federal-state partnership, as prescribed under federal law, is maintained.

I would like to again thank our witnesses for taking the time to join us today—I know we all look forward to your testimony. I now yield to the ranking member of the subcommittee, the gentleman from Ohio, for an opening statement.

PREPARED STATEMENT OF HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Chairman Bilirakis, for holding this important hearing today. I appreciate your Subcommittee's efforts to examine the problems associated with Medicaid financing. I also want to thank our witnesses, Dennis Smith, the Director of CMS Medicaid Operations and Barbara Edwards, the Deputy Director of the Ohio Medicaid program.

Medicaid is the critically important program that was created to pay for the health care needs of the poorest Americans. It should never be a financing mechanism to help states pay for other state spending that has nothing to do with providing health care for the poor. Yet, that is exactly what some states are doing with Federal Medicaid funding.

I was deeply disturbed to hear the testimony that the General Accounting Office and the HHS Inspector General recently provided to this Subcommittee. They identified how some states are misusing Federal Medicaid funds, to pay for such things as education expenses and to reduce their budget deficits. In a time of budget scarcity, it is unacceptable that vital Medicaid dollars are being taken away from providing care for vulnerable individuals and diverted to fund other state priorities—however worthy they may be.

I was also troubled to learn about how some state financing schemes contribute to Medicaid beneficiaries being placed at an increased risk of receiving inadequate care. We heard the Inspector General testify about one state that required a nursing home to use an inter-governmental transfer ("I-G-T") to transmit approximately eighty-two million dollars back to the state. This transfer was happening at the same time that the state's auditors were finding a pattern of substandard care in that facility. We need to ask why states are able to remove millions of dollars from such institutions at a time when the facility was clearly in crisis and could have used those dollars to improve the treatment of Medicaid beneficiaries.

I-G-Ts have many legal and permissible uses. No one is suggesting that all I-G-Ts should be prohibited or eliminated. We do, however, need to identify how to ensure that Federal Medicaid dollars are used to provide health care services for the poor. Schemes that divert these dollars away from such uses, or that violate the basic principles of the Federal-state Medicaid partnership, need to be stopped. I look forward to hearing from the witnesses today to learn how we achieve that goal.

PREPARED STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. Chairman, we were here two weeks ago to discuss the enormous burden that the Bush administration is placing on State Medicaid programs, and I am here again today to express my deep concerns about the direction the President is taking the Medicaid program. I believe we should be strengthening this program that is the largest source of insurance today in the United States, and that serves over 51 million seniors, disabled and poor Americans. Instead, the President is advocating a radical overhaul of Medicaid.

Mr. Chairman, we must remember here that by proposing Medicaid reform, specifically with regard to IGTs, the attempt to "crack down" on fraud and abuse only serves to victimize beneficiaries. Our Medicaid programs are in trouble, our states are strapped for dollars, and there are real people who depend on these services for their life and livelihood.

My home state of New Jersey has done nothing illegal, and any funding it has received through IGTs has gone directly back to the Medicaid population, primarily elderly residents of nursing homes. NJ is phasing out its IGT programs and is complying with every law on the books, but nevertheless, the state, like many others across the nation, is being held hostage by CMS.

NJ has an extraordinary number of HHS audits that to date have all come clean, and that are invariably impeding the work of our Medicaid directors. In addition, any state plan amendment offered by NJ or other states that proposes an innovative avenue under statute for providing better and more efficient Medicaid services, or any health service, is literally be used as a ploy by CMS to scrutinize that state's record on Medicaid and employment of an IGT program.

States are being told that unless they make changes to their IGT programs, their state plan amendment application cannot be considered. I would like to reiterate that States, particularly NJ, have not done anything illegal and have used funding to provide services for Medicaid beneficiaries. I am appalled that state plan amendments are being held hostage because of a state's IGT status, especially when the amendment has absolutely nothing to do with Medicaid.

Mr. Chairman, the Bush administration cannot change the rules in the middle of the game. And might I add, this is not a game. By cutting Medicaid funding and offering the proposals outlined in his budget, the President is undermining access to care for the poor, elderly, sick and disabled, and overall, the President's proposals weaken the health care safety net and adds to the widening credibility gap that is putting him, and Republicans that support his proposal, further out of touch with the American people.

PREPARED STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Thank you Mr. Smith and Ms. Edwards for joining us today to discuss Medicaid financing. This is an issue of great importance to the State of Michigan.

I would like to open with a reminder that any cut to Medicaid will cause seniors to lose benefits, children of working families to be turned away, and health care professional's reimbursements to drop yet again. In Michigan, Medicaid has been a godsend for families and seniors, especially during this economic downturn. In the past four years, Michigan's Medicaid program has grown by almost 30 percent, now covering about 1.35 million people.

I am for transparency and honest-bookkeeping. But I believe the purpose of these hearings is dubious. Every time Republicans want to cut Medicaid to fund tax cuts they talk about "reform."

Mr. Smith, in your prepared testimony, you say that that fundamental structural reforms are needed to return Medicaid to a "federal and state partnership." As the former director of Virginia's Medicaid program, I'm sure you know well the importance of the word "partnership." But, from what we've been hearing from states, CMS's recent actions have undermined the federal and state partnership. Frankly, many states believe they are under siege.

Never has it been more important that states and federal governments work together. There are 43 million uninsured in this country. The unemployment rate in a large portion of my district is 12 percent, 12 percent! And, again, Michigan's Medicaid roles have grown 30 percent. Yet, the Administration doesn't seem to be interested in a partnership. For instance:

The president's budget cut Medicaid by $23.5 billion dollars over ten years. That's a $385 million cut over 10 years for Michigan, or $77 million per year. How does a state like Michigan, whose Medicaid enrollment has increased 30 percent in four years, fill a $385 million hole?

Michigan could cut the Home and Community Based Waiver program that allows people to stay in their homes instead of nursing homes. Michigan could cut coverage for 77,000 of Michigan's most vulnerable adults. Or Michigan could cut its low prescription drug benefit program for 14,000 low income seniors.

There is wide agreement that during this economic downturn, with the ranks of uninsured growing, no cut to Medicaid is acceptable. In fact, 250 groups opposed the cuts in the House budget.

In addition, the president's budget does not include an extension of $20 billion in state fiscal relief, including $10 billion in relief directly for Medicaid. The House and Senate budgets did not include an extension either. This critical funding expires June 30th.

States are doing their part in meeting the needs of the uninsured. In Michigan, more than $400 million in state funds have been added to the FY05 Medicaid budget, including

- $168 million to replace the loss of federal fiscal relief set to expire June 30th.
- $150 million to cover the cost of phasing out intergovernmental transfers and
- $86 million for changes in the Medicaid caseload and the increased utilization of services.

Again, states are working hard to help the low-income working families and seniors. They need the federal government to be a partner in their work. I'm looking forward to hearing from Mr. Smith about how CMS intends to be that partner and from Ms. Edwards about what that partnership should look like.

Mr. NORWOOD. Mr. Smith, you are now recognized to offer your statement. We would like to keep it to 5 minutes, but know that if you go over a little bit, I will be very generous.

STATEMENTS OF DENNIS SMITH, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND BARBARA EDWARDS, DEPUTY DIRECTOR, OFFICE OF MEDICAID, OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

Mr. SMITH. Thank you, Mr. Chairman, and members of the subcommittee. I appreciate the opportunity to appear before you today.

I have submitted a written statement for the record and will try to move quickly through some verbal comments.

First, I want to assure everyone on this subcommittee that in no way are we attempting to prevent the States from using their right under the statute to share their cost of the Medicaid program with local government entities.

Second, I would like to say at the outset again, the savings that have—we have estimated to the President's proposal represent less than 1 percent of total Federal Medicaid expenditures over the next 10-year period of time.

There does appear to be a great deal of confusion about the term, the "intergovernmental transfer," or IGT, and confusion about our position as well. I want to assure you that we consider an IGT that meets the conditions set out of the Medicaid statute to be a permissible source of State funding of Medicaid costs.

Statutory provision governing IGTs is an exception to the very restrictive requirements governing provider-related donations. The IGT provision was meant to continue to allow units of local government, including government health care providers, to share in the costs of the State Medicaid program. This provision was necessary in light of the prohibitive nature of the provider-related donation requirements that are applicable to all nongovernmental entities.

In order for a health care provider to transfer funds that are protected under the act, the health care provider must be part of the—it must be a unit of State or local government. Therefore, a governmental health care provider, to make a protected transfer, it must have access to State or local revenues; and accessing State or local tax revenues means that the provider must either have a direct taxing authority or must be able to access funding as an integral part of a governmental unit with taxing authority, so no contractual arrangement with the State or a local government is necessary for the health care provider to receive taxes.

There has been a great deal of interest in our activities in reviewing State plan amendments and what we have been finding. Since August 2003, we have been asking States for additional information, and the questions that we have asked the States have been attached to my written statement, asking questions on how they are financing their share of the Medicaid program through the State plan amendment review process. These questions related to State financing are applied consistently and equally to all States under the State plan amendment review.

During that review process we have discovered that several States made claims for Federal matching funds associated with certain Medicaid payments, payments which the health care providers are not ultimately allowed to retain. Instead, State and or local governments are requiring the health care provider to forgo or to retain certain Medicaid payments to the States, which effectively shifts the cost of the Medicaid program to the Federal Government.

These asserted IGTs do not meet the conditions of the Medicaid statute, because they are not derived from State or local taxes. Instead, they represent a refund of some or all of the Medicaid payment, and there are is not a protected IGT, as some have claimed.

It is critical to note that these financing techniques are prearranged and usually involve an agreement of participation. This

means that only health care providers that willingly agree to participate in the redirection or return of Medicaid funding are eligible to receive the initial payment from the State. Upon receipt, the health care provider must send back to the State or local government or ultimately some part of the payment—at least some part of the payment. In many respects, it has been a very large percentage of the payment.

Clearly, these financing mechanisms require that—which require the return of payments made for services provided to Medicaid individuals are not State or local tax receipts, which is a necessary requirement of the statutory provision of the governing IGTs. I would also note that they are not helping the providers themselves in that they have given up payments for services that they have provided to Medicaid-eligible individuals.

These recycling mechanisms have created tensions among the States and undermine the integrity of the program. The Federal Government, we believe, should match real expenditures for the Medicaid population at the real statutorily described match rates, which are updated and recalculated on an annual basis.

I have already exhausted my time. Let me move very quickly.

We would like to give you an example of what we mean in terms of what we believe that the Federal Government should be matching, and again this is an example in our written statement as well. But to illustrate our point, the President's budget provides that States—that the Federal Government be matching real or net costs of the program. We believe that this is appropriate and supported by a number of General Accounting Office reports and the Department's own Office of Inspector General which recommended this approach about 2½ years ago.

Specifically, the OIG has recommended that CMS, "require that the return of Medicaid payments by a county or local government to the State be declared a refund of those payments and, thus, be used to offset Federal financial participation generated by the original payment." Some have alleged that our strategy would hurt safety net providers, but I think—in fact, we see—that the excess amounts being returned to the States themselves are not benefiting the providers.

Our clear objective, as we have worked with the States and their plan amendments, has been to secure payments for those providing the services. We believe that the solution that we have laid out is a relatively simple one and one that is based on truly what payments were actually made for services provided themselves.

So I appreciate the opportunity to appear before you today and look forward to your questions.

[The prepared statement of Dennis Smith follows:]

PREPARED STATEMENT OF DENNIS SMITH, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Chairman Bilirakis, Ranking Member Brown, distinguished Committee members, thank you for inviting me to discuss intergovernmental transfers (IGTs) and the financing of the largest government health insurance program in the United States, Medicaid. Medicaid and Medicare Federal expenditures are of similar magnitude, and, in fact, prior to implementation of MMA Medicaid expenditures exceeded those of Medicare and will continue to do so until 2005.

There have been numerous studies over several years from the General Accounting Office (GAO) and the Office of Inspector General (OIG) regarding state actions

to effectively shift a larger portion of state Medicaid costs to the Federal government. As the problem has been well documented elsewhere, I will focus my remarks on our views of intergovernmental transfers and our strategies for addressing this issue.

BACKGROUND

Medicaid is a partnership between the Federal Government and the states. While the Federal Government provides financial matching payments to the states and is responsible for overseeing the Medicaid program, each state essentially designs and runs its own program. States have great flexibility in administering their programs, and the Federal Government pays the states a portion of their costs by matching certain spending levels, with statutorily determined matching rates, currently ranging between 50 and 77 percent. This creates a natural tension in which states strive to maximize Federal matching dollars.

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

Additionally, regulations at the time allowed states to impose special taxes on specific provider groups. These regulations led states to impose taxes and receive donations from providers that led to new ways to finance states' share of Medicaid expenditures. In 1986, Congress was concerned that states were not reimbursing Disproportionate Share Hospitals (DSH) for their uncompensated care costs. Legislation was passed that eliminated any limit on DSH payments. The combination of new revenue sources from donations and taxes and the ability to pay unlimited DSH reimbursement led to a significant increase in Medicaid expenditures claimed by states. Once these exploding loopholes began to be limited, states pursued the Upper Payment Limit (UPL) loophole more aggressively. Using these mechanisms, many states have managed to inappropriately draw down more Federal Medicaid dollars with fewer state dollars, resulting in an effective FMAP that is higher than the statutorily determined matching rates, creating inequities among states. CMS has begun to close these loopholes and ensure that states receive appropriate matching rates, but it is a long, complicated process.

CMS OVERSIGHT ACTIVITIES

CMS has a strong interest in strengthening financial oversight and ensuring payment accuracy and fiscal integrity. Federal matching funds must be a match for real Medicaid expenditures. At the Federal level, our primary role is to exercise proper oversight and review of state financial practices and to provide guidance and support for states' efforts to ensure program and fiscal integrity. While we have made substantial progress in helping states identify and reduce improper payments, we are now turning our attention to strengthening Medicaid Federal financial management activities.

We have taken some initial steps to improve our financial management processes, but we know that more work can and must be done. As part of the President's FY 2003 Budget, we have dedicated $10 million from the Health Care Fraud and Abuse Control (HCFAC) account to develop a comprehensive Medicaid program integrity plan. The FY 2004 Budget allocated $20 million from HCFAC for this effort. The FY 2005 Budget also proposes to allocate $20 million from HCFAC for this initiative. We are increasing attention to, and emphasizing the importance of Medicaid financial management at all levels of our Agency and across all of our regions. This effort involves improving Federal oversight capabilities of state Medicaid financial practices, and focusing attention on program areas of greatest risk, so that our resources are targeted appropriately. The following are examples of improvements and progress we have made as part of our Medicaid financial management and program integrity redesign.

Creating National Reimbursement Teams

In an effort to improve national consistency in the issuance and application of Medicaid reimbursement policy, we have put together a team of Central and Regional Office staff, the National Institutional Reimbursement Team (NIRT), who are responsible for reviewing all institutional reimbursement state plan amendments, providing technical assistance to the states, and developing Medicaid institutional reimbursement regulations and policy. For example, the team is currently using a

standard set of questions that must be answered by states before a state plan amendment will be approved and will help ensure that the payment methodology is clear. Questions include issues such as, "Do providers retain all of the Medicaid payments including the Federal and state share (including normal per diem, DRG, DSH, supplemental, and enhanced payments) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization?" As a result of this effort, we will better know what we are paying for and how we are paying for it. The team's work will help ensure consistency in the application and review of our Medicaid policies. We also have established a Non-Institutional Provider Team (NIPT), which functions similarly to the NIRT, but for non-institutional providers, namely physicians. The NIRT and the NIPT have been working together on UPL transitions for those states with both inpatient and outpatient UPL phase-outs.

Upfront Reviews of State Funding Sources and Expenditures

We will be redirecting and adding resources this year with the goal of changing the emphasis of the Financial Management (FM) review of state Medicaid/SCHIP programs from an after-the-fact review to an upfront and proactive review. Our new emphasis would be primarily to review the non-Federal share amounts and related expenditures prior to the beginning of the fiscal year so that any problems or issues can be resolved before any claims are submitted. This process would provide an approval of the state's operating plan for the upcoming year, with the goal of eliminating the need for CMS to intervene and disallow Federal Medicaid funding after it has already been spent by the state and to identify any unallowable funding mechanisms or expenditures before they actually happen. We recognize that the comment period provided for in the January 7 Federal Register notice was not sufficient. In that regard, CMS will be consulting with the National Governor's Association and the National Association of State Medicaid Directors (NASMD) to ensure full understanding of the process and requirements prior to its implementation. Furthermore, following these consultations, CMS intends to republish the notice in the Federal Register with a full 60-day comment period. This process will not be implemented until the full consultation with our state partners is complete.

Making Federal Matching Payments Only When State Plan Amendments Are Approved

In the past, states have been allowed to draw down Federal matching payments for state plan amendments that were submitted, but not yet approved. This allowed states to assume a financial risk if their plan amendment was subsequently disapproved. Since Federal matching payments were readily available while their state plan amendments were being considered, states had little incentive to ensure their plan amendments were approved. In fact, some state plan amendments were pending for years while the states continued to draw down Federal matching payments. In January 2001, we issued a state Medicaid Director letter informing the states that we would no longer make Federal matching payments until state plan amendments were approved, thus removing the previous incentive for states to keep plan amendments pending. For our part, we have changed our policy so that we will either approve or disapprove plan amendments within 90 days.

Partnership with State and Federal Oversight Agencies

Another key element of our new financial management strategy is to strengthen our working relationships and our exchanges of information with several state entities. Every state has one or more audit entities responsible for ensuring that state expenditures, including those in the Medicaid and State Children's Health Insurance Programs, are properly made and documented. Furthermore, every Medicaid Agency has a surveillance and utilization review staff to pinpoint and pursue questionable provider claims and Agency payments. Finally, as you know, virtually all states operate a Medicaid Fraud Control Unit, typically housed in the Attorney General's office, to pursue instances of suspected Medicaid fraud. By better cultivating our relationships with state agencies that perform these types of functions, we believe we can continue to enhance our oversight of the Medicaid program nationwide. In addition, over the last several years, at the Federal level, we have developed a close collaboration with the Department of Health and Human Services' Office of the Inspector General. We intend to continue this relationship. CMS is in the process of hiring and assigning 100 new full time equivalent (FTE) positions that will be responsible for audit and compliance work within the CMS regions and in each state.

Since August 2003, CMS has been requesting information from states regarding detail on how states are financing their share of the Medicaid program costs under the Medicaid reimbursement State Plan Amendment (SPA) review process. The questions related to state financing of the Medicaid program are applied consistently and equally to all states under the SPA review process. New SPA proposals will not be approved until states have fully explained how they finance their Medicaid programs and until such time that states have agreed to terminate any financing practices that contradict the intent of the Federal-state partnership. (Attachment)

During that SPA review process, CMS discovered that some states are utilizing financing techniques that do not comport with the intent of the Federal-state partnership. Specifically, CMS has discovered that several states make claims for Federal matching funds associated with certain Medicaid payments, payments of which the health care providers are not ultimately allowed to retain. Instead, through the "guise" of the IGT process, state and/or local governments require the health care provider to forgo and/or return certain Medicaid payments to the state (on the same day in many instances), which effectively shifts the cost of the Medicaid program to the Federal taxpayer.

The result of such an arrangement is that the health care provider is unable to retain the full Medicaid payment amount to which it was entitled (a payment for which Federal funding was made available based on the full payment), and the state and/or local government may use the funds returned by the health care provider for costs outside the Medicaid program and/or to help draw additional Federal dollars for other Medicaid program costs. The net effect of this re-direction of Medicaid payments is that the Federal government bears a greater level of Medicaid program costs, which is inconsistent with the Federal medical assistance percentages specified in the Medicaid statute.

Some may suggest that the action taken on UPL has addressed the concerns of the subcommittee. Experience shows this is not the case. Since we began our in depth review of state plan amendments that deal with reimbursement last summer, 82 have been approved, 4 have been disapproved and 5 have been withdrawn entirely by states. Thirty-nine SPAs have been temporarily withdrawn by states as a result of our requests for additional information. Another 153 SPAs are under review at CMS.

The FY 2005 Budget proposes to build on past efforts to improve Federal oversight of Medicaid and ensure that Federal taxpayer dollars for Medicaid are going to their intended purpose. The Administration proposes to further improve the integrity of the Medicaid matching rate system through steps to curb IGTs that are in place solely to avoid the legally determined state financing. To be clear, CMS always considers legitimate IGTs permissible sources of state funding of Medicaid costs, which are meant to allow units of local governments, including government health care providers, to share in the cost of the state Medicaid program.

In this regard, we are developing a proposal under which the Federal government, when matching a claimed state expenditure for a service provided by a public provider, will only provide matching payments on the basis of the state's true net expenditure. For a simple illustration, assume that a state with a 50/50 match rate submits a claim for $100 for service provided by a public provider. If the public provider is required to return 5 percent of the claim to the state as an intergovernmental transfer, we believe the net expenditure is only $95 so the federal match should be only $47.50 instead of $50. As noted previously, the Department's Office of Inspector General recommended this approach as part of its September 2001 final report. Specifically, the OIG recommended that CMS "Require that the return of Medicaid payments by a county or local government to the State be declared a refund of those payments and thus be used to offset the FFP generated by the original payment."

The Administration proposes to restrict federal reimbursement for Medicaid payments to individual government providers to no more than the net cost of providing services to Medicaid beneficiaries. Limiting Federal reimbursement to no more than net cost would curb excessive payments while preserving a state's ability to pay reasonable rates to such providers. Both the U.S. General Accounting Office and the HHS Office of the Inspector General have recommended that payments to government owned facilities be tied to costs. GAO has recommended that Medicaid allow states to reimburse government facilities no more than costs, while OIG has recommended that facility specific limits be established based on costs. CMS is continuing to develop our full legislative proposal and intend to submit it shortly.

CONCLUSION

Although CMS has several efforts underway to improve Medicaid's financial oversight and management, these are all temporary solutions. Medicaid financing needs fundamental structural reforms that will return the program to a Federal and state partnership and will reduce waste, fraud and abuse. CMS is interested in working with Congress and our state partners to resolve issues related to financial recycling mechanisms and making sure that Federal dollars remain in the Medicaid program and Medicaid payments remain with providers. We believe an approach under which the Federal government will provide matching payments on the basis of the state's true net expenditure when matching a claimed state expenditure for a service provided by a public provider would address the financial recycling mechanisms now in use.

Through complex, creative financing mechanisms, states have artificially maximized Federal Medicaid matching funds. Such practices undermine accountability, responsibility, and ultimately, public trust. We look forward to working with you to find a permanent solution to this growing concern.

ATTACHMENT

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan.

1. Do providers retain all of the Medicaid payments including the Federal and State share (includes normal per diem, DRG, DSH, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (ie, general fund, medical services account, etc.) For DSH payments, please also indicate if you are making DSH payments in excess of 100% of costs and the percentage of payments in excess of 100% that are returned to the State, local governmental entity, or any other intermediary organization.

Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan.

2. Please describe how the state share of each type of Medicaid payment (normal per diem, DRG, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the state share is being provided through the use local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan.

3. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.
4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).
5. Does any public provider receive payments that in the aggregate (normal per diem, DRG, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Mr. NORWOOD. Thank you very much, Mr. Smith, and I want to say to the committee that we are out of regular order just a little bit, and I ask unanimous consent that rather than go to the next witness, we allow the ranking member to have his 5 minutes of opening statement, which I think is the right and fair thing to do.

If there is no objection, so ordered.

Mr. BROWN. Thank you, Mr. Chairman. Thank you for your fairmindness. I apologize for my late arrival. I didn't realize that we had voice voted on the floor as early as the rest of you realized it.

I want to thank our witnesses for joining us, especially thank Barb Edwards, who does a terrific job running the Medicaid program. Thank you both for joining us, especially you, Ms. Edwards.

I want to begin by making a request to the chairman that we schedule a hearing that will give members the opportunity to hear from Medicaid beneficiaries. If there is fraud—and I will make that request personally of Mr. Bilirakis later. If there is fraud and abuse occurring, we should put a stop to it.

I believe Ohio's Medicaid program acts in good faith and fully complies with existing laws and regulations. However, if some States are, in fact, stretching the rules, it must stop.

That does not mean we should use that as an excuse to reduce the net funding available to State Medicaid programs. If we cut dollars from Medicaid, we should replace those dollars. It doesn't matter whether the States divert dollars from Medicaid into road construction or the President diverts dollars from Medicaid into tax cuts. Unless we replace those dollars, we hurt children, we hurt disabled people, we hurt seniors in nursing homes. We need to hear from these men and women.

The President needs to hear from these men and women. His budget includes a $23 billion cut in Medicaid. That is irresponsible, and we should not follow his lead. I am going to request, as I mentioned, a hearing so members can see the human consequences of Medicaid cuts.

Second, there are reports that CMS has been engaging in some questionable tactics to reduce Federal liability for Medicaid. State Medicaid directors reported that CMS is trying to change the rules midstream, that CMS has also been withholding payments in an attempt to convince States to block-grant Medicaid programs.

This isn't a game. The administration doesn't win if they figure out new and innovative ways to starve Medicaid. Instead, we all lose. We lose a health safety net that protects all of us. We lose ground because more Americans become uninsured as our economy continues to not produce the jobs that we need.

If this administration wants to change Medicaid policy, it should do it in the light of day. It should follow the procedures in place to ensure public input and transparency. Under no circumstances should it change the rules despite the law.

The laws governing Medicaid are under this subcommittee's jurisdiction. The buck stops with us. Not only are we responsible for ensuring that the States play by the rules, we are responsible for ensuring that CMS plays by the rules. Again, whether it is one of 50 States or the Bush administration playing fast and loose with the Medicaid rules, the victims are the same.

I want to share with you, in closing, one Medicaid director's comments, a Medicaid director from a State with a Republican Governor. And this is a bit lengthy but I would like to read it.

"I am concerned the administration's attack not cause Congress to lose sight of the fact that Medicaid provides critically important health care services to real people with real health needs, that we pay real doctors and hospitals and nursing homes and pharmacies and home health aides to provide those services.

"In my State, Medicaid," this letter continues, "ensures one of every three children, 50 percent of children under 5. Seventy-five percent of the expenditures are for people of all ages with disabilities and impoverished seniors; 50 percent of spending is for people with Medicare.

"My State has not been an abuser of IGT. We have legitimate local match dollars, especially in community health programs and MRDD, and a federally approved UPL program that provides enhanced payments to public hospitals. The UPL funds go to the providers, not to State coffers.

"In some areas, CMS is starting to change the rules. They are actually trying to enforce new standards that aren't contained in any rules. Increased scrutiny is leading to delays in State plan approvals, and they are questioning programs they have previously approved.

"I want to be clear," she writes, "I am a strong supporter of the need for integrity in the fiscal relationship," I would add, we all are, "between CMS and States over Medicaid. If our State has problems, we will fix them," she continues, "but what we need is clarity in the standards, rules promulgated instead of 'Dear State Medicaid Director' letters that set policy without public debate, and a responsive Federal oversight agency that is committed to the success of these health plans. If these standards are going to change, many States will need transition time to accommodate new requirements without undue hardship to consumers."

In her last paragraph she concludes, "I really hope the underlying need to address the cost drivers in the health care system," that it "is not lost in this current debate over whether the State taxpayer, the Federal taxpayer is paying how much of the bill."

Mr. Chairman, there are at least three important messages in this Medicaid director's comments. One, don't forget that Medicaid is a lifeline for people in need—the young, the disabled, the elderly; two, don't try to stretch, manipulate or bypass the rules at the expense of those people in need; and three, don't fool ourselves into believing that cutting Federal dollars from Medicaid is a solution to any of these problems. Health care is necessary. Health care is expensive, whether or not Medicare covers it.

I hope these messages register. Thank you, Mr. Chairman.

Mr. NORWOOD. Thank you, Mr. Brown. I am sure they will register, and it is always good to hear from you and your thoughts about what should be done.

Ms. Edwards, I apologize that we disrupted our normal schedule. You are now recognized, hopefully for 5 minutes, but we will be a little lenient for that.

So if you would, begin.

STATEMENT OF BARBARA EDWARDS

I am going to be very brief, because in fact I am the Medicaid Director that made many of the remarks that Mr. Brown has shared with you, and it really is the substance of my comments to you this afternoon. I would like to present a written comment from—on behalf of the National Governors Association for the record and simply reiterate what the Congressman said, that from Ohio's perspective, the use of intergovernmental transfers is an important funding stream in a couple of our programs, particularly in community mental health and in community mental retardation and developmental disabilities where we rely on local tax dollars.

We also have an approved upper payment limit program, where hospitals that are public receive enhanced payments up to 100 percent of the Medicare payment. The dollars go to those safety net hospitals in major urban areas and in rural areas in our State. They do not go to State coffers.

I am optimistic that the intergovernmental transfers that Ohio currently employs, in fact, are—have been approved by CMS as legitimate and would continue to be.

I think that you will see in the NGA's statement that the States broadly believe that the mechanisms that they have in place are compliant with current regulations and standards under Medicaid, in many cases have been approved by CMS explicitly; and I would just underscore that if, in fact, the rules are going to change—and certainly there have been instances in the past where Congress or the administration have made explicit changes in how Medicaid financing can be accomplished—that we have to recognize that if that results in reduced Federal financing in this current environment, that it undoubtedly would result in changes to the program at the State level.

I certainly know that in Ohio we are in a condition where the revenues are continuing to lag below expectations. There are no reserves. State agencies are facing cuts even within this biennium from what was originally budgeted, and any loss of Federal funds will be felt at the program level through program cuts.

We are committed to integrity in this program with regard to the fiscal relationship. I, in fact, believe that my office as the single State agency at the State level has a fiduciary responsibility to the Federal Government with regard to the administration and the financing of this program, and we take that seriously.

What we need are clear standards, and we will do our best to meet them. What we often have today does feel like a changing set of expectations that are being figured out on a case-by-case basis as State plan amendments are filed.

I have sympathy for the CMS folks in trying to figure out some of the questions that they are interested in at the State level, but it is a darn hard way to run a program at the State level if, in fact, you can't know what the standard is that you are going to be held accountable to with regard to financing. It has caused us, in fact, to begin to question arrangements that have been long-standing, and we aren't sure which plans and which standards are going to end up being acceptable and which are not, and that makes the management very difficult.

So we do ask for clarity. We ask for standards that are established with public input from the stakeholders—in writing would be nice. And we look forward to continuing to have a strong Medicaid program.

These are critical programs in our States. They serve important people, and we will all be winners if, in fact, we can get our focus back on the issue of the underlying costs in this program. It is the same taxpayer, whether it is the State taxpayer or the Federal taxpayer; and it is important that we return our focus as quickly as we can, I think, to the underlying challenges of what is driving the rising cost in health care, because that is what it is going to take for us to have a sustainable program over the long term.

And I am happy to answer questions. Thank you.

[The prepared statement of Barbara Edwards follows:]

PREPARED STATEMENT OF THE NATIONAL GOVERNORS ASSOCIATION

INTRODUCTION

The Medicaid program is the largest and most important health care program in the country. It currently provides $300 billion per year in critical health care and long term care services to more than 50 million low-income children, working families, frail seniors, and people with disabilities. It is a lifeline and a safety net for the most vulnerable members of our society.

Medicaid is actually 56 separate programs administered by the states and territories and jointly financed by the states and the federal government. The percentage of the state's share varies depending on several factors, but averages about 57 percent federal and 43 percent state. The "non-federal" share can be financed entirely through state funds, but states also have the option to require local governments to share the costs. Of this "non-federal" share, up to 60% can be financed by local contributions. These contributions, or intergovernmental transfers (IGTs), were designed by Congress and are in the Medicaid statute, have been authorized by federal regulations, have been approved by the U.S. Department of Health and Human Services (HHS) for many years, and are a legitimate mechanism that many states rely on to finance the Medicaid program.

INTERGOVERNMENTAL TRANSFERS

Section 1902(a)(2) of the Medicaid statute codifies this arrangement by requiring states to "provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan . . ."

Furthermore, Section 1903(w)(6)(A) states, "Notwithstanding the provisions of this subsection, the Secretary may not restrict States" use of funds where such funds are derived from state or local taxes (or funds appropriated to state university teaching hospitals) transferred from or certified by units of government within a state as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider . . ."

Finally, this is also recognized in federal regulations, which authorize the use of public funds as the state share of Medicaid spending if the funds are "transferred from other public agencies (including Indian tribes) to the state or local (Medicaid) agency and under its administrative control . . ." (42 C.F.R. 433.51(b)).

STATE AND LOCAL GOVERNMENTS

The funding of Medicaid follows two broad models: centralized, where the state is responsible for raising revenue and distributing to the local level; and decentralized, where the local entities have much greater authority to raise and spend revenue on their own. IGTs, in part, recognize that state-raised revenue and county-based revenue are essentially equal in the eyes of the law and therefore, neither should be discriminated against.

Without the benefit of IGTs, large county-based states, such as New York, California, Wisconsin, and North Carolina to name just a few, would literally be unable to finance their Medicaid programs, destroying the safety net in many parts of the country and drastically increasing the numbers of the uninsured.

Therefore, attacks on the very existence of IGTs would fundamentally threaten the decentralized form of government that these states have chosen and would rep-

resent an attempt by the federal government to statutorily favor state governments that are centralized and do not rely on the ability of counties to raise revenue.

We remain hopeful that this is not the intended result of any congressional or administrative actions.

FEDERAL CONCERNS

The Administration and some members of Congress have accused states of manipulating Medicaid financing mechanisms in inappropriate ways. States have been accused of misusing IGTs in association with Disproportionate Share Hospital (DSH) payments, Upper Payment Limits, and Provider Taxes. These claims are not new, and have resulted in the past in federal action clarifying what is appropriate.

If there continue to be concerns about how states are financing Medicaid, we would recommend that discussions be held that are open, exhaustive, and include all impacted stakeholders. These discussions should at least acknowledge that not only are the state actions in question legal, but have been approved by HHS, and in many cases encouraged by them in the past.

FINANCING MECHANISMS ENCOURAGED BY HHS

An excellent example of how states and the federal government worked together is in Nebraska. The state, with the full support and blessing of both the HHS central office and regional offices, developed a plan to increase reimbursement to nursing homes to the federal maximum. They then utilized an intergovernmental transfer and dedicated the extra money into a trust fund that would be used solely to assist nursing homes in a physical conversion to assisted living facilities. Everyone benefited. Nursing homes were able to embrace the economics and demand of the 21st century—the increasing preference of seniors to reside at home or in community settings. The state was able to transform its long-term care infrastructure to assisted living facilities "which are much cheaper to maintain than nursing homes. The federal government also benefited by saving money in the long run, and by working with the state to meet the shared goal of decreasing reliance on institutional care.

DO NOT CHANGE THE RULES MIDSTREAM

Regardless of what changes Congress may consider, it is critical that the financing rules of Medicaid not be changed midstream. States have acted within the parameters of the law and the regulations when negotiating budgets—and all financing mechanisms are both legal and approved by HHS. For these rules to be changed midstream, without notification or congressional directive, would be a presumption of guilt that is inappropriate in a state-federal partnership. In addition, such changes may well constitute an illegal impoundment of funds and violate other bedrock provisions of the Medicaid program.

It is therefore inappropriate for HHS, without legislation approved by Congress, to move forward with changing these rules and policies. We are finding that such a practice is occurring with increasing frequency, much to the concern of our members and their Congressional delegations.

States who have already received federal approval for this funding have designated the money to go towards such important goals as financing expansions of home- and community-based long-term care, increasing physician reimbursements so that access to care is not jeopardized, ensuring that tier one trauma centers keep their doors open, and in many states, ensuring that small rural hospitals are not forced to close or otherwise jeopardize patient care.

STATES CANNOT CONTINUE TO FINANCE MEDICAID AND THE NEEDS OF THE DUAL ELIGIBLES

Medicaid currently accounts for roughly 20 percent of any given state's budget, making it the second largest expenditure next to education. The Medicaid program is also growing at almost double digit rates, due to significant pressures in prescription drug costs and long-term care. Growth that large in a program Medicaid's size is unsustainable even in a good economy. Unfortunately, states are not in good fiscal standing. The combination of Medicaid growth and lower than projected revenue has created a situation where Medicaid costs are eating up every dollar of state revenue, leaving no room for increased funding for education or other key priorities.

This unfortunate situation is exacerbated by the difficulty states have had in dealing with unfunded federal mandates and by the fact that increasing amounts of the Medicaid budget (and also state funded programs) are devoted to filling holes in the federal commitment to Medicare beneficiaries.

Forty-two percent of the entire Medicaid budget is spent on services for elderly and disabled Medicare beneficiaries, the so-called "dual eligibles." This is a shocking number when you consider that they comprise only twelve percent of the total number of people served by Medicaid and that they are all fully covered by the entire Medicare benefits package. Medicaid's responsibility includes acute care services beyond Medicare's limitations, prescription drug coverage, which Medicare does not yet provide in any comprehensive fashion, payment of expensive co-pays, premiums, and deductibles, and most importantly, long-term care services.

It is critical to be mindful that the Medicaid program is essentially the only funding source for long-term care services in the nation, paying approximately five times what Medicare does in total. Medicaid is responsible for more than sixty percent of all nursing home care in this country. As the baby boom demographic starts to reach Medicare eligibility within the next decade, these trends will worsen substantially unless common-sense reforms are enacted.

Congress first attempted to address prescription drug coverage in the Medicare Catastrophic Act of 1988. This legislation created a drug benefit for seniors and required the Medicaid program to pay significant amounts of cost sharing for low-income seniors through the creation of the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs. Congress quickly repealed the drug benefit, but left intact the Medicaid requirement to cover Medicare cost-sharing. Consequently for the past thirteen years, states have borne billions of dollars in increasing costs for the QMB and SLMB programs, and tens of billions of dollars in providing prescription drugs for low-income Medicare beneficiaries.

We were strongly encouraged by Congress' recent effort to enact a comprehensive Medicare prescription drug benefit into law, and appreciate the decision to qualify the dual eligibles for the Medicare benefit. However, states will still be required to finance the vast majority of these costs, through the "clawback" effect. This will create an unprecedented reverse block grant of funds from states to the federal government, one in which states will have no control over how the money is spent.

States have never been in a position to welcome these burdens on behalf of the federal government. Strong state revenue growth in the mid 1990s helped mask an unsustainable load that has now become unbearable. Without additional federal help, states will be unable to afford current Medicaid commitments, let alone ponder the significant expansions that would be needed to address the growing problem of the uninsured.

States are spending significantly more money on the Medicaid program now than they were 10 years ago, despite the increased financing through Upper Payment Limit mechanisms. The state share of Medicaid in 2000 was $94 billion, as compared to only $50 billion in 1992, and $70 billion in 1997. This demonstrates state commitment to funding the program and proves that the increases in the Medicaid budgets are not being financed overwhelmingly by federal funds.

Finally, the temporary state fiscal relief will end in fiscal 2004. Because of this, and because of the continued growth of Medicaid overall, the total amount of state dollars in Medicaid will increase by 15 percent to 20 percent from fiscal 2004 to fiscal 2005. This will create a fiscal situation ill-suited to absorb additional reductions in the federal commitment to Medicaid funds.

CONCLUSION

The Governors oppose any reductions in Medicaid spending as well as changes to the current policy that would jeopardize funding for underserved populations. The current policy represents a well thought-out balance that seeks both accountability and sufficient funding for the health care safety net. Changing the policy now could have disastrous consequences for public hospitals and the individuals they serve.

Mr. NORWOOD. Thank you, Ms. Edwards, for your testimony and taking time to come all the way to Washington to give us your thoughts and feelings on this.

I would now like to yield to the gentlelady from New Mexico, Mrs. Wilson, for 5 minutes of questions.

Mrs. WILSON. Thank you, Mr. Chairman.

Ms. Edwards, thank you for being here today. I have a certain amount of sympathy for your managerial challenges, having been formerly a cabinet secretary in State government for children in New Mexico.

I wanted to ask you, as the State Medicaid Director, what data do you gather on the health status of those dependent upon Medicaid?

Ms. EDWARDS. Congresswoman, we are, through our HMOs, doing some health survey in regard to folks as they enroll. We rely, however, pretty heavily on the broader public health surveys with regard to health status in general, so it is not a piece of information that for the general population we have a great deal of information on for folks as they enroll in Medicaid.

We do consumer satisfaction surveys, generally by telephone, and part of those surveys involve asking questions about how a consumer perceives their own health status. We also sponsor a statewide survey that surveys more broadly than just the Medicaid enrollee, and there are some health status questions that are asked as a part of that survey process as well; but this is an area in which we still rely more on the public health survey than on work that we do directly with our consumer population.

For folks that are in waiver programs, we have much more information on their health status.

Mrs. WILSON. With respect to the HMOs that gather data, does Ohio have a waiver under which you cover Medicaid eligibles through HMOs?

Ms. EDWARDS. Mr. Chairman, we are still operating our managed care program through waivers rather than under the State plan amendment, because that has accommodated our program design better, so we are using a waiver.

Mrs. WILSON. Thank you.

Mr. Smith, I thank you as well for being here today. I wanted to ask you a couple of questions about the upper payment limit issue and, particularly, whether you have estimates about how much Medicaid—how much it would affect the Medicaid budget if we eliminated. There is a question of excessive claims for upper-payment-limit States, and there is a phaseout in place. If that phaseout was shortened, if the transition period were shortened for those that were granted 5-year and 8-year phaseouts, how would that impact the Medicaid budget?

Mr. SMITH. I don't have the exact figures. I do want to—I do want to state, we have not proposed changing the transition periods that States now have, and in fact, again, our proposal would preserve the transition periods that States have under upper-payment limits. I think we can probably get the figure for you fairly quickly about how much is involved in those.

At this point in time, you are basically talking about the 5-year and 8-year transition periods for States. We can get that precise figure for you.

Mrs. WILSON. I would be interested in that data, particularly as the GAO issued earlier this month a report on upper-payment limits which was, at least in part, critical of the way CMS is going about this; and I think that is a question of what these phaseout periods should be and how—you know, all of us want to get a dollar and 10 cents worth of value out of every dollar that we spend, and we want to make sure that the money gets to the people that need the care and that it improves the quality of their health and

their lives. And that means, in part, seeing where money is not going in the right place.

And if you could take a look at that, I would very much appreciate it.

Mr. SMITH. We can get you those figures.

Mrs. WILSON. Thank you, Mr. Chairman.

Mr. NORWOOD. Thank you, Mrs. Wilson.

I now yield 5 minutes to Mr. Brown for questioning.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Smith, as a Medicaid administrator, you certainly recognize the problems these days in the States. In the last 3 or so years we have lost almost 3 million manufacturing jobs. We have lost in my State of Ohio, one of the hardest hit, we have lost some 236,000 jobs, which comes out to about 200 jobs every day in the last 3 years. Our manufacturing—those people who had pretty good health care benefits, have been particularly hard hit, so obviously Medicaid rolls in my State, as Ms. Edwards knows, and other States are continuing to expand.

But it is not just Medicaid beneficiaries who obviously—whom we serve that are so important. It is also—Medicaid has also been a pretty big engine to drive the economies in our States. In Ohio, in 2001, Medicaid contributed $11.5 billion in business activity. Its spending generated—Medicaid spending generated 132,000 jobs in Ohio, increased wages by—or provided $4.1 billion in wages. Each Medicaid dollar spent in Ohio—and I don't think other States are any different—generates somewhat in excess of $3 of business activity.

In June of this year, as you know, the FMAP legislation which Mr. King and I worked on, and others in the House and Senate, the FMAP funds expire. The Federal share—that means Ohio will see the Federal share of its Medicaid program drop from 62.2 percent to 59.7 percent, a significant loss of funds. On top of that, the Bush administration is proposing a $23.5 billion cut. They have given us no information on how much that means in each State, but clearly its impact is very significant in large and small States alike.

This strikes me as pretty unwise economic policy. You give tax cuts to the wealthiest people in society who are unlikely to spend it instead of contributing to an economic engine like Medicaid that really will create—generate economic activity and create good jobs in the health care system.

My question is, last year the administration opposed the FMAP—$10 billion at FMAP. The administration, the Republicans and Democrats alike in both Houses, went ahead and did it anyway. My question is, does the administration support this year, beginning in June as the $10 billion expires, some kind of fiscal relief for States for Medicaid?

Mr. SMITH. Mr. Brown, a couple of things. We did not put in the President's budget either an extension of the FMAP nor did we repropose specifically. The President's budget last year in fact would have provided the equivalent of an FMAP increase, had that been enacted.

The $23 billion that you refer to—again, that is over a 10-year period of time—that would not have an immediate impact on—that size of an immediate impact on the States themselves.

Mr. BROWN. The expiration of the $10 billion annually in June would?

Mr. SMITH. Congress passed a temporary FMAP increase last year.

Mr. BROWN. Let me interrupt you because I don't have a lot of time.

So if you are not willing to say, yes, the President and the administration will support extending that FMAP money for another year of $10 or $15 or whatever billion, would you support some sort of targeted relief for those States that quantifiably can show that they have been hit the hardest?

Mr. SMITH. As you know, the President's budget does not include that at this point in time. I have not had further discussions about a proposal and whether or not that increase is going to be extended or not.

Mr. BROWN. Do you have any advice for people in my State, those that lose their jobs because of this 62 down to 59 percent, representing the loss of funds? Those that lose their jobs or those that lose their health insurance, do you have any advice for them or solutions for us for them?

Mr. SMITH. We have, in fact, had a couple of different proposals that would help people who are uninsured or become uninsured. Medicaid obviously is one part of that solution and——

Mr. BROWN. But those solutions are not for tomorrow. Those solutions are not for June. Those are solutions some of us agree with, some of us don't, that would perhaps deal with the uninsured; but what about for those in June who get a pink slip because you are cut, you are not renewing the FMAP money, and for those who lose their health insurance in Ms. Edwards' State or any of the other 49 States?

Mr. SMITH. Mr. Brown, as you know, the FMAP—the Secretary has no authority to change a State's FMAP rate. We have no authority on our own to provide additional funding for the States themselves.

The FMAP increase was a——

Mr. BROWN. Obviously, we have no authority because we did the $10 billion last year even though you were against it, but if you were for it, it would make it a whole lot easier to convince this Congress that maybe we ought to help the States on Medicaid.

Okay, thank you.

Mr. SMITH. If I may also—you asked about the impact on the States of the $23 billion. It would have no impact on a State that has not been recycling Federal funds.

Mr. NORWOOD. Thank you, Mr. Smith.

It may be useful to the committee to recall back that Senators Collins and Nelson, when they worked this FMAP money through the Senate, indicated at the time that it was only a temporary thing. They never did—they never indicated once that it would be permanent.

Mr. BROWN. Well, Mr. Chairman, I think we operate under the assumption that——

Mr. NORWOOD. You are recognized.

Mr. BROWN. [continuing] that this economy would grow some jobs and—am I speaking out of turn, Mr. Chairman?

Mr. NORWOOD. Yes, you are.

Mr. BROWN. You have been awfully nice to me. I am just going to be quiet for the rest of the day.

Mr. NORWOOD. Mr. Deal, you are now recognized for 8 minutes' worth of questions.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. Smith, we have had discussions previously with regard to some specifics in my State of Georgia, and I would like to just review a few of those, if I might, at this point.

Our State-by-State statute in 19—excuse me, 2003—instituted a nursing home provider fee. In July 2003, our Medicaid State plan submitted an amendment to incorporate that nursing home provider fee as a part of an amendment.

The discussions have been going on with your office for, I think, about 9 months. We thought—I think our State thought that the matter had been resolved.

We understand there are 21 or 22 other States that also have a nursing home provider fee. The most recent wrinkle has apparently been a concern of UPL—some UPL concerns with regard to the nursing home provider fee. That was a new wrinkle that came very late in these discussions and, quite frankly, has caught our State off guard in that respect.

Could you tell me, or could you provide me if you can't say right now—could you provide me with information as to what the UPL concern is as it relates to these fees; and has the same concern been voiced for the other 21 or so States that have the same basic format? We understand, for example, that New Hampshire has now been approved with theirs.

We had a problem at one point apparently with the lack of uniformity, and a waiver was requested about the lack of uniformity, and I think we thought that was the problem. So we withdrew the waiver request and went back to the basic amendment. And that appears to still be a problem now with UPL.

Could you enlighten me as to what that might be?

Mr. SMITH. Yes, Mr. Deal, and I appreciate the question.

And the Georgia situation illustrates precisely what we have been seeing among the States themselves. We basically—and, again, we have provided for the subcommittee the list of questions that we ask all States that have the financing State plan amendments.

Basically, we are looking for two things. What is the source of funding? Again, Federal dollars follow State dollars, State, slash, or local dollars, so we are looking for, have you put up your share of the match? And second, does the money stay with the provider? The provider tax issue is the first part, is your source of funding good? And we have been working with the State—again, Georgia—we have been working over this period of time to where we understand Georgia is willing to modify their original proposal to where that would be a permissible provider tax.

And as you note, a number of other States have also this year—and I believe we are working with 11 States all together in terms

of that questionable variable rate provider taxes. So we believe we have solved the tax issue.

The other part was, does the money stay with the provider itself? And again, in our review, I think people were focusing on the first part and not focusing on the second part, whereas, we have now identified the second part with the State. And I believe we have had a couple of recent discussions with the State to say, how can we—as you mentioned, New Hampshire and other States as well—how can we move forward on the State plan amendment, are you willing to make modifications, or at what point in time can modifications be made?

So we try to—we do try to work these things out with the States themselves; and I am confident we can reach the same type of agreement with Georgia.

Mr. DEAL. As I understand, April 7 is sort of the deadline, is that correct——

Mr. SMITH. Yes, sir.

Mr. DEAL. [continuing] to get this resolved?

Mr. SMITH. We work on two 90-day clock periods, and my understanding is, we are next—we are near the end on the second 90-day clock, so we have to work very quickly, and that will be our intention.

Mr. DEAL. Will you give me assurances that you will do that for our State, because they have real concerns about the urgency of this matter?

Mr. SMITH. Absolutely.

Mr. DEAL. The second part of your focus, as you indicated, was whether or not the money stays with the provider. At this point, have there been policy guidelines developed as to what you must show in order to satisfy that criteria? And if not, are there policy guidelines being developed in that regard?

Mr. SMITH. In terms of—we believe that that is what the statute and all the regulations say now in terms of we are matching expenditures for services to Medicaid recipients. We think that is underlying the act. The questions that we have been asking have generally been getting down to what happens when payments are made, to what extent are payments then recycled; and there are States that do not use intergovernmental transfers at all, and it is completely State funded. There are no local funds whatsoever involved. There are States that, again, the source of revenue from the local level is tax revenue and there are no issues there.

The question arises with the—if the payments are actually returned, we are questioning whether or not then we are really matching an expenditure. We, in many respects, were unaware of those situations until we started asking the questions and finding out how the flow of funds is actually working in the States.

Mr. DEAL. Maybe I am oversimplifying it, but obviously once money is returned, whether you call it a "fee," whatever you want to call it, "tax," whatever you choose to call it, once that money is returned to a State entity, a State governmental entity, I guess the—my question is, is there an automatic presumption that that is invalid just because it has been returned?

Or can the States simply show that we have had money returned, but we are also using that money within the Medicaid sys-

tem of our State? And what would they have to show in order to do that?

Mr. SMITH. Well, again, what we are trying to achieve and what we believe the program all along has required is that we are actually matching an expenditure. And I will quickly use an example.

A claim for $100 in a 50-50 State, the State would have provided $50. When they submitted it to us, we would have provided the $50 match as well. But if the money then that was provided by that hospital or nursing home sends $5 back to the State, then it looks to us not to be a $100 expenditure, it looks only like a $95 expenditure and we should have, therefore, only been matching that part.

I think this is consistent with the other parts of the program in terms of someone in a nursing home who is paying part of the cost of their care. Their share gets deducted first, and then the balance is allocated between the State and the Federal Government.

So, again, if we have matched $100, if we have put up our $50, but the State gets part of that back, then you have shifted the matching rate for that expenditure, in our view.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. NORWOOD. Mr. Deal.

Mr. Smith, I apologize, I am a little hard of hearing. Did I understand you to say that in the State of Georgia, that State plan amendment we have that we are all working on, you will help them get that done by April 7.

Did I hear you say that, just for the record?

Mr. SMITH. You did, Mr. Chairman, yes.

Mr. NORWOOD. I thought I heard that, but you know, you never can tell. It will reduce the cost of health care in Georgia if you will do that. It will prevent a great number of heart attacks. So let me just point out to you, it is very important.

Mr. SMITH. We will still need a little bit of help from the State.

Mr. NORWOOD. You will get that.

Mr. SMITH. Thank you.

Mr. NORWOOD. I would now like to recognize my friend, Mrs. Capps, for 8 minutes.

Mrs. CAPPS. Thank you, Mr. Chairman.

Ms. Edwards, thank you for being here today. The administration claims that by ending abuses of IGTs, they can cut $23 billion from the Medicaid budget over 10 years. I am really concerned that cuts of that size could jeopardize a State's ability to sustain their current Medicaid program.

Can you tell us what kind of changes you and the Ohio State legislature are considering as you anticipate perhaps making such large—seeing such large chunks of Medicaid taken away? What kinds of impacts?

You are close enough to communities where services are provided. What kind of impact would these cuts have, and, for example, the people who reside in nursing homes, the elderly and perhaps those young children with severe disabilities who depend on Medicaid for chronic medical needs?

Ms. EDWARDS. I would reiterate that Ohio remains hopeful that our intergovernmental transfer procedures are, in fact, perfectly legitimate and would continue to be so under any set of standards, because we think, in fact, that they are legitimate.

I think it is reality that when Medicaid is forced to cut the size of the program, whether it is the loss of Federal revenues or the inadequacy of the State revenues, there are really only three places to go: You have to look at what you pay to providers, you have to look at who you insure and where you have flexibility in that, and you have to look at what benefits you provide.

Some of the benefits are optional, and in fact, Ohio, in the last budget cycle, had to look at all three of those issues because of the state of the State's budget. We made proposals that eliminated any rate increases for providers. We made proposals that reduced—we have reduced eligibility for low-income parents.

Other optional populations include children covered by the CHIP program. We also looked at eliminating some of the optional benefits for adults like dental and vision and podiatry services. Those are really the options you have under the program; they all have a tremendous impact.

Providers are critical to having access to services, and if rates become inadequate, access can be threatened. Consumers—you know, our proposal to reduce eligibility for parents would have caused 60,000 parents below poverty to become uninsured. And I would like to say "thank you" to Congress, because that is what we did with the dollars when the enhanced FMAP appeared in the State, literally at the 11½ hour, the passage of our 405 budget. The conference committee, in fact, with the receipt of those funds, restored funding for the optional parent coverage, and that is something for which I am truly grateful.

So those are really the options States have. It is benefits, it is people, and it is what you pay.

Mrs. CAPPS. And you are hopeful. I mean, our budget cuts Medicaid, whether it comes from the IGTs or whatever source. So I remain hopeful, too, but I don't know.

I have a quick question to ask you before I turn to Mr. Smith. Do you agree with Dennis Smith's statement that CMS regulations and rules are clear and consistent?

Ms. EDWARDS. Respectfully, I do not.

Mrs. CAPPS. Thank you.

Mr. Smith, you cited 23—and this is a quick kind of response, and then I want to ask you some more in-depth questions. But you cited a $23 billion reduction in Medicaid over 10 years and suggested that it all arises from what you call, "recycling." and I wonder if you have available in writing an analysis of which States and how much, that we could get information from you so that States can plan.

Mr. SMITH. Yes. We are compiling the State-by-State list of those States that we have identified through the plan review process as having recycling funds.

Again, I would like to restate again that the $23 billion is over a 10-year period of time. Federal, Medicaid expenditures continue to go up every year.

Mrs. CAPPS. I know, and my question is, if you are compiling it now, how do you know it is going to be that?

Mr. SMITH. That is our estimate based on the plan amendment reviews that we have to date. We have reviewed over 200 State plans——

Mrs. CAPPS. So you are projecting based on analysis that you already have?

Mr. SMITH. Yes.

Mrs. CAPPS. And we can have those made available?

Mr. SMITH. We would be happy to make it available to you. And again, as I said, this is—for an individual State, if you are not recycling Federal funds, this has no impact on you whatsoever.

Mrs. CAPPS. A number of States represented on this committee have not yet recovered from what the National Governors Association has called the worst State fiscal crisis since World War II.

Last year, over the strenuous objections of the administration, Congress enacted fiscal relief for the States in the form of a 2.95 percentage point increase in the Federal matching rate; and the hopefulness that I note in Ms. Edwards' response is, in part I think, based on that experience. This fiscal relief that you really could consider a legitimate intergovernmental transfer was crucial to the ability of a number of States to avoid making really drastic cuts in Medicaid eligibility, benefits and provider payments, the three things that Ms. Edwards outlined.

Unfortunately, this fiscal relief now ends on June 30, and unfortunately, many State economies are still not out of the woods, mine in California included; and unfortunately, but not surprisingly, the budget for this fiscal year starting October 1 does not propose to extend fiscal relief. Instead, it proposes to cut more.

The results will have to mean more of the cuts in the three areas that Ms. Edwards outlined, more uninsured Americans, more uncompensated care for providers and fewer Medicaid funds flowing into the States that have to make these cuts, with a loss of capital that will further injure their economies.

My question to you—I have two populations in mind. First of all, what should States do if they don't want to slash the service in their programs? And second, what are the individuals going to do who face these cuts? An elderly woman in a nursing home, where is she going to turn for coverage for her care if the Medicaid that she depends solely upon for her medical care is gone? Or a child with spina bifida?

Mr. SMITH. Thank you for the questions. I will try to answer them in a helpful way, but still be brief.

A couple of things: Again, last year, the administration had a proposal. I know the proposal was met with some amount of skepticism which, again, we recognized last year that the States were feeling financial pressure, and we came up with a proposal that we believed would have helped them last year, would have helped them this year, would have helped them next year and for a few years into the future.

So we did recognize the pressure that the States were under, and we were willing and believed it was good policy to kind of move up some money that was going to be in the outyears to earlier years to help them through those tougher times and to help them to make changes in their program that we believed would be helpful as well.

There are a number of other things that States can do, are doing, we have helped them do. Twenty States now have supplemental rebate agreements for prescription drugs that we have approved.

Mrs. CAPPS. That doesn't take care of nursing care.

Mr. SMITH. It does in terms of States achieving savings in their program, which is what we are trying—again, if the States need to find savings somewhere to be able to continue to afford services elsewhere in their program, and they are generating savings because of changes that they are making in the way they are paying for prescription drugs, in supplemental rebates, et cetera, that helps them control the cost of their program.

We believe that—again, Medicaid on the long-term care side of the program is still generating an increasing share of the cost of the program. We believe you can improve the quality of services to the people who rely on your care and at less cost.

Mrs. CAPPS. I understand I have used my time, but I just have to say that this is in the face of States that are not able to meet their match because of their own fiscal problem.

Mr. SMITH. Again, we agree that we believe a long-term approach to Medicaid is what we need to be talking about. We tried to start that dialog last year.

Mrs. CAPPS. I hope someone will ask what that long-term dialog means. Thank you.

Mr. NORWOOD. A lot of interesting things came up there, and at some point, I hope we get back to it.

If you think the rolls are fair and consistent, and Ms. Edwards very politely said, maybe we don't, which is a proper question to ask. At some point in here I am going to ask you to respond to that, because if you think they aren't consistent and you think they are, something is not exactly right.

Mr. Green, you are recognized for 8 minutes.

Mr. GREEN. Thank you, Mr. Chairman, and again, I appreciate both our panelists for being here and particularly Ms. Edwards because we all have State-specific questions, and coming from Texas, I have some concerns. Let me ask some general questions, though.

Mr. Smith, you said in your testimony that questions CMS requires for the State plan amendments are applied consistently and equally to all States under the SPA review process. Can you provide our committee with those criteria used by CMS in determining whether State plans are acceptable? Are these criteria made available to all the States when they are drafting them?

And I will continue that I heard from many State Medicaid directors that are confused and frustrated because they think CMS may be moving the goalposts and delaying approving the SPAs. And CMS should, I hope, be responsive to these and give them the criteria so they can jump through whatever hoops are needed to deal with it.

Can you share that—I guess going back, could you share the criteria with the committee for determining whether State plans are acceptable?

Mr. SMITH. Mr. Green, we have attached to my testimony the questions we asked the States, all States, and it is the answers to—it is their answers to the questions that determine—again, we are looking at two things: Is your source of funding good and does the money stay with the provider? And if the answer to both of those are positive, the plan amendment gets approved. And, in fact,

we have approved 82 financing State plan amendments; we have only disapproved four.

Mr. GREEN. I have a lot of questions. Let me ask Ms. Edwards to respond.

Do you have a feeling about that as State director?

Ms. EDWARDS. Let me give an example from real life, and I have to be very nice, because I still have a State plan amendment awaiting approval.

Look, the reality is, the standards are changing. As CMS asks more questions, they think more thoughts and they form some opinions and then come back and ask more. But my best example of this is a very real one.

Back in 2000 or 2001 we filed our first request for an upper-payment-limit program for non-State-owned public hospitals. It took almost a year to negotiate an approval to that State plan amendment, and this was pursuant to Federal regulations that are, in fact, promulgated and were available and presumably would be fairly clear about what was an acceptable way to do an upper-payment-limit program.

Later in 2001, after receiving approval to the first State plan amendment, we filed an almost identical State plan amendment for the State-owned hospitals to institute a similar proposal for upper-payment limits up to 100 percent of Medicare to those hospitals. CMS would not approve the same methodology that they had just approved prior that year for the non-State-owned hospitals. We spent another year or so negotiating a new methodology.

We have since refiled the original State plan amendment to make it consistent with the second one, and it has been 6 months, and we are still answering questions from CMS about what now ought to be identical to the second approved plan, and we still don't have approval.

So I think that is an example. The standards aren't that clear. There may be very legitimate questions that are still being asked, but that is a reality for a State; and I think that, respectfully, that does not—it is not quite the simple process that Mr. Smith would suggest.

Mr. GREEN. Mr. Smith, Texas does not have a plan up there now, but we have an unusual situation, I guess, although I am hearing more and more about it is not that unusual. We have nine public hospitals, urban hospitals, in Texas, and through IGTs they provide the State portion of Medicaid funding for the DSH allotments. In using the IGTs, Texas then is able to draw down Federal dollars that we share not only with those nine public hospitals, but also with 87 rural hospitals and 64 other urban hospitals, both profit and nonprofit, and seven children's hospitals. One hundred percent of those funds are returned to the hospitals to assist them with uncompensated care.

Unfortunately, in Houston, I have a public hospital system, but again, they can't serve all the need in Houston, so we need the funding in some of my suburban hospitals that also serve poor folks.

Now, is there anything illegal or troubling to you about this arrangement, because that was the decision Texas made long before

I was the State legislator for 20 years, that health care would be provided on the local level?

Mr. SMITH. Mr. Green, again I assure you that is the way it works that the local—the counties are putting up the State share of the match and the money stays with the providers. That is exactly what we are trying to achieve.

Mr. GREEN. One of my—in my time that I have left, my colleague from, Louisiana Mr. John, had to be over on the floor for a transportation bill and he wanted to ask the question, what State plan amendments with IGTs has CMS approved in full or in part, involving the 175 percent rule; and has CMS approved any State plan amendments involving an IGT with 175 rule for the full term of the 175 percent rule?

Mr. SMITH. We have approved a couple of State plan amendments with the 175 percent with an agreement from the States that the part that has been recycled or the State intended to recycle, part of that 175 percent would end at a date certain. Again, we understood that 175 percent DSH provision as a way of helping public safety-net hospitals. We want the 175 percent to stay with the hospitals. That is our goal.

Mr. GREEN. I hope CMS provided guidelines to the State so they would have that ability to respond and comply with it. Is there a set date that you have given?

Mr. SMITH. We have been working with the States so we do not interrupt their budget cycle. We have been forwarding it through the following budget cycle. We are trying to be responsive, and we believe it is very disruptive when you are in the middle of your budget cycle to be hit with a disallowance or a deferral.

What we have been applying consistently is continuing that funding through the State budget cycle, which is why we may end up with different dates.

Mr. GREEN. I am finding out more about Louisiana than I want to know, but if they recycle that money and it goes to the providers and does not stay with the original providers—for example, in Texas, we have nine public hospitals. And if it is distributed to other hospitals to help with uncompensated care, whether it is Texas or Louisiana, that would not be a problem as long as it is providing payments to providers to serve uncompensated care for poor folks?

Mr. SMITH. There are disproportionate share hospital rules, so I cannot give you a general okay. Each hospital has their own level that they can accept based on the uncompensated care.

Mr. GREEN. Since Georgia got a time certain——

Mr. SMITH. I will have a conference call with Louisiana as soon as the hearing is over.

Mr. GREEN. Okay. Louisiana is in the process of approving that final determination, hopefully by April 7. Nobody from Louisiana wants Georgia to get ahead of them.

Mr. SMITH. We have a conference call this afternoon.

Mr. NORWOOD. They may not want us to, but we are going to.

Mr. Waxman, you are now recognized.

Mr. WAXMAN. Mr. Smith, intergovernmental transfers have long been recognized as a legal source of funding for the Medicaid program. They are explicitly recognized and protected in the law.

Despite the provision of the law and despite the history of years of intergovernmental transfers as legitimate funding sources and despite instance after instance where State intergovernmental transfer plans have received explicit approval, it sounds like you decided to change the rules. Under what authority do you have to change the rules?

If you want to cripple a State Medicaid program by taking billions of dollars away from them on intergovernmental transfers, isn't it up to you to propose specific legislative language to the Congress of the United States and let us decide what is appropriate to do?

Mr. SMITH. Mr. Waxman, again, we are in very much agreement on both points in that intergovernmental transfers——

Mr. WAXMAN. My question is: Do you have the authority to change the rules on intergovernmental transfers?

Mr. SMITH. We do not believe we are changing the rules. We believe we are applying the rules that exist.

Mr. WAXMAN. Can you give us what your plan is? The Committee on Ways and Means is holding a hearing at this moment on how this Administration would not even give us the cost estimates for the Medicare program.

You are going one better, you are not even telling us what you are going to do on these intergovernmental transfers.

Why aren't we, as Members of Congress, entitled to know? Why can't the States find out what you are proposing to do to revise the law by doing something that will withhold billions of dollars from them?

Mr. SMITH. On both points, you asked for legislation. We will be sending up legislation itself. We will send up what States we have identified through the State plan review process that we believe have problematic recycling.

I have tried to——

Mr. WAXMAN. We need specifics. You have to give us a State-by-State breakdown.

Mr. SMITH. To the best of our knowledge based on our State plan reviews. If a State has not come in to us, we may not know.

Mr. WAXMAN. I am not talking about when they apply for a State plan.

Mr. SMITH. But that is how we are finding out whether they are recycling money.

Mr. WAXMAN. How do they know what the rules are?

Mr. SMITH. Mr. Waxman, the questions are all based on trying to understand how their funding works.

Mr. WAXMAN. No, I think the question is, how do the Federal rules work? We have a history of the Federal rules working in a particular way. I think Ms. Edwards referred to this.

States cannot run their programs if you change the rules and hold up their State plans. This is a Nation of laws, not arbitrary decisions by you when a State comes in for a plan to be changed. They should know exactly what the proposals are that they will need to meet.

When will you give us the analysis and the legislative proposal?

Mr. SMITH. Shortly, I hope. I cannot give you a specific date.

Mr. WAXMAN. We are being asked to cut billions of dollars out of the Medicaid program. We need specifics. Is April 7 a good day? We need specifics. We ought to get the information before we pass a budget, but we passed a budget. Give me a date.

Mr. SMITH. I will do my best to have it to you by April 7.

Mr. WAXMAN. It seems to me that we want to know also what the impact would be on Medicaid beneficiaries and the providers that serve them.

Mr. Smith, when did you start at HHS, in any capacity, as a consultant or employee?

Mr. SMITH. This is my third time back at HHS. I started about February 1, 2001.

Mr. WAXMAN. Before that, you were the head of the Medicaid program in Virginia, weren't you?

Mr. SMITH. Yes.

Mr. WAXMAN. As part of the Medicaid program in Virginia, did you work on a proposal for the Virginia Medicaid program upper payment limit which was submitted to the Federal Government?

Mr. SMITH. That was submitted to the Federal Government. I believe it was submitted under my signature.

Mr. WAXMAN. And you participated, obviously, in this proposal. Did Claude Allen participate in the development of the UPL proposal for Virginia?

Mr. SMITH. I believe he was aware of it.

Mr. WAXMAN. Aware of it? Did he participate in the development of it?

Mr. SMITH. It would be a long story to describe the entire history of that proposal. But he was aware of it. I am not aware of all of the discussions that took place.

Mr. WAXMAN. Governor Gilmore was also part of the decision?

Mr. SMITH. Yes, Mr. Waxman.

Mr. WAXMAN. A decision was made some time between inauguration and April 3 to revise the final Clinton regulation and to allow some State plan amendments to be approved under the old rules, that is, those issued in January.

Did you participate in any way in discussions, meetings, briefings, papers, correspondence or decisions regarding that policy change?

Mr. SMITH. Regarding the policy, yes, I did.

Mr. WAXMAN. Did Claude Allen participate in any way?

Mr. SMITH. I am not certain. I don't know that he had been in the Department as yet. I don't remember when he came to the Department.

Mr. WAXMAN. Do you know if he was aware of the decision by HHS that was in the works?

Mr. SMITH. I don't know. I don't remember when he came to the Administration.

Mr. WAXMAN. Did any person who had worked for the State of Virginia before coming to HHS participate in any way in discussions, meetings, briefing papers, correspondence, or decisions regarding that policy change? For example, Mr. Leean or Ms. Mantho?

Mr. SMITH. They were from Wisconsin.

Mr. WAXMAN. This applies to both of them.

Mr. SMITH. I am sorry, I thought you asked about somebody else from Virginia. I believe I was the only one from Virginia.

Mr. WAXMAN. Did they participate at HHS in this opening up of the rule?

Mr. SMITH. The policy itself, they very well may have.

Mr. WAXMAN. Whose idea was it——

Mr. SMITH. Joe Leean was in a capacity that I don't know he would have been involved in that policy. He was doing things other than Medicaid. Offhand, I would doubt that he was involved at all.

Mr. WAXMAN. Directly. How about indirectly?

Mr. SMITH. I have no idea.

Mr. WAXMAN. Whose idea was it to reopen and revise the January 12 regulations?

Mr. SMITH. I believe there was a request from Governors to clarify what appeared to be ambiguous and vague rules.

Mr. WAXMAN. Were there HHS staff who were against this reopening and revising the January 12 regulation?

Mr. SMITH. That is a very broad——

Mr. WAXMAN. To your knowledge.

Mr. SMITH. My recollection is that we began looking into it again based upon a request from Governors that the original regulation had gaps in it.

Mr. WAXMAN. So from Virginia and Wisconsin particularly, they were interested in changing?

Mr. SMITH. I don't remember who made the request.

Mr. WAXMAN. I am going to ask more questions in writing.

It seems to me this Administration came into power touting the idea of giving States more flexibility and more ways to get waivers. I remember when Governor Thompson was a Governor and not secretary, and he argued for this.

Now it seems to me you are harassing the States when they want to change their plans with more and more requirements that they come through and show you. I suspect they are being harassed in order for them to give up on perfectly legal activities by threatening delays and investigations into their State plans.

Are you trying to get them to adopt block grants by this sort of harassment?

Mr. SMITH. No, Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. SMITH. If I may make a couple of points?

Again, the policy that you referred to, my recollection is it became an issue based upon a request from the Governors that the policy had gaps and was ambiguous and vague in that there were plan amendments in the pipeline, and there was uncertainty about effective dates, et cetera.

The policy itself would have applied to all States, and again, at that point in time, we believed we were writing a general policy of general applicability to all States.

In terms of State plan amendments from specific States, I was recused from Virginia at the time. The secretary and his staff were recused from Wisconsin, action on Wisconsin State plans at the time. I remain recused from any action on Virginia State plans as the secretary remains recused on any Wisconsin State plans.

So in terms of any review of a policy and how that applied to either Virginia or Wisconsin, I was not involved, and the secretary was not involved.

I hope that is helpful to you.

Mr. NORWOOD. Mr. Stupak, you are recognized for 5 minutes.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. Smith, Michigan has an application pending with HHS to create a multi-State prescription drug purchasing pool. Michigan has joined with Vermont to put forth an innovative approach to help the States save money along with the Federal Government. Michigan estimates that by pooling together, it will save them $40 million a year.

Other States would like to join, like Nevada, Alaska, Minnesota and New Hampshire. In the year since Vermont and Michigan made their proposal, CMS has made one request for modification after another. And each time, both Michigan and Vermont have complied.

In February, CMS said they were going to deny their program. The Michigan proposal makes sense to me because is combines the State's purchasing power, complies with CMS guidelines on supplemental rebates, will save the State, Federal Government and taxpayers' money, and is based on a free-market bidding using a commercial model.

On July 1, 2003, in a National Public Radio interview, former CMS Administrator Tom Scully says, "States have every right to negotiate and use their market power to get the best possible prices they can."

My question is, what is the problem with the Michigan-Vermont prescription drug pooling program? Why is the Administration blocking the program? And what are the next steps and what is the timeframe for approval of this proposal?

Mr. SMITH. We are not trying to block it, but trying to get to an approval. Michigan has itself received a letter from us.

Mr. STUPAK. When was that letter sent? Three weeks ago, there was an article in Roll Call saying you were disapproving Michigan's plan.

Mr. SMITH. That was clarified. The letter itself was around the time of the National Governors Association meeting in Washington where Governor Granholm raised this issue to the secretary. The secretary assured the Governor that he had instructed me to get to an approval, and that is what we were working on.

Mr. STUPAK. So what timetable are we looking at for the approval?

Mr. SMITH. I don't know the exact status. We did send some additional questions to Michigan that we have shared with the other States that are involved in the purchasing pool as well, New Hampshire, et cetera. I am hopeful we will do that this month.

Mr. STUPAK. I understand the most recent problem was that CMS wanted the States to pick up PBM through a competitive bidding process.

Mr. SMITH. I believe they have done that.

Mr. STUPAK. So what is the hold-up now?

Mr. SMITH. I don't remember.

Mr. STUPAK. Can you get back to us on that?

Mr. SMITH. I am happy to. But the secretary has made it clear to me we will get to an approval.

Mr. STUPAK. I hope so. That $40 million, Michigan is facing financial troubles, like everybody else.

We have some other States that want to join us, and we think it is a better proposal than the prescription drug plan that may possibly be coming.

Second, States are desperately trying to figure out what the new Medicare Drug Law means to them. The higher-cost estimates released by CMS actually could negatively impact the States. As it stands now, the States are estimated to lose $1.2 billion over the next 3 years as a result of this law.

First, I am concerned the States are losing 50 percent of their prescription drug enrollees. Thus, they will lose a lot of leverage in negotiating supplemental rebates to help control drug costs.

Second, the amount States have to pay to the Federal Government for drug costs under the so-called clawback provision is based on national drug growth rates. This will penalize States who have done a good job of controlling their drug costs.

Third, States are penalized because the base year for determining their contribution is 2003. If States enacted cost controls since 2003, it will not be reflected in their payments to the Feds under the clawback.

Finally and most importantly, if Part D drug plans have formularies that are more restrictive than those in Medicaid, seniors risk losing coverage of needed medicine.

This bill seems like a bad deal for States and seniors. No. 1, would the Administration support fixing any of these flaws? Can the Administration support fixing any of these flaws?

No. 2, can the Administration fix any of these problems without legislation?

No. 3, what is the Administration doing to ensure that lower-income seniors in rural plans have a choice of drug plans and a choice of plans that have a low premium?

Mr. SMITH. I will do my best. You get me back into the Medicare area that I am probably not the best expert to speak on.

Mr. STUPAK. The new drug law supersedes some of that, and it is going to hurt us.

Mr. SMITH. The point that the States are going to lose half of the people, again, my understanding at least—and I am happy to go back and refresh my memory—but I thought that, certainly, a very strong indication was that was a bipartisan effort. I think it was something like Medicare beneficiaries or Medicare beneficiaries first, that is where people have been moved out of Medicaid into Medicare so there is a uniform eligibility, et cetera, not based on State income.

So the fact that States have—the fact that the dual eligibles have moved out of Medicaid into Medicare I thought was something that people were generally very supportive of, and that is what they were trying to do.

In terms of what States can do to reduce the cost of drugs, again, we have approved supplemental rebates for 20 States, including Michigan, to which they are already getting additional rebates from pharmaceutical manufacturers. So we have been trying to do that.

In terms of 2003 as the base year, obviously, Congress had to pick some point in time in which to base the State contribution on in order for the State contribution to work. We have been meeting with the States again to try to make those numbers as accurate as possible.

The argument that States in 2004 and 2005 were going to dramatically change the way they have been delivering prescription drugs for quite some time, that that would be a dramatic impact on the cost of drugs, I have heard the argument. But I am not certain that it truly was going to make a lot of difference in calculating those per capita costs.

Mr. NORWOOD. Thank you, Mr. Stupak.

Mr. STUPAK. I might follow that up with a written question.

Mr. NORWOOD. We will leave the record open for written questions.

Mr. Rush, you are recognized for 5 minutes.

Mr. RUSH. Thank you.

Mr. Smith, can you tell this subcommittee what hard evidence you possess that would show and prove that States are abusing the system by diverting IGT funds to non-Medicaid services? Can you follow that up with a list of States that you think are abusing the system?

Mr. SMITH. We are preparing a list of States that are recycling funds.

Again, Mr. Rush, the States have told us, "Here is a claim for a Medicaid benefit to a Medicaid individual, we want your share of the cost of that expenditure," and we give it to them.

The States themselves in our review process are now telling us, and I think in many respects we are finding this out for the first time, that at least part and in some States a huge part of that payment is being returned back to the State.

Mr. RUSH. What States——

Mr. SMITH. So we are having difficulty saying what expenditure.

Mr. RUSH. What States do you know are diverting these funds to roads and bridges and other non—other similar type non-Medicaid services?

Mr. SMITH. When the funds are returned back to the State and are simply in the State fund, I think it would be very difficult to trace it from there.

Mr. RUSH. In Illinois, IGT has been used exclusively to add funds to the State Medicaid program. My State IGT has funded approximately 10 percent of the overall Medicaid base, and revenues generated have permitted my State to cover 1.8 million individuals and over a million children. It allows seniors, to the tune of 160,000 seniors, to have comprehensive drug coverage.

According to the information that I have from the Governor's office, not one dime of IGT money has gone to anything other than Medicaid services and care for the poor. Can you tell me, would you consider that recycling or abusing the system?

Mr. SMITH. It sounds like, from what you have told me, that is recycling. If they are telling you they are recycling 10 percent of the funds, you have effectively moved the match rate.

Mr. RUSH. And that is abusing the system? Is that what you are saying?

Mr. SMITH. I hate to put an adjective on it, only pointing out, by doing that, the State has changed its statutorily defined match rate.

Mr. RUSH. According to my State, we have increased funding for Medicaid by a total of $27 billion from 1992 to 2003, and over that same period, IGT funds have totaled $5.2 billion. And so Illinois has increased funding for Medicaid by a much bigger sum than the IGT funds it received. Is this a logical argument that Illinois has wrongfully diverted IGT funds to non-Medicaid services?

Mr. SMITH. Again, Mr. Rush, I would simply point out what you are telling me is the State itself has said they are not meeting their financial obligation to the Medicaid program. They are required to put up their share of the cost of the program.

Mr. RUSH. And you are saying that my State isn't?

Mr. SMITH. From what you are telling me, that is what it sounds like to me.

Mr. RUSH. Let me ask, is this something that is not in line with what the program, the IGT mission is?

Mr. SMITH. Again, I think what we are discovering as we are doing our State plan amendments, that the States, by having providers return Federal dollars that were claimed specifically to pay for a Medicaid service to a Medicaid beneficiary, some or a large portion of that expenditure is being returned to the State. That changes the State's match rate, and we believe that is an issue that needs to be addressed in order to preserve the integrity of the program.

Mr. NORWOOD. Mr. Rush, your time has expired.

We are happy to have Mr. Barton, the chairman of the full Committee on Energy and Commerce, with us, and you are recognized.

Chairman BARTON. Thank you, Mr. Chairman.

Does CMS, Mr. Smith, have any analysis or any data that would indicate how much money might be saved if we were to reform IGTs in some way? What is the potential pool of savings if we were to statutorily make some changes in the way IGT payments are calculated or distributed?

Mr. SMITH. Our estimate is that would save the Federal Government $23 billion over a 10-year period of time which is about 1 percent of what we are projected to spend on Medicaid. The Federal share.

Chairman BARTON. Would these savings, if implemented, would they be basically shared across the board or would some States be more directly affected than other States? Do you have that analysis?

Mr. SMITH. We are compiling that analysis. It clearly would affect only States that recycle funds. So a State that is not recycling funds, our proposal would have no impact on them.

Chairman BARTON. My assumption is that the Administration, just like the majority of this committee, we do not oppose intergovernmental transfers per se, we simply think if you are going to have them, they need to be directed and calculated and used in such a way that the money actually goes for health care services that are eligible.Is that a fair statement?

Mr. SMITH. It is, Mr. Chairman, and we are in agreement. That is the purpose.

Chairman BARTON. Does the Administration have a position on whether we should start trying to make some of these changes in this budget cycle as opposed to waiting until the next Congress?

Mr. SMITH. Our proposal, again, our intention is to submit legislation to the Congress for its consideration. As part of that, in our discussions, there are States that have upper payment limit transition periods, and it would be our recommendation not to interfere with those because States have already built those into that. We do not intend to try to interfere with the previous public law that has already guaranteed certain States a transition period.

Chairman BARTON. I have only been chairman for about a month, but I have been a member of the subcommittee for a lot longer than that. It does not mean that it has not been presented, but I am not aware that we have actually received a definitive legislative proposal? Has that been presented or has it not been presented?

Mr. SMITH. You are correct, Mr. Chairman, we have not transmitted it yet.

Chairman BARTON. Is there an appropriate way for us to interact on the preparation of that proposal or is that something the executive branch has to do in a vacuum and then spring on us, and we react to it in shock and awe?

Mr. SMITH. It would be our intention to be helpful on what the legislation should be. That is our intention of submitting proposed legislation to you and then, obviously, providing any other assistance that we can in your consideration.

Chairman BARTON. It is not a given that the House and the Senate are going to agree on a budget resolution. Those discussions are going on right now.

If that were to occur and we actually get a budget resolution between the House and the Senate, it is not a given that we are going to do reconciliation where the authorizing committees have to draft and present statutory changes to meet whatever savings are required by the reconciliation language.

But if that does happen, if we actually go through reconciliation, we are going to start that in this committee sooner rather than later. I am not stating that we are going to do it. I have not touched base with the minority leadership on this committee. I have had some informal discussions with some of the members of this subcommittee on the majority side.

But if in fact we are going to do this, I would strongly encourage you to, in whatever the appropriate method is acceptable, to begin to work with the subcommittee chairman and the ranking member on the minority side so we could possibly come up with a bipartisan set of proposals to meet some of these targets. That needs to begin as soon as possible, and that is on the assumption that we are going to go through with a budget which has a mandatory reconciliation that has to be met.

Mr. SMITH. I will carry that message back, Mr. Chairman, and clearly, we want to be helpful to you.

Chairman BARTON. I thank the chairman and yield back.

Mr. NORWOOD. Thank you, Chairman Barton.

Mr. Strickland, you are recognized for 5 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman.

Mr. Smith, do you have a proposal to cut $23.5 billion or to save $23.5 billion from Medicaid?

Mr. SMITH. We have not submitted the legislation as yet. We have that under review internally. Our intent, after the chairman's admonition, is that we send it up as quickly as possible.

The savings, the $23 billion, are over a 10-year period of time which represents about 1 percent of what the Federal Government is projected to spend.

Mr. STRICKLAND. I am sorry, I wasn't here earlier, but I have been told you indicated you do not have a specific proposal. Maybe you do.

Mr. SMITH. We have not cleared it internally. We do intend to submit it as legislation.

Mr. STRICKLAND. You will be able to tell us at some point what is in that proposal that will lead to a savings of $23.5 billion?

Mr. SMITH. Yes, sir.

Mr. STRICKLAND. That is interesting. Do you have any idea when you may have that proposal available for us?

Mr. SMITH. We are working to get it cleared to where it can be transferred up in the normal fashion.

Mr. STRICKLAND. Would you estimate days, week, months?

Mr. SMITH. Weeks.

Mr. STRICKLAND. Weeks?

Mr. SMITH. One member asked me to have it by April 7, and I said I would do my best to have it by April 7. So days would be my response.

Mr. STRICKLAND. Ms. Edwards, you are a Buckeye, and I was not here for your opening statement, but my staff says you are terrific, so welcome.

We understand there is a need to make sure that funds are expended appropriately, and there is no inappropriate use of funds.

Some of us are concerned about the proposal that will cause CMS to delay or withhold funding to States which urgently need to cover the uninsured. Can you make a comment about your feelings regarding the new prospective budgeting requirement that CMS wants to implement?

Ms. EDWARDS. I am assuming we are talking about the CMS-37 proposal, that we require that States submit their Medicaid budget for review by the Federal staff prior to the beginning of a State's fiscal year and presumably prior to the release of any grant funds.

I am a member of the Executive Committee For the National Association of State Medicaid Directors. We have spent the last 1½ days with Dennis and some of his staff in conversation. One of the things that we have committed to doing is to help staff, a working group, take a hard look at what kind of process might work. Again, our emphasis is, we need clarity in the standards.

So the first thing we need for a process like that to be useful and doable is to be clear what the standards are. Frankly, as we have pointed out, I am beginning my work right now for the fiscal year 2006 and 2007 budget. The original proposal, which I think has been withdrawn, was to begin this Federal review 150 days prior to the beginning of the fiscal year.

Frankly, finding out within 30 or 60 days of the beginning of my fiscal year that I have a major problem with a funding stream is

not enough time for the State of Ohio to make a change to our expectations and plans for the program. It would not even be enough time for us to take down benefits or eligibility groups in terms of coming within a different funding stream.

I think we are going to urge that we have much more clarity on the standards up front, preferably in rules, written guidance with public input in the development of those standards. And, second, that we then have adequate time to really work through any issues, particularly in the transition phase.

Again, the States are not opposed to fiscal integrity. Clarity is a good thing, and we are willing to work with CMS to provide the level of assurances needed. We do ask for their help in return. We need the rules to be clear before we start, not as we go.

Mr. STRICKLAND. Mr. Smith, would you agree what Ms. Edwards says is very reasonable and would you commit that you will take her concerns and work with her and other States to address her fears for what this process might do to States?

Mr. SMITH. Absolutely. As Barbara mentioned, we agreed today to form a work group, I believe, of four States being represented from the Medicaid director's side of it.

There has been a lot of—I think we got off on the wrong foot with what we were trying to accomplish. The goal of what we were trying to accomplish was to avoid some of the unfortunate situations that States find themselves in now.

We are very pleased that the States have agreed to do the working group and move forward.

Mr. NORWOOD. Thank you very much.

Mr. Engel, you are recognized for 5 minutes.

Mr. ENGEL. Thank you, Mr. Chairman.

Mr. Smith, the burden of providing basic health services to the poor and uninsured has grown tremendously over the last decade. Health care costs have surged, and the number of unemployed has surged just as strongly.

In response, States have utilized many tools at their disposal to weave a very fragile safety net for those in need. My State of New York has done so as well.

It appears that the Administration, at a time of high unemployment and a record number of uninsured, CMS is seeking to further curtail the ability of States to provide care to its most vulnerable population.

In your testimony, you assert and I am quoting you, "Through a complex, creative financing mechanism, States have artificially maximized Federal Medicaid matching funds. Such practices undermine accountability, responsibility and ultimately public trust."

I disagree vehemently with that statement and believe at a time when more and more Americans are finding themselves without a job or health insurance, we need a strong public health infrastructure. And the effort to cut Medicaid funding undermines the public trust in their Government.

The President's budget calls for $10 billion in savings from Medicaid by curbing these IGTs and the use of upper payment limits, and at the same time a temporary F-MAP increase will expire in June. What it all boils down to is, when facing these types of cuts, States are going to have to try to find creative ways to maximize

Federal Medicaid matching funds, and I don't believe that cutting Medicaid funding is a solution to this problem.

I think all of these issues would be avoided if we would adequately fund programs that provide health care to the poor and uninsured. Yet I hear nothing about how to deal with the real problems facing the Nation in this regard other than the Administration being willing to cut us off at our knees.

Do you have any recommendation as to how States can continue to provide care for the millions of Americans who rely on our Government for assistance when we are cutting funding for essential programs like Medicaid?

Mr. SMITH. Well, I think a couple of things. One, we had a proposal last year in terms of taking a long-term look at the needs of Medicaid, not just a short-term look. On the uninsured, the President has had proposals on trying to provide assistance to individuals who are uninsured.

In terms of the opening part of your comments in terms of the safety-net providers, that is precisely what we have been trying to do in terms of achieving that. What we have been discussing here earlier this afternoon is the money that is going to those safety-net hospitals is not staying there. The States are requiring them to send money back to them is what we are calling recycling.

Congress saw this earlier, created the 175 percent uncompensated care rule for DSH, for the disproportionate share hospital payments. What we have been trying to achieve is for those safety-net providers to keep that money. That is our goal.

Mr. ENGEL. The National Governors Association has said in written testimony to this committee in regards to the Administration's proposal on IGTs, "changing the policy now would have disastrous consequences for public hospitals and the individuals they serve."

I would urge you to bring this message back to the Administration that the attack on the poor and uninsured is really wrong. I think it is a not well-thought-out policy, and it will exacerbate the growing problem of how to provide care to those in need. The public hospitals, do they support your proposal and actions? I don't believe they do.

New York right now has a State plan amendment pending that would allow the State to move the DSH payment to 175 percent for hospitals. Our Republican Governor strongly supports that plan. It is my understanding that CMS is holding this plan up, and the law clearly states that New York is eligible for 2 years of DSH payments at 175 percent. Why has CMS not approved this plan?

Mr. SMITH. I believe we have approved one of the plans that New York has submitted to us.

Again, we certainly want to work with the States, and we have been trying through our plan amendment review process and discussions with the States to again achieve the goal that I stated which is the money actually stays with the provider who provided the service. We believe we should be matching an expenditure for a service that was provided.

Mr. NORWOOD. Thank you. We are going to keep the record open.

Mr. ENGEL. Can I just have 10 seconds. I want to say that I hope that CMS is not acting on this plan because you intend to disallow these types of transactions in the future. It is legal now, and as

long as it is legal now, it should be approved. I will follow up with you on this.

Thank you, Mr. Chairman.

Mr. NORWOOD. Mr. Brown you are recognized for 30 seconds.

Mr. BROWN. I would like to request this letter be submitted. A number of us in the House and Senate wrote to the secretary expressing our serious concern with the CMS proposal to audit all State funding.

[The information referred to follows:]

COGRESS OF THE UNITED STATES
WASHINGTON, D.C. 20515
March 29, 2004

The Honorable TOMMY G. THOMPSON
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

DEAR SECRETARY THOMPSON:

In January, the Centers for Medicaid and Medicare Services (CMS) issued a *Federal Register* notice requesting emergency clearance of a change in the way the Federal Government pays its share of Medicaid funding. This change would require prior federal approval of state Medicaid budgets and a more detailed and lengthy process before states could receive necessary federal Medicaid funding. Although the CMS ultimately withdrew the emergency clearance request in recognition of a faulty notice process, press reports have indicated that CMS intends to advance a very similar policy again in the near future.

Though the stated purpose of the major change is to combat fraud, waste, and abuse, this overbroad budget pre-approval requirement could hurt the most vulnerable among us, including children, pregnant women, those living with disabilities, seriously and persistently mentally ill, and the elderly in nursing homes, among others. The Administration is now moving both to shift more costs and responsibilities for Medicaid to the states and to interfere with state discretion in setting state Medicaid budgets and financing the state share of Medicaid costs. This appears to be an attempt to make the program more difficult for states to administer, so that states will, under duress, accept a block grant or cap on their program in order to escape ever-increasing federal restrictions.

We appreciate your February 20, 2004, letter to Governor Kempthorne indicating you plan to allow for a formal comment period on proposed changes to the "Form CMS-37" but our concerns go to not only the process for making the change bat to the very substance of the CMS proposal. We recommend that you table the proposal altogether for three reasons.

First, these proposed changes to the CMS-37 form constitute a dramatic shift in the guarantee of federal Medicaid funds that are distributed to states. This will have a dampening effect on states' willingness to provide health coverage under the Medicaid program. Currently, the Federal Government can only retrospectively disallow federal funding after proper notice and opportunity for states to appeal to through an independent judicial process. Under the CMS proposal, the Federal Government would prospectively withhold or delay access to funding if it believed the future use of such funds might be disallowed. Disputes between states and CMS could take months or even years to resolve, and it would appear that a state would bear the financial burden and uncertainty during this period of negotiation.

Even in the best economic times, Governors and state legislatures will be constrained in their ability to provide health coverage to a growing population of vulnerable citizens if there is extreme uncertainty around the Federal Government's commitment to provide its share of funding. The flexibility that comes from the assurance of federal matching dollars to cover all eligible individuals is key to the success of this program and the willingness of states to participate in it. The CMS-proposed changes eliminate that flexibility, and could thus jeopardize the continued existence of health coverage to families under Medicaid.

Second, the administrative burden caused by this proposal would divert staff attention away from providing health benefits to vulnerable populations, and would instead ensnare them in new and redundant bureaucratic tasks in order to respond to this new federal requirement. The Administration is already proposing cuts to state Medicaid budgets in its FY 2005 budget, and the loss of temporary fiscal relief

money on June 30 will mean states will have $11 billion less in funding this year, in spite of an expected state budget deficit of $40 billion for the upcoming state fiscal year 2005. States will be hard pressed to continue their program in the face of these funding reductions coupled with new and unduly burdensome bureaucratic requirements.

Third, CMS appears to be outside of its legal bounds in making such a change to the fundamental nature of the Medicaid program. The Medicaid statute allows for federal funding to states to be increased or decreased based on over or under payments in *prior* quarters; the statute does not allow reductions in funding for states based on expected future overpayments in subsequent quarters.[1] Likewise, current federal regulations enumerate the only reasons the Secretary may withhold federal funding from states, specifically for impermissible expenditures in *previous* quarters[2] or where a state's plan has changed so it no longer complies with federal requirements.[3] There is no provision for withholding federal funds if the Secretary merely *believes*, without a full opportunity for a hearing, that the future use of such funds may be disallowed.

If CMS is concerned that states are inappropriately requesting federal funds through various financing mechanisms, it can seek legislative changes or propose new regulations to address those problems, as it has previously. The failure to clearly identify and define specific forms of impermissible financial gamesmanship by states has contributed to the concern that the ultimate purpose of the new policy is to strangle the states with bureaucratic requirements and denial of federal funds and to coerce states into accepting capped federal payments in exchange for regulatory relief.

In conclusion, we urge you to rethink and not republish this proposal which would jeopardize funding for health insurance coverage for the most vulnerable in our society. At a time when the number of uninsured continues to grow unabated, such a policy is unwise in the extreme.

Sincerely,

JOHN D. DINGELL, SHERROD BROWN, CHARLES B. RANGEL,
HENRY A. WAXMAN, PETE STARK, EDWARD M. KENNEDY,
JEFF BINGAMAN, MAX BAUCUS, AND JOHN D. ROCKEFELLER IV.

Mr. NORWOOD. Without objection, so ordered.

Mr. BROWN. You said the only States that are recycling funds would be affected by this proposal. Secretary Thompson said 34 States would be affected. How many States will be affected?

Mr. SMITH. I think it would be in that ballpark.

Mr. BROWN. How many States are recycling funds?

Mr. SMITH. We believe it is in that neighborhood of 34. Again, we are finding this out through our State plan review process. Sometimes it is difficult for the State to accurately describe the way the flow of funding works.

Mr. BROWN. My State, represented by Ms. Edwards, is not one of them, right?

Mr. SMITH. Thirty-five is our count at this time.

Mr. BROWN. Before you said 34. You just added her?

Ms. EDWARDS. We are all anxious to see who is on the list.

Mr. RUSH. Mr. Chairman, I would like to get a clarification in terms of something that Mr. Smith stated.

Mr. Smith, you told Chairman Barton that the only concern over IGTs was they were being used for non-health-care expenditures.Is that correct? That is what you told Chairman Barton.

Mr. SMITH. I think I said several things.

Mr. RUSH. Including that the only concern was that IGTs were using funds for non-health-care expenditures.

Mr. SMITH. I think we were talking about Medicaid.

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[1] Social Security Act § 1903(d)(2)(A)
[2] 42 C.F.R. 430.30(d)(2)
[3] Social Security Act § 1904; 42 C.F.R. 430.15

Mr. NORWOOD. Mr. Rush, we will pull that exact answer from the record for you.

Mr. RUSH. I just wanted to find out.

It seems if that was the case, I indicated my State, what it was doing for health care related expenditures. And you said they were recycling and it was wrong for us to do that.

I am trying to get an understanding which one is right. Are you concerned about IGTs being used for non-health-care expenditures? And if they are being used for non-health-care expenditures, is that okay?

Mr. SMITH. Our concern is: Is a State fulfilling its obligation to match the Medicaid expenditures for which they are asking us to match?

Mr. NORWOOD. Thank you very much.

I recognize myself now for questioning and closing.

I have waited until the end to ask my questions because I wanted to hear what the members were really interested in and were going to say. I am struck by a couple of things.

No. 1, this group of members from the Energy and Commerce Committee who happen to be on the Health committee are deeply interested in this. I think we can clearly see that. Everybody here would have loved to have had 20 more minutes of questioning.

The second thing I leave here with is, we are all in agreement. I think I am going to prove that with some questions I will ask you in just a minute, Mr. Smith.

I really believe both sides, including yourself, are in agreement. The problem is there is a lack of trust. Now, I don't know that we can fix that very easily. There is a history why people do not trust CMS and all of that.

Generally speaking, what you have been saying is exactly what many other members have been saying, too, so I am going to ask simple yes or no questions.

Is CMS trying to eliminate IGTs?

Mr. SMITH. No.

Mr. NORWOOD. Are you trying to get rid of IGTs that involve State financing schemes that unjustly enrich the State, divert Federal Medicaid dollars away from their intended use, or violate the basic principles of Federal-State Medicaid partnership?

Mr. SMITH. I think the answer is yes.

Mr. NORWOOD. It is.

Mr. SMITH. What I want to clarify, though, is the recycling part that we are talking about is not an IGT really.

A legal, permissible IGT, again from your first question, we are not touching that with a 10-foot pole.

Mr. NORWOOD. But you do not want Federal dollars being matched against State dollars that are improperly being used and not then doing what we all want to do which is to treat the patient?

Mr. SMITH. We want the States to put up their share of the dollars that they are asking us for, for a service to a Medicaid recipient.

Mr. NORWOOD. I have a simple question. Are all Medicaid payments currently being used exclusively for the intended purpose?

Mr. SMITH. We do not believe so.

Mr. NORWOOD. Well then, are you aware of recent incidents where Medicaid funds were used for non-Medicaid expenditures, and I would love an example or two?

Mr. SMITH. When the funding is recycled from the provider back into the State budget, it is very difficult to trace that once it goes into the budget and how the funding flows from there. I do have some examples.

In one State, the State made UPL quarterly payments via an electronic transfer to a nursing home bank account. The State immediately withdrew the amount of the payment less a $2,500 participation fee. The approximate amount of Federal Medicaid payments returned to the State was more than $175 million.

Mr. NORWOOD. Recent examples, please.

Mr. SMITH. Some of these, I don't have the dates.

Mr. NORWOOD. Would you be good enough to submit to the committee recent examples where you believe Medicaid funds are not being used for Medicaid purposes at the State level?

Mr. SMITH. Yes.

Mr. NORWOOD. In recent testimony before this subcommittee, the inspector general cited an example of a nursing home that was required to pay $80 million back to a State IGT. At the same time, this same facility was providing substandard care and exposing beneficiaries to harm. Would you agree this money should have been used to ensure that these beneficiaries received adequate care instead of enriching the State budget?

Mr. SMITH. Yes, and that is our goal.

Mr. NORWOOD. That is my point. That is a horrible example. If there is substandard care and money is being funneled off for other purposes, you have to stop that no matter how scary it seems to some States that they may not get as much money because some schemes may not work. You are obligated to do that, I believe, for the patients first and, second, for the taxpayers.

One other quick thought, in your testimony you described the Administration's proposal to limit Federal Medicaid matching payments to what the State actually spends. Isn't in a sense that the goal now?

Mr. SMITH. Yes.

Mr. NORWOOD. That is what the law says we should do now?

Mr. SMITH. We believe it does. We believe that there should be permanency to that. We believe that also, again, whereas the focus has recently been on nursing homes and hospitals, whenever there is a public provider involved, there is a potential for this to occur.

Again, we have seen new examples of going to other types of county providers potentially being involved in recycling. So we believe there does need to be permanency.

Mr. NORWOOD. Can you tell me how you are going to determine what the State's net spending was or is? Do we know how to do that?

Mr. SMITH. We are trying mightily for the States to tell us exactly how much money is involved. To a large extent, we are relying on them to tell us the amount of money.

Mr. NORWOOD. You have to know the right amount for this system to work. It makes sense, if we can get the systems all right so they can work and be enforced.

Ms. Edwards, I would like to congratulate you as a witness. Ohio is very fortunate to have you running their program.

Mr. BROWN. It is hard to believe that someone as good as she is from Ohio, isn't it, Mr. Chairman?

Mr. NORWOOD. It is. It gives me great hope. We appreciate you being here.

I wish we could figure out why you believe the standards are not uniform and why Mr. Smith believes they are. There is something that we are not going to get in this afternoon's hearing, but we do need to get a better understanding of that.

I thank all of the members, and I feel sure, I don't know this, but I think the chairman is going to have another hearing on this subject as it is vitally important to us.

With that, this committee is now adjourned.

[Whereupon, at 4:21 p.m., the subcommittee was adjourned.]