S. HRG. 102-392

MEDICAID/MEDICARE FINANCING AND IMPLEMENTATION OF CERTAIN PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

JULY 26, 1991

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
49-668 WASHINGTON : 1992

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-037246-1

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MEDICAID/MEDICARE FINANCING AND IMPLEMENTATION OF CERTAIN PROGRAMS

FRIDAY, JULY 26, 1991

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Donald Riegle (chairman of the subcommittee) presiding.

Also present: Senators Bentsen, Roth, Chafee, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-31, July 22, 1991]

SUBCOMMITTEE TO CONSIDER MEDICAID, MEDICARE ISSUES; FOCUS WILL BE ON FINANCING, IMPLEMENTATION OF CERTAIN PROGRAMS

WASHINGTON, DC—Senator Donald Riegle, Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, Monday announced a hearing on Medicaid rules on voluntary donations and taxes, reorganization of the Maternal and Child Health Services Block Grant program, and the Medicaid buy-in program for low-income Medicare beneficiaries.

The hearing will be at *10 a.m. this Friday, July 26, 1991* in Room SD-215 of the Dirksen Senate Office Building.

"This hearing will focus on a series of issues including the states' use of voluntary contributions and provider taxes for financing Medicaid and the Administration's proposal to transfer the Maternal and Child Health Services Block Grant program to the new Administration for Children and Families," Riegle (D., Michigan) said.

"An additional focus for the hearing will be on an issue I have been working on now for over 2 years and thet is the poor implementation of a special benefit to low-income seniors and disabled persons who are currently receiving Medicare," Riegle said.

"Many senior citizens and disabled people are not receiving their full benefit under Medicare. Under a law passed several years ago, Medicaid should pay for deductibles and copayments under Medicare, which can be over $1,000 annually, but millions of people living in poverty do not know they are eligible. One of the purposes of this hearing is to find a comprehensive legislative solution to this problem," Riegle said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. The committee will come to order. Let me welcome all those in attendance this morning, and very particularly our three distinguished colleagues who will be leading off here shortly.

Today's hearing focuses on three issues relating to government health care programs including, number one, solutions to ensure

that low-income Medicare beneficiaries actually receive the financial assistance with their out-of-pocket costs that they are entitled to; number two, that States' use of voluntary donations and provider taxes in the Medicaid program be also dealt with appropriately; and three, administrative relocation of the Maternal and Child Health Services Block Grant Program into the newly created Administration for Children and Families.

As many of you would know, a recent report by Families U.S.A. indicates that there are at least 2 million Medicare beneficiaries that are not receiving benefits to which they are entitled because they do not know that they are eligible, or they face other barriers that make it difficult for them to apply for the benefits.

Under a program called the Qualified Medicare Beneficiary Program passed several years ago, Medicaid should pay for premiums and other cost-sharing under Medicare which can cost well over $1,000 annually.

Two years ago, together with many of my colleagues, I asked Secretary Sullivan to notify beneficiaries and fully implement this important program. But just 1 month ago, we had to write another letter calling on the Secretary to immediately design a program to seek out, notify, and enroll seniors and disabled persons that are eligible for this program.

So, today I am introducing comprehensive legislation with several colleagues to improve enrollment in the program through better outreach and notification; including grants for face to face counseling, and to provide for refund for seniors or disabled persons who are eligible, but did not apply for benefits. And I am pleased to say that Senator Chafee, my ranking member on this subcommittee, is the lead co-sponsor of this bill, and that Senator Cohen, ranking minority member of the Aging Committee, is also a co-sponsor. And the indications are that we will have a much broader co-sponsorship as the bill is examined by other colleagues.

I am happy to say, too, that the bill is supported by many organizations, including Families U.S.A., the National Council of Senior Citizens, and many others.

I have certainly been hearing about these problems throughout the State of Michigan. I have one such case that I will not take the time to relate now; I may a little bit later in the morning. First, I want to get to my colleagues here.

Also on the agenda for the day, the subcommittee will explore the complicated issue involving the right of States to use certain methods of financing their portion of the Medicaid program.

As many of you would know, under the Medicaid program, State funds are matched with Federal funds based on a formula. Many States are now using a variety of mechanisms involving voluntary donations, or provider taxes to fund the State share.

Last year, Congress enacted laws that would allow for provider taxes and put a hold on administrative regulations prohibiting voluntary contributions. The administration—in particular, the Office of Management and Budget—has indicated that it wants to restrict activity by the States in both of these areas. To do so may require legislative action.

States, on the other hand, continue to face extreme financial burdens as health care costs continue to skyrocket. States feel that

they need and have a right to have flexibility in designing their programs. So, we will be hearing today from the administration and the States on this, as well as Maternal and Child Health advocates.

Finally, we will also hear today about the administration's proposal to relocate the Maternal and Child Health Block Grant Program to the new Administration for Children and Families.

Many of us on this committee are concerned about the potential fragmentation of the Block Grant Program if part of the program remains in the public health service while the rest is transferred to a new agency.

Senator Chafee and I, along with others on the committee, including Senator Bentsen, have been working for some time now to make sure that the Block Grant is fully appropriated. This year, the Senate version of the Labor HHS bill fully funds the program at $686 million. So, it is especially important that the program be able to operate effectively. We will hear from the administration on their proposal, and from Maternal and Child Health advocates.

So, we are really covering three diverse subject matters today. I know my Senate colleagues will each have comments that will relate to one or more of those subjects, and so I want to move to them very shortly. But let me, before introducing our colleagues and calling on them, call on Senator Chafee.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Well, thank you very much, Mr. Chairman. I commend you for convening today's hearing. We are addressing a series of very, very important issues.

Over the past few years, Congress has enacted legislation to provide relief to low-income Medicare beneficiaries by requiring the States to pay for the cost of Medicare premiums, deductibles and co-payments through the Medicaid program.

Unfortunately, these individuals are largely unaware of this program because the States and the Federal Government have not taken the necessary steps to notify them of their eligibility.

Congress and the administration have to take some action to ensure that the eligible individuals receive the benefits, but this program is not reaching beneficiaries.

I am joining with you in introducing legislation that would ensure implementation of the law by requiring the Secretary of HHS to notify the new Medicare beneficiaries of the program, as well as requiring annual notification of potentially eligible individuals.

In addition, I am going to introduce today legislation which will expand the QMB Program by allowing States to cover the cost of out-patient prescription drugs for the poor and near-poor elderly who do not qualify for this benefit under the State Medicaid programs.

States could provide this benefit for qualified Medicare beneficiaries—the QMB's—with incomes below 200 percent of the poverty level. For those with incomes between 110 and 200 percent, States

may charge a premium, which would be limited to 5 percent of the gross income.

A second issue which we are going to address today is the States' use of the voluntary contributions and provider-specific taxes in the Medicaid program. We went through this last year in the conference, and this is a very, very ticklish subject. I suspect that both of these Senators, certainly the Senator from Missouri, is going to address that issue.

We are going to hear about Secretary Sullivan's plans to relocate Maternal and Child Health Block Grants into the newly-created Administration for Children and Families. Many groups have expressed opposition to this, but I do not think automatically that we should reject it; let us hear them out. And I think that is why this is going to be a beneficial hearing.

So, thank you very much, Mr. Chairman.

Senator RIEGLE. Thank you, Senator Chafee.

I am going to go, of course, in the order of seniority. I know one of our colleagues has a bit of a time bind, but I think we will be able to accommodate that.

Senator Alan Dixon, certainly a very distinguished colleague of ours from the State of Illinois, is going to testify today about legislation that he has introduced regarding better notification of low-income seniors about the availability of Medicaid funds to help them cover their Medicare costs. So, Senator Dixon, we will start with you, and then we will go to Senator Bond and Senator Graham.

STATEMENT OF HON. ALAN J. DIXON, A U.S. SENATOR FROM ILLINOIS

Senator DIXON. Thank you very much, Mr. Chairman. I will be very brief. I want to first congratulate you for your usual careful attention to the problems of the senior citizens and the needy people of this Nation.

I greatly appreciate your accommodation in giving us this opportunity to be heard this morning. I thank Senator Chafee for being here and for his excellent contributions to this important subject matter.

As both of you know, and as my colleagues here at the table with me know, when we repealed the Medicare Catastrophic Coverage Act of 1988, the Congress left intact the requirement that beginning in January 1989, the Medicaid program was to be responsible for all out-of-pocket costs for Medicare-covered services to poor seniors and poor persons with disabilities.

I was shocked to receive this letter, Mr. Chairman—which all of us received—dated June 17, 1991 from Families U.S.A. Foundation, signed by Ronald Pollack, the executive director of that association, calling our attention to the fact that, as you have carefully pointed out in your remarks, and Senator Chafee in his, most poor Medicare beneficiaries are not aware of the benefits which the Congress made available to them.

I was shocked to find, Mr. Chairman, that in my State, 100,000 people are not receiving the QMB benefits. So, extrapolating that

number—I heard Senator Glen say the other day that in Ohio it is about 100,000—I would think Michigan would be similarly situated.

In the country, more than 2 million poor people below the poverty line are not receiving these benefits the Congress provided for them. This would be individuals with incomes of $6,620 or less a year, or couples with incomes less than $8,880 a year. In my State of Illinois, $6,289 or less a year for individuals, or less than $8,436 for couples.

Now, that represents the very poor people of this Nation, Mr. Chairman. So, imagine that these people who do not know about the QMB benefits that are available to them are paying $29.90 a month out of their meager funds for Medicare premiums, a total of $358.80 per year. Or, in the alternative, they are denying themselves medical benefits they terribly necessarily require because they are not aware of this provision of the law.

Now, what have I done? Well, Mr. Chairman, on July 17, I introduced S. 1482 which does just three things. First of all, I require the Secretary of the Department of Health and Human Services to do the following: provide information about the QMB program to all persons who apply for or seek information about Medicare benefits.

Anybody who comes in a Social Security office, applies for or asks about information regarding Medicare benefits would have to be advised of the existence of the QMB program.

Second, and perhaps most importantly, I provide that the Secretary must include a clear and simple highlighted explanation about the QMB program in one of HHS's annual mailings to all Medicare beneficiaries.

Now, note, may I say to my colleague, the chairman, and to my friend, the distinguished Senator from Rhode Island, I am not asking for new mailings. I am just saying in the mailing already required by law that the Secretary already has to do, he simply put in there a clear, simple, highlighted explanation. "Hey, look here, you are entitled to this benefit. Look here. You deserve this benefit," so people will know.

And then third and finally, I require the Secretary to make recommendations to Congress not later than January 15, 1993 on any legislative changes that may be needed to improve implementation of the QMB program.

May I simply say in conclusion, Mr. Chairman, I congratulate you for what you are doing in your legislation, which I am sure the Congress will welcome. Yours has some retroactive provisions; I have no problem with that.

S. 1482 is simply a prospective bill saying for the future, do these simple things. I think it will cost no money to bring this law to the attention of the people of this country.

I just want to say that in my State, which has suffered for a long time I am sad to say, with high unemployment and difficult economic circumstances, to suggest that 100,000 people making less than $6,300 a year are not receiving a benefit they ought to receive is just an outrage.

I hope that the Congress, at its earliest opportunity, Mr. Chairman, will do all that it can to rectify this situation and make people aware of this benefit that Congress has provided for them.

I thank the Chair for letting me come here this morning.

Senator RIEGLE. Senator Dixon, let me just say, I think you have sent us an excellent bill. I think the two bills can be put together and dove-tailed, and it is my intention to do that. I really appreciate the leadership you are taking on this issue.

This problem is affecting low-income seniors in their ability just to stay healthy. If there is a group in our society that we want to try to help deal with their health problems, it certainly is someone in that category.

And so, I commend you for your efforts in this area, and I want to indicate that we will work with you on this to take and put these two bills together, and move ahead and get something enacted.

Senator DIXON. Well, thank you, Mr. Chairman. May I quickly respond by saying in the first place, I think you provide a tremendous public service just by the nature of your act in having this hearing, which begins to bring this to the attention of the country. When I introduced S. 1482, I went around my State to have press conferences just in the hope that some new people would find out about the QMB program. I was absolutely overwhelmed by the number of telephone calls from people saying, my goodness gracious, thank you for letting us know. You are letting people know, Mr. Chairman, and this is very significant. I have no pride of authorship in this issue, as I usually feel. The important thing is that we accomplish what the end purpose is of what we do.

So, I congratulate you. I want to work with you. It is a wonderful service you and the Senator from Rhode Island are providing in having this hearing.

I do not know if this letter is in the record. If it is not, Mr. Chairman, I would like to suggest that we ought to put it in from the distinguished executive director of Families U.S.A. Foundation concerning the fact that so many people do not know about the existence of the QMB program.

Senator RIEGLE. Very good. Without objection we will make it a part of the record, and we thank you again.

[The letter appears in the appendix.]

Senator RIEGLE. Let me now call on our distinguished colleague from Missouri, Senator Bond, who is here to testify about his State's program that uses voluntary donations from medical providers to help finance the State's share of Medicaid. And so, we are delighted to have you, Senator Bond, and we would like to hear from you now.

STATEMENT OF HON. CHRISTOPHER S. BOND, A U.S. SENATOR FROM MISSOURI

Senator BOND. Thank you very much, Mr. Chairman and Senator Chafee, for calling this hearing. It is sort of like "old home week" for the five of us to be together again, calling you Mr. Chairman.

But, first, I want to associate myself with the comments of Senator Dixon, and I commend you and Senator Chafee for the program for notifying the qualified Medicare beneficiaries.

The subject of my testimony today is on the use of voluntary contributions and/or provider-specific taxes in the Medicaid program. I

note that my former colleagues and former colleagues of Senator Chafee and Senator Graham and the National Governors' Association are going to be testifying later on in this hearing, and I think Senator Chafee and Senator Graham will join me in saying that the positions taken by the National Governors' Association are taken after a great deal of thought and debate, and represent the very careful consideration of the chief executives of the States. We particularly appreciate your giving them the opportunity to testify.

I want to talk to you today about the State of Missouri and our State's ability to use funds from voluntary contributions. We think this revenue is critical to the ability of Missouri to implement the expansions of the Medicaid program that have been mandated by Congress with the support of the Bush administration. These mandated expansions provide health care for pregnant women, infants, and children, but, obviously, they also carry a significant cost.

In Missouri, the total cost of these mandates will reach $147 million this year alone. Since the——

Senator CHAFEE. Out of a total of how much?

Senator BOND. Pardon?

Senator CHAFEE. Out of a total State budget, how much?

Senator BOND. State budget in general revenue this year is——

Senator CHAFEE. Well, roughly.

Senator BOND. $2.5 to $3 billion. I might add one other figure that the Governor gave me a couple of months ago when we were talking about the Medicaid expansions. He told me at the time of the new revenue projected for the coming fiscal year in Missouri, 85 percent would be consumed by new or increasing Federal mandates.

So, to the extent that Missouri has new dollars coming in—coming about from growth in the economy and/or inflation—85 percent of that will be consumed by Federal mandates. Not all of these are from Medicaid, but Medicaid is clearly a very significant part.

Since the enactment of OBRA 87, Missouri's Medicaid spending has increased by 121 percent. The mandates have added 50,000 new eligibles to the rolls in the last year alone—a 15 percent increase.

The Medicaid Prescription Drug Law enacted by Congress last year was supposed to reduce the burden of rising prescription drug costs. In Missouri, it will actually increase Medicaid drug expenditures by $13 million.

Congress also reduced benefits to veterans, and shifted those costs to the Medicaid programs. That will cost an additional $5.2 million this year in Missouri.

There are also hidden mandates imposed on the States by the Federal Government. Several of Missouri's amendments to the State Medicaid Program have not been accepted because our inflationary adjustments have not been large enough to suit the Health Care Financing Administration. Thus, the State is forced to increase spending, which obviously requires more Federal funds as well.

Missouri's voluntary contribution program helps pay hospitals for the rising cost of uncompensated patient care. That care obviously occurs when a patient is unable to pay his or her hospital bill.

Now, helping hospitals bear the burden of this uncompensated care, I would argue, is good public policy, because otherwise, hospitals would have to pay millions of dollars each year and raise their charges for insured patients who do pay. These increasing uncompensated care costs force insurance premiums to rise, and take money out of the pockets of working Americans.

As we all know, there are many factors that lead to the 10 to 20 percent annual cost inflation in the Medicaid program—health care cost inflation; congressional mandates; and uncompensated care among them.

I do not believe that States should be penalized or blamed when the cost to the Federal Government also rises. We should be focusing our efforts on the true causes of health care cost inflation that affect all sectors of the economy, and develop solutions to bring that cost inflation under control while assuring top-quality health care to our citizens.

It is an open secret that next week the Health Care Financing Administration intends to issue regulations slamming the door in Missouri and other States' face by totally eliminating the Federal match for this source of revenue.

I have heard that some at OMB believe the States should have to endure the pain of a tax increase to implement the needed expansions. As a former Governor, I find that just unacceptable.

The Federal Government should not support mandated expansions for Medicaid on the one hand, and then turn around and limit States' ability to raise revenue to pay for them.

The States that are abusing voluntary contributions should be dealt with. We need to sit down, I think, and set reasonable limits and reasonable criteria to eliminate abuses. But we should not sit idly by while HCFA and OMB kill legitimate voluntary contributions programs in an effort to eliminate what may be viewed by some as "bad apples."

If HCFA and OMB reject reasonable limits and ban the States' use of voluntary contributions totally, in my view, it is just a money grab by OMB. They will call all voluntary contributions programs abusive, and suggest we could save billions of dollars by eliminating them.

However, the fact is, the only way you can cut Federal costs under a ban is if States drop health care services to the needy, or hospitals are forced to eat more of their costs. Either way, Americans who need health care end up holding the bag, and I think that is a rip-off.

It should not be the administration's goal to back States like Missouri and others into a corner that will force them to eliminate services and ration health care, or raise taxes.

I strongly urge my colleagues to take a serious look at the implications of banning voluntary contributions. Yes, there may well be abuses that should be eliminated. But legitimate programs help the needy get essential health care, and those should be allowed to continue. We should work to develop reasonable criteria for States to accept voluntary contributions.

Mr. Chairman, I would conclude by asking that your consent to include letters to Dr. Gail Wilensky, Administrator of HCFA, and the Honorable Richard Darman, signed by all 11 members of the

Missouri congressional delegation, including your colleague on the committee, my senior Senator, Senator Danforth. And I would ask that these letters be made a part of the record.

Senator RIEGLE. Without objection, it is so ordered.

[The letters appear in the appendix.]

Senator RIEGLE. I have an idea that I want to share with you in just one minute. We have been joined by the chairman of the full committee here, who has a great interest in these issues, and is concerned that we address them directly.

Let me call now on Senator Bentsen.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Thank you very much, Mr. Chairman. First, let me thank you for holding these hearings. These are really time sensitive and very important issues, and, I must say, some quite contentious issues.

I am looking forward to hearing the testimony later today from Families U.S.A. as to the question of availability of information for low-income Americans when it comes to the paying of the premium on Medicare for these folks. I am told that in my own State, we have some 100,000 of them that have not had that kind of assistance.

And I am particularly interested in what Senator Bond, and I would guess probably Senator Graham will discuss, insofar as voluntary contributions to Medicaid payments. States have come to depend on that type of program, and I want to see what the administration's thoughts are on that, and what we can do about it.

And finally, I am looking forward to hearing about the administration's plan to transfer the Maternal and Child Health Block Grant to the new Administration for Children and Families. I have a great deal of confidence in the ability of that agency's administrator, Jo Anne Barnhart, and I am pleased she has joined us here today.

But I am concerned about the transfer or reorganization of the MCH Program; how it might affect the long-term viability by undermining its ability to serve the many chronically ill children, pregnant women, and others who benefit from this highly effective, time-tested program.

So, it is going to be an interesting hearing, and it is obvious from the number of people who are attending here today. I thank you very much for holding it.

I know that you, too, Chairman Riegle, have legislation addressing the question of notification of low-income Medicare beneficiaries about Medicaid assistance, and we would look forward to hearing about that.

Senator RIEGLE. Thank you, Senator Bentsen. Just one thought before we proceed with Senator Graham. You know, I am struck—and today helps highlight it—that we have in our Senate membership a number of very distinguished former Governors: two who are seated out here now, former Governor Bond, and former Governor Graham. And, of course, Senator Chafee also having served as Governor of his State. And this issue of cost-shifting and mandates

continues to gather force; more and more States are coming to us on different issues, where responsibilities are being shifted over, and the need to deal with the problem of paying for them and covering people.

I am going to suggest that we think about a manner in which we might have a hearing, or a roundtable discussion in a hearing format, where we collect our former Governors in the Senate. We have a number of others—Senator Exon, and many others—to perhaps think aloud together about this question of how we are shifting in area after area; and maybe altering the balance in ways that may or may not be good for the country.

Obviously, we want to have good overall national results, in terms of the whole country being able to come ahead and thrive. But it seems to me that we may have a way to bring that issue into focus in some larger sense.

I just put the idea out there. I am not quite sure how we might do that, but I would like to pursue it, because I think there is some value in making that kind of an assessment using the people that we have in our own body who could reflect wisely upon it.

Let me now call on Senator Graham, our very distinguished colleague from Florida, who is going to testify about his State's use of provider-specific taxes to cover some of the health care services that Florida's Medicaid program is required to provide. And so, we are delighted to have Senator Graham here.

Senator Graham.

STATEMENT OF HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator GRAHAM. Thank you, Mr. Chairman. I would like to commend you for holding this hearing on three important topics, and for Senator Bentsen and your colleagues' participation this morning.

As Senator Dixon has previously said about the Qualified Medicaid Beneficiaries (QMB) Program, and Senator Bond as to his State's impact, these are very important issues for our citizens, and for States which are attempting in a sensitive and responsive way to meet their medical needs.

Mr. Chairman, I would like to ask to have a full statement included in the record. In respect to your time limitations and heavy schedule, I would summarize it in my remarks.

Senator RIEGLE. Very good. Without objection it is so ordered.

[The prepared statement of Senator Graham appears in the appendix.]

Senator GRAHAM. I would like to give a brief history of the provider tax program in Florida. In 1984, Florida passed legislation creating the Public Medical Assistance Trust Fund, which I will refer to as the "fund." This fund was financed through a 1.5 percent assessment on the net operating revenues of all hospitals, augmented by State general revenues.

This program was developed in conjunction with the hospital insurance industry, the business community, representatives of Florida's elderly, and the legislature. It was a very positive demonstra-

tion of how various segments of the State, from their particular points of view, could come together to meet a common goal.

Why was this program adopted in 1984? First, to level the playing field. In Florida, most of the indigent medical care was being borne by a smaller and smaller group of hospitals; primarily public hospitals, particularly in urban areas.

Conversely, many hospitals were avoiding any contribution towards indigent health care. One of the purposes of the fund was to see that all hospitals would—at least to the level of assessment—participate in providing indigent medical care.

Second, was to allow the State's Medicaid program to improve and expand its available services in response to federally-mandates and optional programs which were allowed.

Third, to respond to an administrative directive—a directive of the Reagan White House—asking States to utilize innovative mechanisms for its State Medicaid match.

And finally, to provide funding for optional indigent medical care beyond mandated Medicaid programs. And I would like to talk later about that specifically, because it relates to the QMB issue.

Florida's hospital assessment was based on all public and private hospital revenues. It is required regardless of whether a hospital participates in Medicaid.

For instance, it applies to psychiatric hospitals, whose inpatient care is not covered by Medicaid. And it is regardless of the extent of Medicaid participation. The 1.5 percent assessment is not included as an allowable cost in the Medicaid cost report for the hospitals that do provide Medicaid services.

What has been the experience in Florida? Last year, Florida raised $147 million from this 1.5 percent assessment. Most of that money was used to meet the increasing cost of Federal mandates in the Medicaid program; $30 million was used for non-Medicaid indigent care purposes. The $147 million of revenues from the assessment was augmented by $20 million in general State tax revenues.

Congress has, in a series of actions over the last several years, prohibited regulations which would limit the use of provider taxes and donations.

In 1990, the law precluded the Secretary from limiting Federal matching funds for any type of State taxes. And, as a safeguard, the statute excludes provider-specific taxes from a provider's cost base for purposes of calculating Medicaid reimbursement.

On July 19, I received a response to a letter that I had sent to the HHS Secretary, and I would like to ask, Mr. Chairman, if a copy of Secretary Lewis Sullivan's letter to me of that date could be included in the record.

Senator RIEGLE. Without objection, so ordered.

[The letter appears in the appendix.]

Senator GRAHAM. I received a response to an inquiry regarding the administration's interpretation of the provider tax provision of 1990. Secretary Sullivan, in his letter, stated that the administration's concern is with the recent escalations in certain provider-specific donation and tax programs designed merely to capture more Federal dollars. I cannot accept the administration's narrowing the scope of provider taxes and attributing it to this motive of the States.

I am concerned, as the National Governors' Association will express later, with the encroachment upon States' rights to raise revenues as necessary to meet Federal mandates and provide quality health care to its needy population. But the facts of our State belie the statement of Secretary Sullivan.

In fact, the State assessment, since established, has been growing at a rate of 8 percent a year. The State's Medicaid program has been growing at 27 percent per year.

Clearly, it is not the State tax assessment which is driving Medicaid costs higher, it is the expansion of benefits—many of which were mandated by Congress—and the increasing number of people who were deemed eligible for Medicaid.

In the case of Florida, when the program of the hospital assessment commenced in 1985, 16.4 percent of the State's Medicaid match was being paid through that source. In 1991, 9.3 percent of the State's Medicaid match we paid through that source. There is no basis to the argument that the States have adopted this program "merely to capture additional Federal funds."

Mr. Chairman, there are some 23 States which use either provider taxes or donated funds as a means of meeting their Medicaid match. If the administration eliminates the State's ability to do so, there will be some devastating effects. Let me just mention some in my State. We would likely have to curtail some important programs, including programs such as the mandated QMB program.

In Florida, we not only provide for the out-of-pocket costs to the poor, elderly Medicare recipient—such as the $29 a month in Part B premiums—we also provide under an optional Medicaid program, full coverage; which means, for instance, that prescription drugs, which are not covered under Medicare, are paid under Medicaid for that program.

We would be sorely pressed to be able to continue to do that for our indigent elderly if we did not have access to this hospital assessment program.

Mr. Chairman, I hope that the committee will be very careful in its review of the administration's regulations to ensure that the administration is operating based on facts which truly comport with the situation of what the States are doing; that they are doing so within the 1990 law which allows for these programs; and that they are doing so with the recognition of the deleterious effect on the health care of many Americans which would result from this misguided interpretation of the law.

Mr. Chairman, I appreciate the opportunity to testify, and I submit my full statement for the record.

Senator RIEGLE. Thank you very much, Senator Graham. I might just note in passing we had a hearing in the Budget Committee within the last week. OMB Director Darman came in to testify, and he indicated to us that $132 billion worth of projected revenue in the overall fiscal plan had disappeared over the next 5 years; just vanished into thin air. And it was attributed to a computer malfunction in terms of just the way the projections had been done.

But in any case, it is a huge item. It did not get a lot of press attention at the time, but $132 billion just vanished out of the projected revenue stream coming into the Federal Government.

I mention it because the off-loading of mandated service requirements and the shrinking of Federal dollars going to States in a variety of ways to help meet some of these mandated and real needs, I think, is likely to become more extreme because of this loss of projected revenue coming in at this level.

We are going to have to take a look at what that means in its implications, but it obviously has a direct bearing on the kinds of issues we are debating here.

Senator Durenberger has joined us. Senator Durenberger, did you have an opening comment to make?

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Well, if I might, Mr. Chairman, I am going to ask that my statement be placed in the record, but I would like to make three comments.

First, I want to thank my colleagues, the former Governors, for being here, and Alan, whom I did not get a chance to hear, and to express my gratitude to you, Mr. Chairman, even though it looks like a complicated agenda and we are going to be here a long time, for combining these three issues for all of the reasons that you have indicated.

We have had hearings on the MCH Block Grant Program in a couple of committees, and I think my position on that matter is well-stated. For 10 years or more now, we have been trying to do that one right in this committee.

This really is an unnecessary deviant, if you will, and the chairman has been leading, as you in the subcommittee have, to do something right by way of the Federal/State partnership. And so, I just hope that the Secretary and Jo Anne are re-thinking that.

On the issue of the QMB's, of course, this committee has been at this 1 for 5 years. Mr. Chairman, I think you initiated the letter 2 years ago that asked the Secretary to straighten out this problem. And according to the Families USA report, very little has been done. So, maybe it is just another way of expressing appreciation for the hearing and frustration that we have to have the hearing.

Finally, on the very interesting comments by our colleagues, the former Governors, on the subject of Medicaid provider taxes and donations. I think Bob Graham is right; we really should not spend a lot of time debating the motivations of the State.

I will just sort of lay out my position and say that, in effect, that I have tried to discourage this whole business, whether it is a deliberate provider donation—such as my State wanted to do and other States have done—or it is a tax on receipts. And I think Florida was one of the first to do that.

No matter what form it takes, it is simply another way to cost-shift. I mean, the breakdown in the insurance system today is a cost-shifting process. You add the costs for those who cannot pay to the insurance of those who can, and I think the tax is much the same way. You tax those that can pay their way into a hospital or to see a doctor to cover the cost of those who cannot.

There was a day when cost-shifting was, I think, economically appropriate. I think that day is long gone. It is not necessarily for

budgetary reasons, but I think for good economic reasons—trying to get some efficiencies into health care in this country—that we need to do all we can to end any one of these approaches, which take money from some of the providers in order to give money to others.

In this testimony we will hear more about it. I just hate to see the States get into a proposition that looks like a scam when, as Bob Graham says, it was never intended to be that sort of thing.

But no matter how you cut it, even a Florida tax is a tax on the receipts from everybody who goes into the hospital in order to cover the low income or the others. And that is just no longer, I think, in health policy, an appropriate way to finance access.

[The prepared statement of Senator Durenberger appears in the appendix.]

Senator RIEGLE. I know my colleagues have other requirements. Senator Bentsen, did you have any questions that you wanted to address to either of our witnesses here?

The CHAIRMAN. No. Thank you very much, Mr. Chairman.

Senator RIEGLE. Senator Chafee.

Senator CHAFEE. Mr. Chairman, thank you. I will just be very, very brief. I understood the presentation that Senator Graham made, and appreciate the circumstances.

But there is no question that we have got a problem here with some States gaming the system. Let me just give you a possible scenario. The States levy a charge on their hospitals. Let us say they get $1 million. They then use that $1 million to be its matching fund for Medicaid, and thus, get back $2 million.

At the same time, they increase the reimbursement rates to the hospitals by the $2 million. I mean, the States set the reimbursement rates to the hospital, so that a hospital, for an investment of $1 million, gets back $2 million. Now, there is the problem, as I understand it, from this voluntary contribution, or taxing the providers that are subsequently reimbursed through the Medicaid system. So that I do not think that the administration is all wrong on this.

What I do think is that infrequently there are very legitimate efforts being made, that is not a gaming of the system, and that the solution should be for the Congress and the administration somehow to work out a system—that recognizes those legitimate voluntary or taxing contributions and forestalls the gaming.

Now, back to Senator Bond. We are very conscious of this tremendous increase in the cost of Medicaid to the States and to the Federal Government.

Now, as I understand, I believe in Jackson County, Missouri, you have tried on a waiver system to give up the fee-for-service and implement management care system for your Medicaid beneficiaries, is that correct?

The real solution to this is not shifting from the Federal Government to the State, or the State to the Federal Government; both of them are broke. The real solution is to reduce cost through more efficient delivery of health care services, or at least reduce the rate of increase of the costs of coverage for all beneficiaries, whether they are Medicare, Medicaid, or have private insurance coverage. And I have always thought managed care can play a role in achieving this objective. What do you think?

Senator BOND. Well, Senator Chafee, let me just begin by agreeing with what you said about "gaming the system." I know of instances where taxes or voluntary contributions may be used as a scheme merely to increase reimbursement. I think that is one of the things that can be dealt with.

Senator CHAFEE. With physicians also, by the way.

Senator BOND. Well, the specific example I had in mind was with physicians, but I would have to disagree with my colleague from Minnesota that we are just gaming the system. We are talking about a massive burden that has been placed on the States to achieve our goals of better health care.

I think when the States come up with additional dollars for expanding care, that we should not hasten to put on our green eyeshades and say OMB can save money for the Federal Government, when we are going to wind up rationing health care to the poor folks.

Now, with regard to what Senator Chafee raised about Jackson County, MO, which is the county in which Kansas City, MO, largely exists, in the early 1980's, as Governor, I obtained a freedom of choice waiver for the State of Missouri from HCFA. In other words, we locked in Medicaid recipients to an excellent network of community health centers and managed care plans, and we found two things that were very significant in Jackson County. Number one—and most important—people had better health care.

And I think the Medicaid recipients in Jackson County—knowing that they have to go to a community health center, getting involved with the community health center, and getting the preventive care that the community health centers have provided—have received better care.

Second, significantly reduced costs. Lower number of admissions to hospitals, fewer days in the hospital, and it came about by better health care. They know, if they are recipients of Medicaid, they have to go to a community health center, so that is their provider in Jackson County. This took away some freedoms of Medicaid recipients, and that was a concern. But we think it worked, and that is one form of managed health care I believe is working, and we would invite the attention of the committee to that experiment to see if you would wish to offer the expansion of that opportunity.

Senator DURENBERGER. Mr. Chairman, I just must set the record straight. I am not the one that accused anybody of gaming. I said specifically I do not doubt anyone's motivation. I just said it is clearly cost-shifting, and that is a very legitimate part of the way we pay for health care today; I just do not happen to agree with it as a future way. But I am not the one who accused anybody of gaming the system.

Senator CHAFEE. I was the one. [Laughter.]

Senator GRAHAM. Mr. Chairman.

Senator RIEGLE. Senator Graham.

Senator GRAHAM. Briefly, in response to comments by Senator Chafee and Senator Durenberger, the current law—going back to your example of the hospital that contributes $1 million, uses that to match to draw down $1 million and then puts that all in its cost basis for reimbursement—specifically excludes provider-specific taxes from a provider's cost basis for purposes of Medicaid reim-

bursement. So, they could not include the $1 million under your hypothetical in arriving at their Medicaid reimbursement under the laws that exist today. There may be some further safeguards that the committee might consider, but I think that one has already been provided.

Second is cost sharing. I am concerned about the cost-sharing from citizen to citizen. But what was happening in our State—and I do not think we are peculiar—is that increasingly, the whole burden of indigent health care was being borne by a very small group of hospitals; largely, the public, primarily in urban areas. Many hospitals were eschewing any responsibility to provide indigent care.

Part of this is to see that all hospitals—as part of their public responsibility as a health care provider—contribute towards indigent health care in the State. And this was a means of accomplishing that objective.

Senator DURENBERGER. But, Bob, is it not correct to say it is not the hospitals that make the contribution, it is the people who go into the hospitals who make the contribution in the more affluent area to people in the poor area. That is my only point.

Senator GRAHAM. Well, I guess that is a matter of health care economics.

Senator DURENBERGER. Yes, that is all.

Senator GRAHAM. If you think that the health care system is so inelastic that there is no marketplace discipline and, therefore, hospitals do not have to be concerned with their costs, because without exception, they can pass those on to their customers, then we do have some very serious problems.

I do not think the other hospitals would have resisted—as they did the imposition of this assessment—unless they thought that some of that cost was going to come out of their shareholders' and their bottom line profit, and would not be a total passthrough to their customer.

The CHAIRMAN. Mr. Chairman, if I might comment.

Senator RIEGLE. Yes, Senator Bentsen.

The CHAIRMAN. In talking about the expansion of Medicaid—and frankly, I am one that has pushed very hard for prenatal, and neonatal, and health care for children. I think that it is one of the biggest payoffs for taxpayers we can have in trying to have children born with sound minds and bodies. But I was interested in the study of the administration of some nine States, and CBO joined in that study. And they made the point that 59 percent of the cost increase to the States is not mandates, but is due to the increased costs in health care services alone; 59 percent of that cost increase.

And then, when they are talking about those benefits that are mandated that have added to the cost, they comment on the QMB's and they talk about nursing home reform as bringing about those kinds of increases. Now, I understand that States are worried about the future, where we take coverage up to the age of 19 in Medicaid, and what that might result in.

Senator RIEGLE. Gentlemen, we thank you very much for your testimony. It has been very helpful to us. I think the perspective you both bring as former Governors is especially important, and I

appreciate the time and the effort that went into these presentations. They will be very helpful to us.

Senator CHAFEE. Mr. Chairman, can I say one word about mandates?

Senator RIEGLE. Yes.

Senator CHAFEE. Because I have been on the conferences in connection with the Medicaid expansions and many of the mandates. And I know that the Governors complain because they are hit by these mandates—many of which occur in the dark of night—that they are not aware of, and suddenly they wake up and realize that they are forced to cover a whole series of services that they never would have before in coverage of poor children.

The other side of the coin is that we believe that those mandates are resulting in better health care for our citizens. They have never been adopted willy-nilly.

The objective has always been to make sure that these lower income individuals are taken care of; something that the chairman of the committee has been so conscious of for many years.

So, I know that they are difficult and it is levying a financial burden on the States, but I would like to think that the States recognize that it produces a healthier population eventually. At least, that is our belief.

Senator GRAHAM. Senator, I do not think that you would find very many State officials who are not deeply concerned about the health care of their systems. That comity of recognition of the appropriateness of the Federal leadership role in Medicaid, I think, should be met with an equal respect for the States' legitimate right to determine the methods by which it will finance its share of the responsibility. That is what Senator Bond——

Senator CHAFEE. Well, as you know, frequently we make these expansions optional. And if the States want it, they can do it. Some do; some do not. But also, we make plenty of them mandatory. Many of the Governors are not conscious of what we have done until much later. I do not blame them for being upset.

Senator RIEGLE. Senator Bond.

Senator BOND. I was just going to add to what my colleague from Florida said. Sometimes those of us who serve in the body are not aware of what has been slipped in in the dark of night in conference when it comes back. And I think to address the specific point about improving health care, there are a number of different ways that States can go about it. And in our State, we continue to see great needs for the prenatal care, and the care for very young infants as being one of the most cost-effective, most vitally needed, most important for the human health and well-being of our children. And when the mandates for coverage to older and older children are implemented, then there is a shift in spending, because most States are operating under very tight budgets.

Washington has made the decision for the States as to their priority health care needs. And all of these needs that you have mentioned are important. But there may be some different priorities.

When Congress says you shall cover children up to this age, you may, in fact, be taking away the ability for a State to say we have a very high infant mortality rate, we have a very high rate of children born with disabilities, and we could use some of those dollars

on additional programs at the early end. So, I do not think that the wisdom is all with the Congress. We can, perhaps, learn from the States.

Senator RIEGLE. I must say, just one observation and then we will move on to our next panel. I have been visiting a number of neonatal units in hospitals around the State of Michigan with respect to this preventive care particular with children. We have so many underweight babies being born now because mothers are not getting the medical attention they need. The technology, of course, now allows us to save infants that even come in at 2 pounds, or less; they are so tiny, it is hard to imagine how small they are. But on the average, we are spending about $100,000 in the first 90 days of life of a child that is born severely underweight because of an absence of prenatal care.

I have been struck by the fact that as you go into these neonatal units, you will see dozens of these little children in these circumstances, getting this intensive medical help that they obviously need and should get. But, we have invested the equivalent of a 4-year education at Harvard in these children in the first 90 days of their life, when much of that expense could be avoided. These babies could come to full-term if the mothers were getting some measure of proper nutrition and care during pregnancy.

It is just stunning to watch the doctors and nurses applying this wonderful, professional care; and state-of-the-art medicine. But the cost is absolutely extraordinary when I think we could spend a tiny fraction of that somewhat earlier and avoid all of that expense, and the grief and the heartache because many of these children, of course, are impaired.

Even with all of the high technology help, they end up not being able to have a normal life. And then you have a sadness and a hardship going out into the future that affects many people.

So, these are areas that I think we just have to press ahead, and I appreciate the help of my colleagues on that.

Senator BOND. Mr. Chairman, you have just made the very best case for some of the things that we have addressed in the Families in Need Act, a piece of legislation I introduced recently specifically on that topic, with the support of the March of Dimes, the American Academy of Obstetricians and Gynecologists. I would invite your attention to this bill, because we have seen the same thing in Missouri.

The CHAIRMAN. Well, I must say, if I may, Mr Chairman.

Senator RIEGLE. Please.

The CHAIRMAN. To go into those intensive care departments and see a baby no larger than your hand and see the situation resulting from hard drug abuse by the mother, and then see that baby end up as a boarder baby—meaning it's a boarder at the hospital, because no one will call for that baby—presents some of the most difficult moral problems that we are facing today, I think.

And I congratulate you, Senator Bond, on your bill. I have one, too, insofar as trying to address some of those kinds of concerns. But certainly in the first year of a child's life, the money we spend on prenatal and neonatal health care—and we are getting so many children having children—that pays off at least three dollars to one

to the taxpayer, apart from the question of compassion and the emotional concerns that are involved.

Senator RIEGLE. Just one other observation. Within the last month and a half, I have seen two of these infants that have come in under these circumstances, that have never left the hospital, as you say, boarder babies—because they are too ill to go home.

At less than 1 years old the costs in their lives exceed $1 million. These are two cases that I saw requiring extraordinary help. Of course, the technology is there to work miracles but it is a stunning problem that is just mushrooming, and is driven by drugs, poor nutrition, lack of access to health care and maternal counseling during pregnancy.

Senator BOND. Birth defects.

Senator RIEGLE. Birth defects.

Senator BOND. Smoking, alcohol.

Senator RIEGLE. AIDS, Senator Chafee says, alcohol, tobacco we also know now, too, also has an impact. But we thank you very much for your testimony. You have been very helpful to us.

Let me now call our next set of witnesses to the table. Our first witness is Jo Anne Barnhart, who is the Assistant Secretary at the Department who heads the newly created Administration for Children and Families. She is going to testify about the transfer of the Maternal and Child Health Block Grant Program from the public health service to the new agency. The two accompanying witnesses, also representing the administration, will testify on the topic of Qualified Medical Beneficiary Programs.

We will hear from Gwendolyn King, who is the Commissioner of the Social Security Administration; and Ms. Kevin Erbe, who is the Associate Administrator for Communications of the Health Care Financing Administration. We welcome their testimony on the efforts that the administration is making to notify and enroll potentially eligible beneficiaries. These two agencies have already undertaken some activities in these areas, and we look forward to hearing from them and working with them in the future.

So, we will start, Ms. Barnhart, with you, and we will make your full statements a part of the record. We would like you to summarize as best as you can.

STATEMENT OF JO ANNE B. BARNHART, ASSISTANT SECRETARY, ADMINISTRATION FOR CHILDREN AND FAMILIES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary BARNHART. Yes, Mr. Chairman. In the interest of time, I have a very short statement to make this morning.

Senator RIEGLE. Very good.

Secretary BARNHART. I appreciate the opportunity to appear before you to discuss the administration's decision to provide a health component within the newly organized Administration for Children and Families, or ACF.

In the early 1900's, at the first White House Conference on Children, government officials acknowledged that the medical, social, and financial circumstances of children and families are closely, and perhaps inseparably, interwoven.

These linkages between poverty and health are widely accepted, and yet, our attempts to improve conditions for poor families most often occur separately. The needs of families call us to find ways to link our programs together. I believe that they demand that we work together if people are our priority, rather than programs.

It is important that we forge a strong link between social programs and health programs that serve low-income families. The Maternal and Child Health block grant (MCH) provides that link. MCH is committed to the health needs of women and children, particularly low-income women and children.

The announcement in the Federal Register which gave ACF the responsibility for administering the Maternal and Child Health block grant reflects Secretary Sullivan's strong commitment to integrating medical and social services. We intend to carry out his plans for reorganization in such a way that it will not disrupt the current administration of MCH grants at the State and local level.

All of the resources necessary to effectively administer the Maternal and Child Health block grant will be within ACF.

We will continue to work closely with the Public Health Service to maintain the necessary health expertise, and to ensure that MCH activities remain an integral part of the full range of public health efforts at Federal, State, and local levels.

The Administration for Children and Families will be the focal point for HHS efforts toward children and families, and we want to ensure that those efforts address all aspects of what are truly complex problems. Through the inclusion of MCH in ACF, we will begin to bridge the gaps between the delivery of social and health services to vulnerable children and families.

Any transition to a new organizational structure is difficult. Yet, when the difficulties associated with transition pass, that which remains will better serve the needs of our most vulnerable citizens.

Before the exact organizational details are final, we will be in touch with you and your staffs. We are committed to maintaining the integrity and improving the effectiveness of what is already a valuable block grant for children and families.

That concludes my statement, Mr. Chairman.

[The prepared statement of Secretary Barnhart appears in the appendix.]

Senator RIEGLE. Thank you. Ms. King.

STATEMENT OF GWENDOLYN S. KING, COMMISSIONER OF THE SOCIAL SECURITY ADMINISTRATION

Ms. KING. Thank you, Mr. Chairman. I am delighted to be here this morning with this committee to discuss ways the Social Security Administration can assist in providing that very important Qualified Medicare Beneficiary benefit.

I would also like to add that it was only 2 years ago, Mr. Chairman, when I came before this committee, and I want to thank you again for confirming me as the Commissioner of Social Security, and not the HCFA Administrator. [Laughter.]

As you know, Social Security does not administer that particular QMB program, but Social Security stands ready to do whatever we can under the law to assist in letting people know about the pro-

gram. I say under the law, because clearly, this is not a program that we can pay for under Title II benefits, and anything we do at Social Security would have to be reimbursed by the Health Care Financing Administration.

I did want to lend my support, Mr. Chairman. I have a full statement I would ask that you submit for the record.

Senator RIEGLE. Without objection, so ordered.

[The prepared statement of Ms. King appears in the appendix.]

Ms. KING. I would only add that Social Security right now is coming to grips with its own workloads that most of you are already very familiar with. We are facing a situation even in the next fiscal year with our current appropriations bill where we are looking at a potential loss of $90 million from the President's budget request.

So, with workloads growing, with our disability workloads growing, I would only reiterate that any role Social Security can play must be reimbursed, and we would hope that you would take that into consideration.

We stand ready to work with the committee. I have seen some of the provisions of your bill, Mr. Chairman. We applaud your efforts in this regard, and we will do whatever we can. We do have pamphlets we have revised, and we are making camera-ready Courier reports available in our Capitol Hill office over in the Russell Building for those of you who send out newsletters and would like to get the word out about QMB. We want to make sure that we are a part of the solution and that we contribute to the effort.

Thank you, Mr. Chairman.

Senator RIEGLE. Ms. Erbe.

STATEMENT OF KEVIN LYN ERBE, ASSOCIATE ADMINISTRATOR FOR COMMUNICATIONS, HEALTH CARE FINANCING ADMINISTRATION

Ms. ERBE. Mr. Chairman and members of the subcommittee, I am pleased to be here this morning to discuss the Qualified Medicare Beneficiary Program. The Department of Health and Human Services is committed to making low-income Medicare beneficiaries aware of the QMB program and to improving their access to it.

Secretary Sullivan is personally concerned about the notification and enrollment of these vulnerable citizens. Last week, the Secretary sent a letter to every member of Congress indicating his concern that eligible QMB's receive the Medicaid cost-sharing coverage to which they are entitled.

He stated his intent to utilize fully the resources of the department to promote awareness of the benefit. Under the QMB program, States pay the Medicare premium, co-insurance, and deductibles for indigent Medicare beneficiaries.

The Medicare Catastrophic Coverage Act required States to buy-in to Medicare for low-income seniors and disabled persons beginning January 1st, 1989. Immediately following enactment, HCFA moved to implement the new buy-in program.

In October 1988, HCFA sent a letter to all Governors and directors of State Medicaid programs alerting them to the new QMB

benefit and outlining Federal and State responsibilities to implement it.

A State Medicaid manual issuance in December 1988 contained comprehensive policy and systems instructions for the States. To help States notify potentially eligible beneficiaries, HCFA provided them with the names and addresses of Social Security beneficiaries whose incomes would likely qualify them for the QMB program. States conducted outreach to provide information and notify potentially qualified beneficiaries of the QMB benefit.

Several States launched comprehensive campaigns. For example, the States of Texas, Florida, and New Jersey made an all-out effort to notify potential eligibles through press releases, direct mailings, a review of their Medicaid case loads, and a toll-free telephone number for QMB information.

HCFA directly notified all Medicare beneficiaries of the new QMB benefit by providing information in the 1989 Medicare handbook. A QMB inquiry unit in HCFA's central office responded to over 15,000 written and telephone inquiries in a period of just 6 months.

In the summer of 1989, HCFA made a special mailing of a one-page notice to approximately 14 million Medicare beneficiaries identified as potentially eligible for the QMB benefit.

The notice included State-specific locations and telephone numbers for further inquiry. These efforts have taught us that qualified Medicare beneficiaries are difficult to identify.

Of the large number of beneficiaries who responded to the direct mailing, only a small percentage actually qualified for the program. Many met the income requirement, but had too many other assets to qualify.

Beyond notification, other issues relate to enrolling QMB's; beneficiaries must apply at their State Medicaid or public assistance office; many attach a negative stigma to going to the welfare office; some beneficiaries fear that having Medicaid pay for Medicare premiums and co-payments will cause them to have to change their personal physician.

Because an application for Medicaid must be made, it will always be necessary for States to make the final determination of eligibility for the QMB program. We must also keep in mind that funding is not available to support an alternative application process, which would be quite expensive.

Despite our efforts at notification, there are still beneficiaries who have failed to learn of the QMB program. We know that beneficiaries have heard about the QMB benefit.

We need to target our message and deliver it in a way that will sink in with those most likely to benefit. Any information dissemination should be as specific as possible with regard to the eligibility requirements. This would reduce the number of inquiries from people who do not qualify for the program. States currently do not have the resources to manage large numbers of applicants, many of whom will not qualify for the QMB benefit.

We must also consider the cost effectiveness of the outreach method selected. In the current budgetary environment, dollars must be spent wisely. Mass promotions and broad public informa-

tion campaigns have been tried before at great expense and with poor results.

For example, the direct mailing to 14 million potential beneficiaries in 1989 cost over $2 million, but resulted in few additional enrollees. Even if funds were readily available—which they are not—we have no reason to believe another mailing will be more effective than the one in 1989.

While some may argue that the cost of outreach activity should not be a factor, the current pressure on both State and Federal budgets demands we pursue only those methods that have the greatest promise of generating results.

Last week, senior officials from HCFA, SSA, and AOA met with over two dozen consumer groups and representatives from the National Governors' Association and the American Public Welfare Association.

The purpose of the meeting was to share ideas on how the government and private sectors can join forces to ensure that qualified beneficiaries receive the assistance to which they are entitled.

Advocacy groups and organizations in the field are an essential component to making the QMB program a reality for needy beneficiaries. We plan to work with these groups and use their resources to distribute materials about the QMB benefit through the aging network. We will also target public service announcements in areas with the largest concentration of potential QMB eligibles; develop a fact sheet for distribution to senior centers; and write articles for senior publications and for use by others.

The Health Care Financing Administration has done a great deal to inform Medicare beneficiaries of the QMB program. We continue to explore ways to identify this population. The question before us now is how best to target the unenrolled eligible population.

We look forward to hearing your suggestions and comments. Thank you. I would be happy to answer your questions.

[The prepared statement of Ms. Erbe appears in the appendix.]

Senator RIEGLE. Thank you all.

Ms. Barnhart, let me ask you first. It is my understand that to implement the transfer of the Maternal and Child Health Program, that one option under consideration is to transfer grants administration personnel to the new Administration for Children and Families while keeping the Maternal and Child Health Bureau and its health professionals at the Public Health Service. Now, how would that arrangement actually work? And I am wondering exactly what you have in mind in terms of how many people, and what types of positions would actually be transferred to ACF, and who would be responsible for their supervision?

Secretary BARNHART. Mr. Chairman, that is one of several possibilities that we are considering at this time. I would like to emphasize that at this time no decision has been made. We are pursuing a number of alternatives and trying to work out the details.

One alternative does reflect transferring grants management staff, a few health professionals, a senior physician, as well as a senior health service administrator to the Administration for Children and Families; and then entering into a purchase-of-service agreement for medical, and health services that are currently pro-

vided by professionals at the Public Health Service and the Maternal and Child Health Bureau.

Senator RIEGLE. Now, you say a series of options. What are some of the other options you are looking at?

Secretary BARNHART. One of the options that was looked at was to transfer just the grants——

Senator RIEGLE. One that was looked at, or is being looked at? I really want to know what is on the list of viable options.

Secretary BARNHART. One that was looked at, but is not currently on the list of options, was to transfer grants management staff and not have the purchase-of-service agreement. This was ruled out, Mr. Chairman. A second option that has been looked at is the one I just described.

Another that has been considered is increasing the number of professionals that would transfer to the Administration for Children and Families instead of having a larger liaison group of the Public Health Service, actually having a larger liaison office at ACF.

Also, an alternative that is being considered is to move all of the Maternal and Child Health block grant function to the Administration for Children and Families.

Senator RIEGLE. I am wondering if the decision were to separate the grant administrators from the physicians and the nurses, would that not have the potential to be harmful to the operation of a program that now has a 56-year history of success?

Secretary BARNHART. One of the reasons that we have not made a decision is that we are exploring exactly what the consequences and implications would be.

When I say exploring, I have my staff at ACF talking with staff at PHS, and I am talking with Dr. Mason on a regular basis, as well as staff in the Office of the Secretary, to determine exactly how each of these arrangements would operate.

This is one of the reasons that we have not made a decision, because we have not gathered all the information needed to do so.

Senator RIEGLE. I have other questions, but Senator Roth has joined us, and I want to see if he has an opening comment that he wants to make at this point.

Senator Roth.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE

Senator ROTH. Thank you, Mr. Chairman. I do have an opening statement. I will not read it in its entirely, but I would ask that it be included.

Senator RIEGLE. Without objection, so ordered.

Senator ROTH. But I do want to say that I was tremendously pleased to see in March when Secretary Sullivan named Jo Anne Barnhart as the Assistant Secretary in charge of the new agency under the Department of Health and Human Services, thereby bringing together all the child and family-related programs under the same roof.

The transfer of Maternal and Child Health Block Grant from the Public Health Service to the Administration on Children and Fami-

lies is, indeed, not a simple process. And, of course, much is being said both for and against this change.

While some may have concerns that MCH will lose prominence in the Administration on Children and Families, I want to make it very clear that I have full confidence in the Assistant Secretary Barnhart's leadership as the administration's advocate for children and family. I know she cares, and in view of the consolidation, what is important to note is not just the Federal Government that is moving towards better coordination of services for children and families, but many States have established new agencies to emphasize this focus.

Thank you, Mr. Chairman.

[The prepared statement of Senator Roth appears in the appendix.]

Senator RIEGLE. Thank you, Senator Roth.

I think I am going to ask just one more question here, then go to Senator Durenberger, and then go to you, if I may. And I would like to address this question to Ms. Erbe and to Ms. King.

The bill that I am introducing today would allow the use of Social Security offices to accept applications and, where necessary, coordinate with Medicaid offices if further work is needed for a particular applicant to determine eligibility.

It was mentioned in your testimony that the "stigma" associated with welfare offices often deters people from applying. If that is the case, I am really interested in what your views are in using Social Security offices as a point of entry into the system.

Also, I am wondering how much it would cost for the Social Security Administration to do intake and eligibility determinations for the QMB's.

Ms. KING. Mr. Chairman, depending upon the level of involvement of Social Security employees, we have a range of costs. For instance, if the plan is to have a stack of simplified applications in Social Security offices that people who come in for other Social Security business might fill out and have Social Security forward to the appropriate State or County assistance office, we have a range of what that might cost, in terms of workyears for the agency.

If the idea is to have Social Security employees actually sit with visitors to a Social Security office, help them fill out the form, and, in fact, determine eligibility on the spot—as we do for supplemental security income and other programs that we administer—then we have another cost.

And the reason for this is that the requirements for QMB's are different from the requirements for SSI. Therefore, that work would actually have to be added on to the normal workload that Social Security currently is struggling under.

We can provide for the record some costs, depending on the level of involvement of Social Security employees, Mr. Chairman. But again, I must repeat that under the current statute, we are not able to pay for that work from Title II funds, from trust fund monies. Any work that Social Security does on QMB's would have to be reimbursed, again, by the Health Care Financing Administration.

[The following information was subsequently received for the record:]

RESOURCES REQUIRED BY SSA TO MAKE QMB ELIGIBILITY DETERMINATIONS

Cost estimates for SSA to notify and determine eligibility for Qualified Medicare Beneficiaries (QMB's) can range from a low of $4.5 million for a streamlined effort, to a high of $271 million for a full scale effort.

A streamlined effort would involve a simple screening process to identify those applicants who visit an SSA office to apply for Title II or Title XVI benefits, and appear likely to qualify for QMB Medicaid coverage. SSA could provide a pamphlet and a simple explanation of the program to roughly 2 million potentially eligible applicants at a cost of about $4.5 million. Applicants would be referred to State offices for intake and development of eligibility requirements.

A full-scale effort would involve providing potentially eligible applicants with a pamphlet and a brief explanation, and then having SSA personnel take an application and complete development of eligibility criteria. This could cost SSA as much as $271 million to distribute pamphlets, explain the process, and take and develop applications as well as provide employees the training necessary to perform these activities, assuming that 2 million QMB's would apply.

However, for SSA to assume any of this responsibility, the Health Care Financing Administration would need to obtain the funds necessary to reimburse SSA for Medicaid enrollment costs. SSA's administrative appropriations legally cannot be used for Medicaid work.

Senator RIEGLE. I want to ask you what sounds like a simple question, and then I will yield. In your mind, who does the Social Security Administration work for?

Ms. KING. We are public servants, Mr. Chairman. The 65,000 employees at Social Security have committed their careers to serving the public with compassion and efficiency. And I know that when we get new programs going—like our 800-number—people sometimes wonder if, in fact, we are on their side, and wonder if we called it an 800-number because you had to call 800 times to get through.

The truth is that the busy signal rates have all but disappeared; they are down to 1 percent. It is a tribute, I think, to the employees of Social Security that they committed themselves to making sure that that service was provided to the public.

Senator RIEGLE. Well, I know there are a lot of people over there that work hard, and you among them. My question is, in terms of the focus of the operation, who do you see yourself working for?

Ms. KING. We see ourselves serving the public, and again, I say that generally because a lot of people wonder if we see ourselves serving only people who are coming in for retirement benefits; we do not.

Senator RIEGLE. Yes.

Ms. KING. A number of the people who visit our offices are low-income people who are eligible for the SSI program. And, as you know, in some 30-odd States, if you are eligible for SSI, you are categorically eligible for Medicaid.

Senator RIEGLE. Let me ask you this. It seems to me that your principal responsibility is to understand and respond to the people who are within the reach of Social Security programs. That is your first responsibility.

Ms. KING. That is true.

Senator RIEGLE. And obviously, in the name of the general public, not everyone qualifies for Social Security programs. If, in fact, your obligation is to respond to those who are eligible and for whom programs have been designed to assist them, does that not carry with it a requirement that you be aggressive in finding the

people that you are designed to help? I mean, is that not a part of your job?

Ms. KING. We see that as an absolute part of our job, Mr. Chairman. As you know, we have a very aggressive SSI outreach effort that has been under way now for several years.

We work cooperatively with our sister agencies within the HHS umbrella on outreach. We have been working with Dr. Joyce Berry, the Commissioner of the Administration on Aging, whose aging networks have been very instrumental in reaching out and letting people know about our programs.

Our brochures and pamphlets are shared with HCFA and with the Administration on Aging. The whole purpose of our working together has been to provide a coordinated service for people who come into our offices.

Senator RIEGLE. Well, listen, let me tell you something. I get a little exasperated because there is all this work, and all of this effort, and all of this commitment, and we are not getting the job done. You have an obligation to get it done. And you have an absolute, affirmative obligation to get it done. How many meetings have you had together to solve this problem, Ms. Erbe and Ms. King? How many meetings have you had, a dozen? Two dozen? Three dozen? How many meetings have there been to solve this outreach problem?

Ms. KING. Well, there have been several meetings, Mr. Chairman, but——

Senator RIEGLE. Well, how many? I am asking——

Ms. KING. I do not have a number. We will make that available for the record.

Senator RIEGLE. No, I do not want it for the record. I want your best estimate right now. Has there been a dozen meetings?

Ms. KING. At least. But not just with us, Mr. Chairman.

Senator RIEGLE. Is there an action plan?

Ms. KING. Let me just make it as clear as I can. There is a State role that must be played here. We have met with the various State officials who are perfectly willing and able and set up to take applications. There has to be a coordinated role.

Senator RIEGLE. That is what I am trying to get at. Ms. Erbe, let me ask you. I want to get at the coordinating role, because you two have the responsibility to get your heads together and work something out here. Time is passing, and we do not have a plan, and you have an obligation, in my view, working with the States, to come up with an affirmative plan and get this done. There should not be a person in this country eligible for help, that needs it, who is an elderly, sick person in this country, who is not getting the benefits that are designed for them.

I would think that there would be an enormously aggressive effort to get this problem taken care of. What I hear is sort of catch-22. I hear coordination, and I hear meetings, and I hear this, and I hear that. That is all fine; if it leads to a plan that gets the job done. How long do we have to wait?

Ms. ERBE. One of the purposes for all of the meetings that we have been having is to put together an aggressive beneficiary outreach effort.

When we sent out the information to the 14 million beneficiaries that SSA identified for us as possible QMB eligibles, 95 percent of the responses we got back were from people who were not eligible. Clearly, it is a very difficult population to reach. That is one reason why we are going to the advocacy groups, whether it is Meals On Wheels, religious organizations, or State groups. We are looking for community workers to help us get out into the community and reach those people one by one.

Senator RIEGLE. Would it not seem that the people who are in this situation and who are financially distressed, hardest to find, are the ones you ought to make the greatest effort to find?

Ms. ERBE. We are trying to do that.

Senator RIEGLE. Well, it is sure taking a long time.

Ms. ERBE. It is a difficult problem.

Senator RIEGLE. Well, I know it is a difficult problem, but it is not so difficult that it cannot be solved. We solve difficult problems in this country every day. It was difficult to go in and do Desert Storm; we figured out how to do that. It was difficult to go to the moon; we figured out how to do that. I mean, you folks have an affirmative obligation to figure out how to do this. We wrote the Secretary 2 years ago, not 2 weeks ago, or 2 months ago.

Ms. KING. Mr. Chairman, I think we need to make sure you understand that we are trying, and one of the things we have come to grips with is that we cannot do it alone.

Senator RIEGLE. Ms. King, let me just stop you for a minute. I know you are trying. I understand you are trying. I am asking you to succeed. Now, that may be asking too much.

Ms. KING. We are stretching beyond the walls of government to reach out to the community organizations, to the associations nationwide——

Senator RIEGLE. Let me ask you this. Have you made a formal request for additional funds within your organizational structure? Have you asked the administration and OMB for additional money for precisely this purpose?

Ms. KING. My colleague, Gail Wilensky, and I have worked out all the numbers. We have looked at every possible angle. We are working now with the nationwide associations that can also assist us in outreach. When you ask the question, how long will it take——

Senator RIEGLE. No, that is not the question I ask, and I do not want to be impolite to you, but when you do not answer me directly, I consider it an impoliteness on your part. My question is, have you made a formal request for additional monies to achieve this outreach? And the answer is yes or no. Have you, or have you not?

Ms. KING. Mr. Chairman, my requests would be for the programs that I administer. I cannot speak for HCFA. I would have to defer to my——

Senator RIEGLE. Well, I am going to ask you both. But have you made a formal request for additional resources to do the outreach? Yes or no.

Ms. KING. Yes, absolutely, for our SSI outreach.

Senator RIEGLE. All right.

Ms. KING. I have additional requests for public information, which is all that we have under our purview.

Senator RIEGLE. Are they in writing?

Ms. KING. Absolutely.

Senator RIEGLE. Would you send us copies of those?

Ms. KING. Absolutely.

Senator RIEGLE. Very good.

[The following information was subsequently received for the record:]

REQUEST FOR ADDITIONAL RESOURCES FOR OUTREACH

SSA's FY 1992 funding request to Congress outlines SSA outreach activity with regard to making potential beneficiaries aware of the benefits and services available to them through the SSI program. These SSI outreach activities are an effective way of identifying potential QMB eligibles, most of whom are also eligible for SSI. Following are pertinent excerpts from pages 58 and 69-70 of SSA's FY 1992 Congressional Justification:

Research and Demonstration Projects

The FY 1992 request includes $11,000,000 primarily for Project NET/WORK ($6,900,000) and SSI outreach projects ($3,000,000). The remaining funds will be used for demonstration projects seeking effective ways to return disabled beneficiaries to the work force and for several small income security studies.

SSA's SSI outreach strategy has three major thrusts:

—to develop and provide informational material about SSI that will promote a better understanding of the program;

—to reach out to individuals who are aware of the program but are reluctant to apply for "welfare," by working toward a more positive public perception of the program; and

—to make the process of applying for SSI benefits easier.

* * * * * * *

SSI Outreach Activities

SSA is concerned about ensuring that people potentially eligible for SSI are aware of the benefits and services available through this program, and has initiated an outreach program through its field office structure. SSA is working with advocacy groups and community organizations through demonstration projects to expand SSI outreach efforts. Among the activities undertaken in FY 1990 were the awarding of cooperative agreements to community organizations and agencies for SSI outreach demonstration projects in 34 sites across the country, and development and distribution of new SSI public information materials.

Senator RIEGLE. Ms. Erbe, have you made additional requests?

Ms. ERBE. We have been working with our existing funds to try to administer the program.

Senator RIEGLE. Is that a yes or a no?

Ms. ERBE. No.

Senator RIEGLE. All right. So, you have not made any requests. Do you think it is time, maybe, that you do so?

Ms. ERBE. Perhaps.

Senator RIEGLE. Are you afraid to do so?

Ms. ERBE. No. Actually, we are looking at the problem right now from every angle possible so that we come up with the right direction to take. We have been asked to target specifically the areas where there is the largest concentration of QMB eligibles.

We have been asked this by the advocacy groups; by the States; by the hospitals; by everyone we have met with. They have asked us not to blanket the United States with information about this program because in the past, 95 percent of the responses have been from people who, in fact, were not eligible for the program.

Senator RIEGLE. I understand. That tells me that you have not aimed in the right direction. I mean, you have been here this morning. You have heard about all these people. A hundred thousand in the State of Illinois, 70,000 in the State of Michigan. You cannot find them? Are we so incompetent that we cannot find them? I mean, when you say that we have aimed a big effort but we hit the wrong group, I mean, we are not going to give a gold star for that.

We are supposed to be able to aim an effort where we find the right group. And if you do not have enough people and you do not have enough money, then ask for it. You have got an affirmative obligation to ask for it. And if you ask for it and somebody upstairs says, "no, we are not interested," then we need to know about that. But you have not asked for any additional resources.

I know it is not an easy problem to solve, but when you aim at it and you miss it, you have to try again. We are asking you to solve it. And if you need additional resources, ask for them.

You have an obligation. You do not have an obligation to the bureaucrats you work for; you have an obligation to the service population that is out in the country. That is whom your obligation is to. You are missing them, you are failing them; and that is true for both of you.

Senator Durenberger.

Senator DURENBERGER. This is beginning to sound like a hearing on the census. [Laughter.]

Some people are hard to find. I mean, if the SSI rates were 100 percent, I would say they might be lagging on QMB. And I am not arguing with you, and I certainly do not argue with the fervor that you bring to it.

But I just suggest it is not easy to find people whose annual incomes fall below $6,000, $6,020 and less than $4,000 in assets, and couples with annual income below $8,880, and probably some-odd cents, and less than $6,000 assets. I mean, the way we run these programs in America, I think, contributes to the difficultly in pinning a label on those people.

Now, what bothers me, though, is some States seem to be able to do it, and maybe you can respond to that. The figures that I had before me here someplace said that—is it Maine?

Ms. KING. Yes.

Senator DURENBERGER. Maine has an 84 percent participation of those eligible. Vermont is 82 percent; Oklahoma, 78 percent. But Michigan and Rhode Island, and Kansas, and some of the States represented on this committee are not doing so well. Why is it that some States can find these folks and some States cannot?

Ms. KING. I would suggest, Mr. Durenberger, that that might be a question to ask of the States themselves. I think it has to do with getting information out to people. As you point out, the universe of people that we serve is some 43 million people.

Therefore, it is difficult to target this group of 2 million people, though we continue to try over and over again. Some States have done a lot better; some States do not seem to have made any inroads at all.

From a National perspective, we recognize that we absolutely need the cooperation and help of the organizations that operate in

the communities in those States to help us get the word out, as well.

Senator DURENBERGER. But getting to the point of the chairman's question, you said you are trying, you are trying, you are trying, and nothing happens and the chairman is getting upset. And I think we all are getting upset. But if in Maine and these other States they are finding them, do you not know what they are doing?

Ms. KING. We do not. In fact, I am sure that HCFA has explored this as well. We have worked with the various States. It is a conundrum.

We have a similar situation with the disability program. If you look at the disability program in the State of Michigan, you find the State Disability Determination Services there are doing an outstanding job. This is not the case in other States.

We have even taken the disability director from the State of Michigan and had him come into the Social Security Administration to work with us as a consultant to help us try to figure out why some of the other States are having such a difficult problem.

Senator DURENBERGER. Just looking at one of the suggestions I did not see in looking for eligible persons—I know people are exploring the hospitals and the doctor's office—but has anybody thought about retroactive eligibility so that somebody who is going through the hospital system, the doctor system, you discover they cannot pay and they fall in these categories, why not make them retroactively eligible at that point? Has anybody thought to do that?

Ms. ERBE. It is not in the law at this point, but it is possible to do that.

Senator DURENBERGER. So, if we put it in the law then HCFA could do that?

Ms. ERBE. Well, that is not——

Senator DURENBERGER. Pardon me?

Ms. ERBE. It is not there now.

Senator DURENBERGER. Well, Jo Anne, I need to ask you a couple of questions, if I may, Mr. Chairman. Maybe I will just ask you one question.

And I must agree with my colleague from Delaware with what he said about you, and that applies to all three of the witnesses here. We are all very proud of you, but I must also say that I have never seen three such general statements in all my life. The statements lack a lot of specificity.

And that is not said by way of criticism, it may be just the nature of this hearing. But they are relatively noncommittal, and that is a dangerous thing when you are getting close to Labor and HHS appropriations, frankly.

People are doing abortion and AIDS and a lot of things on the HHS appropriation bill, and those of us who care about public policy might be tempted to do something on public policy.

So, let me ask you this question. I read your statement, and it is everything I agree with. "Since the early 1900's, government officials acknowledged that medical, social, and financial circumstances of children and families are closely, inseparably interwoven. The linkages between poverty and health are widely accept-

ed." Secretary Sullivan's strong commitment to integrating medical and social services.

The Administration for Children and Families will be the focal point for HHS efforts toward children and families, will address all aspects of what are truly a complex problem, bridge the gaps between the delivery of social and health services to vulnerable children and families. It is important we forge a strong link between social problems and health programs that serve low-income families. I mean, all of this is about integration.

My question is how do the 174 public servants who currently work at the MCH bureau and the 30 public servants in the Block Grant Program, how do they impair the mission of linking medical and social services in this country?

Ms. BARNHART. Well, I would say Senator Durenberger, they do not impair the mission. In fact, there is significant coordination and linkage at the current time. The Maternal and Child Health block grant now coordinates with Medicaid, EPST, and the WIC Program. ACF has some responsibilities in terms of preventing infectious disease through the Child Care and Development block grant, as well as the exploratory effort to encourage AFDC mothers to get their children immunized with the Center for Disease Control. Various categorical programs—like the Head Start Program and the University Affiliated Program which are in ACF—have health linkages with MCH bureau now.

So, it is a fact that they are not hindering the linkages. I am pleased—and I know Secretary Sullivan is pleased—that we have accomplished and made the strides that we have made to date.

The Secretary's thinking in placing Maternal and Child Health Bureau in the Administration for Children and Families was to place a greater emphasis on the holistic approach to dealing with the problems and the needs of children and families. And in his view as a physician, and, as you and I have discussed, he felt it was important that the Administration for Children and Families have a health component to promote a strong, holistic approach.

I would like to mention just a few of the efforts that I could foresee strengthening the Administration for Children and Families with MCHBG being present there.

We are looking at the problems that our teen parents are facing. They are some of our most at-risk youth, quite frankly. Under the Family Support Act, AFDC teen parents are a targeted group, and it is required that they be in school.

One of the things I would look to do with MCH and ACF would be to provide further linkages between teaching parenting skills and emphasizing the importance of perinatal care through the coordination of MCHBG with the AFDC and the Family Support Act programs.

Another critical area where there is a strong health need is in the child welfare area—child neglect and child abuse. I would look at creating a stronger link between the maternal and child health program and the Title 4(b) services. Perhaps including them in some of our family preservation efforts, as well as assisting parents.

There are a variety of other areas. For example, health care obviously plays an essential role in terms of promoting healthy child

development—a key link for the Head Start program and the Child Care and Development block grant.

It is not a matter of the current situation hindering or preventing linkages, but it is a matter of—further promoting linkages and coordination and filling what the Secretary views as a vital gap that now exists in our attempt to serve children and families.

Senator DURENBERGER. Sure. And I will just say to you in response to that, I chose that question on purpose, and I will say publicly what I have said to you privately. In this day and age—the cost constraints, the inability to finance adequate access to necessary resources—nobody can argue with either the Secretary's thinking, or the things that you would like to do. But the concern that everybody has is you are going to do it at the expense of an existing service organization. And that has been everybody's experience. That has been our experience with practically everything that goes on.

And I guess the concern is, why do you not do all of those things with resources other than the existing ones that administer either the block grant program or the people in the bureau? Why do you not just add resources to give you a sense of direction, a sense of integration?

Ms. BARNHART. Given the current budget situation, it is very difficult. We have to pick and choose very carefully when we propose adding resources. I assume one of the primary motivations behind the recent push towards integrated services is, in fact, that we realize we need to do a better job of coordinating the services where they might overlap. So we are operating in recognition of the budget constraints that we have.

I would like to emphasize something in my statement that I did not read, and that is that I want to say strongly again that——

Senator DURENBERGER. "All the resources necessary to effectively administer the MCH Block Grant with be within ACF". We have been listening to this since 1984 or 1985. It is in everybody's statement. We will always have the resources there. Then we have the situation where it does not show up. I mean, it does not happen.

And it is always very well-intentioned people who put those statements into their speeches. But in reality, it does not happen. You are borrowing, is what you are doing. You are borrowing from what we have now to accomplish a very laudable end. And the concern everyone has is the degree of delusion that goes on during the course of that process.

Ms. BARNHART. Well, Senator, as we see it, we are not borrowing. What we are doing is transferring, we are moving. We are recognizing the obvious linkages that MCHBG has to the health community.

Obviously, it is a part of the health community. We are transferring it from the health community where there is already a strong link into an environment at the Administration for Children and Families so that we can create a stronger link.

There are other programs that could have been put in Children and Families. The difficulty comes in drawing the lines. I believe that Secretary Sullivan with the creation of ACF is redrawing the line in terms of the focus of the programs and to change the approach that we are using for meeting the needs of children.

Senator DURENBERGER. Thank you. I have exceeded my 5 minutes.

Senator RIEGLE. We have, in essence, three other panels that we have got to hear from this morning. I think we have pretty much covered the ground here. I think despite what differences of opinion we may have on emphasis or urgency, it is important that we work together on this issue. I feel just as strongly as I possibly can that if there are people out there in large numbers that we are not reaching, that that is a failure on all of our parts, and it is an inexcusable failure. We can all pat ourselves on the back for what we do, and we all get certain things done, but the things that need to get done that we are not accomplishing, we cannot just keep passing around, in a circular kind of buck-passing situation where we say, "well, we are trying, but we cannot get it done," or "we can do it here," but "we cannot do it there."

That is not what people are paying for. I mean, people pay for this program. They pay for it. They pay for all of us, as public officials, to get it done. And so, they are not interested in why it is not getting done; they are interested in getting it done.

So, the next time we meet here, I want something very specific about exactly what we are doing and how we are doing it. And if we do not have the resources, get the resources. And if you need a different program in one State than another, I want to know that, and I want to get that set up. That is your obligation, not somebody else's obligation. They may share in it, but you have an affirmative obligation in that area, as do we. And that is why we are going to produce something here to try to move this along.

So, let me thank you for your testimony today and we will move on to our next panel.

Let me now invite Mr. Raymond Scheppach to the table, who is the executive director of the National Governors' Association, who is going to testify about the States' use of voluntary donations and taxes on medical providers to cover their share of Medicaid costs.

He is also going to share the States' perspectives on the operations of the Qualified Medicare Beneficiary program for the low-income seniors that we have been talking about.

He is accompanied by Mr. Ray Hanley, who is the director of the Office of Medical Services from the State of Arkansas. So, we are delighted to have you both, and appreciate your patience as we have been working our way through this subject matter today. We will make your full statement a part of the record, Mr. Scheppach, and we would be pleased to hear from you now.

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION, WASHINGTON, DC

Mr. SCHEPPACH. Thank you, Mr. Chairman. I appreciate the opportunity to appear before you today on behalf of the Nation's Governors. As you mentioned, I will submit my full statement for the record, and I will summarize it very briefly.

Our message today, Mr. Chairman, is clear. There is an urgent need to protect the authority of States to raise the revenue necessary to pay Medicaid program costs using donated funds, provider-based taxes, or other revenues.

Currently, Medicaid growth is essentially out of control. It grew 19 percent last year. It is probably growing currently between 25 and 30 percent. However, the reasons for this rapid growth are not the use of donated funds or provider taxes.

Essentially, it is due to: First, optional, and more importantly, Federally mandated expansions in eligibility and services. Second, the recession has substantially expanded the roles. Third, medical inflation is rising at about 2½ times the general rate of inflation. And fourth, State efforts to streamline administration have brought on more providers and more enrollees.

For OMB to blame the growth on Medicaid to States' financing mechanisms is clearly wrong. States must retain the right to raise revenues as they see fit for the following reasons.

First, they have a constitutional right to raise revenues without Federal restriction. Second, these financing mechanisms have allowed States to increase payments to hospitals that have a disproportionate number of poor patients, pregnant women, and children. If States are denied the right to raise revenues as they see fit, many programs will be terminated.

Third, it is unfair to change the rules in midstream, particularly at a time of fiscal distress for the States. States have just raised taxes $18.4 billion this year, on top of $10 billion last year, which is a total of close to $30 billion over the last 2 years just to meet their current needs.

Fourth, in fiscal 1992, only 5 percent of the State Medicaid spending came from donated funds or provider taxes, and only 2 percent of that actually came from donated funds.

Mr. Chairman, I would like to submit for the record a letter from 43 other groups that basically support our right to use voluntary donations and provider taxes.

Senator RIEGLE. Without objection.

[The letter appears in the appendix.]

Mr. SCHEPPACH. Our understanding is that OMB plans to issue interim final regulations that would severely restrict the use of donations and provider taxes on the day before the Congress adjourns for the August recess. If Congress allows this, the result would be to deny millions of dollars to the program that is virtually the only source of health coverage to the neediest of our citizens.

Medicaid budget problems are a symptom of a much larger problem that requires a comprehensive solution. Until Congress addresses the needs of the 34.5 million uninsured, Medicaid's roll as payor of last resort will continue to grow.

Mr. Chairman, that concludes my brief overview. I would be happy to answer any questions.

[The prepared statement of Mr. Scheppach appears in the appendix.]

Senator RIEGLE. Thank you very much. Current regulations, of course, permit Federal matching to be made on funds received by a State Medicaid agency from another State agency, or other public entity as part of the State's share of Medicaid expenses. I understand in the case of New York, for example, the counties, and even New York City have contributed to the non-Federal share of Medicaid for many years.

And I am wondering, can you tell us how common these intergovernmental transfers are, and give us some historical perspective on the extent to which other State agencies, local units of government, hospital authorities, and other public entities have shared in the non-Federal portion of Medicaid costs?

Mr. SCHEPPACH. I think they are relatively small. As I remember, I think California has some either in existence, or proposed. But I think as a percentage, they are very, very small.

Senator RIEGLE. So, in terms of any broader history beyond the State of New York, are you familiar with their history?

Mr. SCHEPPACH. Not the details of it, no, Mr. Chairman.

Senator RIEGLE. All right. Would Mr. Hanley be?

Mr. HANLEY. No, sir. Not in New York.

Senator RIEGLE. It would be helpful to us if you could take a look and see if there are other examples that you might look at in some detail and provide that to us for the record.

Mr. SCHEPPACH. I would be happy to do that, Mr. Chairman.

Senator RIEGLE. Thank you.

Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman. Ray, let me just ask you a question that came up earlier when the former Governors were here.

Mr. SCHEPPACH. Our protectors.

Senator DURENBERGER. Yes. I have been trying to find a way to think about this problem in a sort of a neutral way, rather than good guys/bad guys, and all that sort of thing. And I will just say frankly, the so-called voluntary contribution thing just looks so bad, that I think you should not get into it for that reason.

When it was proposed in my State in the last legislative session, a lot of the nursing home administrators who are getting desperate for adequate payments were tempted to buy into it, but a lot of others said, "I mean, this just looks like hell. We are taking money from paying patients and sending it to the State so it can come back for others." And it looks like a scam. But whether it is an explicit tax on those who can pay for their hospital bills in order to cover the bills of those who cannot, or it is a scammy-looking way to take money from paying patients and put it into the others, I just cannot find a good rationale for doing this, except that we have been doing it forever.

I mean, that is the way we have been running the doctors' office in America, and the hospitals, and the nursing homes. I mean, is an American tradition that those who can pay end up paying for those who cannot. And I guess we use the term "cost-shifting."

Do I understand your statement in opposition to the administration regulations to be that this may not be the best way to deal with the problems of the uninsured, but right now, it is about the only one we have—to continue this process of cost-shifting, if you will.

"In the absence of a consensus on how to reform the entire system, no change in Federal policy that limits the States' ability to meet the demands placed on Medicaid should be tolerated." So that even if the Governors felt it was appropriate to slow down the rate of cost-sharing that is going on, and this particular means of doing it, it is your argument that we have got too many poor hospi-

tals going under, we have got too many poor people being underserved because the Medicaid rates just do not reimburse doctors and hospitals for their costs, to say nothing of reasonable charges, that you ought to permit us, where appropriate—where we can get it through our State legislatures—to continue this process until we all come to some other solution to the problem of everybody who walks into a hospital, nursing home, or a doctor's office having the ability to pay.

Mr. SCHEPPACH. Yes. I think that is right to some extent. I mean, we do not agree that this is a scam. I mean, States are not pocketing the money. It is not going into other needs. It is essentially going back to provide care for some of the neediest people in the Nation.

I think there has been legislation over the last several years on disproportionate share hospitals as a relatively high priority. Cost-shifting is a fact in the American health care system. We shift to some extent, between Medicare and Medicaid, as you shift back. There is private-sector shifting. We are all shifting to small business. So, it is a fact of life, and I think the way to handle this is, as you said, we must deal with the 34 million uninsured in a comprehensive way that stops the cost-shifting. In the interim, though, I think it is inappropriate for something that has been legal and appropriate, to all of a sudden somebody issue a regulation, which is a $3 billion to $5 billion program, to try and shut it down. It is going to cause all kinds of problems. States will have no option but to shut down payment to these hospitals, and you are going to have significant problems.

Senator DURENBERGER. Well, we have not been able to make policy because in reconciliation every year, Henry Waxman puts in an annual prohibition against changing this sort of thing, so it is not that we have not wanted to try to deal with this problem, but there has been an effort to maintain the current cost shifting system in one way or another, or to permit the States to do these so-called creative financing schemes.

Mr. Hanley.

Mr. SCHEPPACH. Ray, you want to add something?

Mr. HANLEY. Yes. Senator, there is another way of looking at cost-shifting on this issue. The ability now for Medicaid in my State and a number of others to pay their fair share, we are paying physicians the same rates that other insurers do now. So, Medicaid then is no longer shifting their cost to other payors, so we, in essence, have stopped part of this cost-shifting. And in looking at some of the testimony of the administration, we not only have stopped some of that cost-shifting, but we have reinvested the provider taxes and the provider fees to bring those payments up to adequate levels.

As Mr. Scheppach said, we did not just put that money off in some other program; we put it in the Medicaid program and we have stopped cost-shifting.

Senator DURENBERGER. Yes, but I hope you understand the concern here that if everyone else were insured, or if everyone else were of equal income, it would not be a problem, because then you could tax those who can pay—like an income tax works—for those who cannot.

But when not everyone is situated equally, where some people have very rich insurance plans that you can continue to add to, while others have experience-rated plans, because they work in small groups, or they are self-employed, or up in New York now, they are going to pay $11,000 a year for an Blue Cross plan if they are self-employed, and $9,000 for a small group plan. And you are going to tax those people to cover those who cannot. Or, if someone walks in the door, they do not have any insurance and they have got to pay it out of their pocket, or out of a spouse's pocket and they are elderly, then down goes the income.

Those are the people you are taxing. Those are the people that this kind of a proposal, whether it is an explicit tax, or it is a donation, those are the people you are taxing, along with the folks who have the first dollar coverage plans, and all the rest of that sort of thing.

Mr. HANLEY. In my State we are not taxing the insurance policies, we are taxing only the Medicaid reimbursement to all providers, so, in that sense, we are not reaching into the Blue Cross plans. We are only taxing the Medicaid payments.

Mr. SCHEPPACH. Each one of these are different, but I agree with your point. I mean, there is taxing of high-income people for low-income people here, which may not be—in terms of income redistribution—substantially different than what you might get under a Canadian model, or a Mitchell pay-or-play type approach.

Senator RIEGLE. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. I would like to ask Mr. Scheppach—is that correct?

Mr. SCHEPPACH. Scheppach.

Senator RIEGLE. Mr. Scheppach, a question. Are there any States that are planning to use provider taxes to increase reimbursement? In other words, I think you were here when I had my illustration with Senator Graham.

There were some scenarios you could put a tax—well, you could levy a tax on doctors, and, indeed, some have restricted it to Medicaid providers. And in return for the income, they then would be reimbursed at a greater rate, and everyone wins. You put in $10 and you get back $20, assuming it is a 50-50 proposition with the Federal Government.

Now, do you know of any States that are doing that either with hospitals, or——

Mr. SCHEPPACH. Well, some of the States have increased their reimbursement rates. In fact, Arkansas is one of them. You may want to talk about it.

Mr. HANLEY. Yes. We have put the lion's share of our tax back into the reimbursement structure, three-fourths of it, I suspect. The rest has gone into expanding programs, such as 185 percent of poverty coverage for pregnant women and infants. But as they say, all politics is local. And the only way we had support for the tax in the legislature was a commitment to reimburse the providers at a more fair level than had been done in the past.

Senator CHAFEE. Well, I have got brief time here. Is that not truly gaming the system?

Mr. HANLEY. No, sir. I think it is using the States' legal, constitutional right to raise its money and reinvest it in its health care delivery system. That is what we have done.

Senator CHAFEE. But I mean, if the tax was on the physicians—you were not discussing a broad-based tax, were you?

Mr. HANLEY. No, sir. No, I was not. Because I believe the law——

Senator CHAFEE. It was not sales tax, or something like that.

Mr. HANLEY. The congressional enacted authority gives us the right to apply taxes that are not of general applicability, which is exactly how we structured our tax because of the authority you gave us last year to do just that.

Senator CHAFEE. Well, do you see any problems? I mean, after all, we do represent the Federal Government here. We are all for the States, but also, we have got to represent the Federal Government and look after its purse strings and see that it is not being hornswoggled in any way, not that I would describe an Arkansas system that way, because I do not want to get into specifics. I want to take a general approach.

Mr. HANLEY. Well, it has been quoted quite often, the low percentage of the total State funds that are made up by these taxes, in our State, it is going to be 10 percent or less, this year, of our general revenue that is raised by this tax. So, in that sense, I would not agree in any form that we are gaming or abusing the system.

Mr. SCHEPPACH. Senator, let me make a point that each one of these State programs is different. I think if there are specific problems in individual States, our position is we would be happy to sit down with you and look at those and come up with some legislation that seemed reasonable. What is happening now, the way in which OMB is approaching this issue, is not a reasonable approach.

Senator CHAFEE. Well, I agree with you. I agree with you on that.

Mr. SCHEPPACH. So this is what is happening: They have sent their SWAT teams out. We would encourage your people to perhaps do some independent investigation. We would be happy to sit down with you and look at that. If there are, in fact, some abuses, then I think the Governors collectively would be happy to work with you to stop those abuses.

Senator CHAFEE. All right. Well, I agree with that, and I think that is the way it should be. I mean, my belief is that there are some abuses. On the other hand, States have to raise money. And because they take a specific approach, it does not necessarily mean it is wrong. So, I would hope that HCFA and you folks could get together, and establish acceptable criteria. I would urge you to do so.

Thank you very much, Mr. Chairman.

Senator RIEGLE. Thank you, Senator Chafee.

If we have no other questions, I am going to thank these witnesses and move ahead to our next witness. Again, we appreciate your testimony.

Mr. SCHEPPACH. Thank you.

Senator RIEGLE. We will now hear from Mr. Brian Mitchell, who is the Principal Deputy Inspector General at the Department of Health and Human Services. He is accompanied by Mr. George Reeb, who is an Assistant Inspector General for Health Care Financing Audits. Please be seated, gentlemen.

We had asked for this part of our analysis for an OMB representative. I just want to say to my colleagues, OMB did not want to send a representative directly to testify, although they have sent Mr. Lieberman from OMB, who is traveling with the two witnesses who are prepared to testify.

So, they are present, but certainly not in the form that we had hoped for in the sense of coming and presenting testimony directly. So, that said, Mr. Mitchell, we would be pleased to make your statement a part of the record, and we would like to hear your comments at this time.

STATEMENT OF BRYAN MITCHELL, PRINCIPAL DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MITCHELL. Thank you, Mr. Chairman. In the interest of time, I will submit my prepared statement for the record, along with the three reports that we have talked about.

Senator RIEGLE. We will make those all a part of the record.

Mr. MITCHELL. I would summarize for you, sir.

[The prepared statement of Mr. Mitchell appears in the appendix.]

Senator CHAFEE. Mr. Mitchell, would you pull the mike a little closer, please? You have to speak right into it.

Mr. MITCHELL. How is that, sir?

Senator CHAFEE. Much better.

Mr. MITCHELL. Thank you.

About the beginning of this year, the Health Care Financing Administration, concerned about the proliferation of financing mechanisms that were being employed by the States, asked the Office of the Inspector General to conduct a survey to begin to uncover the number of these financing mechanisms that were being employed—both donation and tax mechanisms—and to keep this under surveillance reporting back to them and to the administration how many there were, how they were growing, and an estimate of what this would add to the outlays of Medicaid.

I will not talk about the first two that we issued. I will skip right to the third one, which we will issue today to the Health Care Administration.

Our testimony and our reports contain examples of these tax mechanisms and the donation mechanisms ranging from the one that Senator Graham explained so well this morning to the committee, to others that a national newspaper has characterized as a "shell game," to others where the donation programs are made by organizations that are put together to borrow money from banks, and then use that money to make the donation with.

Most of these programs work around the disproportionate share part of Medicaid reimbursements. Today, we are issuing to HCFA our third report on this issue, and we now estimate that the cost of provider tax and donation programs to the Federal Government, the added cost will be $3.8 billion this year. This is an increase of about 51 percent from the estimate we made in May of 1991. By the end of fiscal year 1993, provider programs implemented by 34 States will cost the Federal Government about an additional $12.1

billion, and that is cumulative over the 3 years. We believe that our estimate is conservative.

Although the specifics of tax and donation programs differ among States, there are some commonalities among them. Medicaid recipients are generally unaffected, and continue to receive the same level and quality of care that they received. Providers are generally unaffected as well.

The tax that they pay, or the donation that they make is generally returned to them in the form of increased reimbursements, usually through disproportionate share payments.

The State, however, is a winner, in that they can reduce their share of Medicaid costs and force the Federal Government to pay significantly more.

We continue to believe that provider tax and donation programs must be brought under control to safeguard the Federal/State financial partnership in the Medicaid programs, and to avoid possible bankruptcy of the Medicaid program.

We have recommended that the Health Care Financing Administration issue regulations on this subject and develop legislation that they could submit to the Congress on this issue.

Thank you, Mr. Chairman. We would be prepared to answer your questions.

Senator RIEGLE. Thank you for your testimony.

We know that a number of States are involved in this fashion. Is there any evidence that you found that States are using the funds generated by voluntary donations or provider-specific taxes for anything other than legitimate Medicaid expenses?

Mr. REEB. No. We have not found actual examples of it occurring. But, a provider-specific tax or donation used to supplant the funding traditionally provided by State general funds, does provide relief. To the extent that you do not spend general funds, makes them available for other purposes.

Senator RIEGLE. That is obviously true of any expenditure at any level of government. But you have not found any hint of any diversion of funds collected for this purpose being sent over and misapplied in some other area?

Mr. REEB. What we have noted in several local media articles is that local politicians have said that the use of one of these financial mechanisms frees the money for other purposes.

But our work to date has been more of a fact-gathering, related to where the programs are leading in terms of expenditures. We have not actually gotten into the details that we would have to do during an audit of the State's treasury system to determine what the funds are spent for.

Senator RIEGLE. Mr. Mitchell, as I understand your testimony, you have indicated that you have not found any indication of that, is that correct?

Mr. MITCHELL. We have not actually audited all these programs, Senator, but in terms of a State claim for Federal participation money not actually being spent on Medicaid, the answer is no, we have not found that.

Senator RIEGLE. All right. Very good.

Mr. Lieberman, let me ask you. In recent weeks, OMB and HCFA people have indicated that the administration would issue

interim final rules limiting States' use of voluntary contributions and provider taxes. Can you tell us what the date is when the administration will issue these rules, and will there be a public comment period on the new regulations? And if so, for how long?

Mr. LIEBERMAN. Mr. Chairman, my understanding is that in the report that was issued about 2 weeks ago, Secretary Sullivan and Director Darman indicated that they intended to have the interim final rule in place on July 31. I think the intention is to try to get it out next week.

My understanding is that the Congressional on a moratorium on a rule affecting donations is in effect through the end of this calendar year, and I believe—although this is outside of my area of expertise since I was involved in the specific study and not the ongoing policy area—that there would be a final regulation that would be issued at the end of this calendar year which would take into account any comments.

Senator RIEGLE. All right. Is your understanding that that timetable by the end of July is on track? Is that going to be met?

Mr. LIEBERMAN. I think the intention is to be very close. My understanding is that people hope to work it out by the end of the next week. Whether they will do it by the middle of the week, or not, I am not sure, sir.

Senator RIEGLE. I appreciate the delineation you make in your answer. So, you are not really on the policy side of this issue within OMB?

Mr. LIEBERMAN. No, sir; I am not.

Senator RIEGLE. Do you know why the policy OMB person is not here with you?

Mr. LIEBERMAN. No, sir; I do not. Other than my understanding was that I was asked to come up to address specifically the efforts of the Medicaid SWAT effort, the joint HCFA/OMB review team, which I was one of the co-leaders of, along with Mike Hudson, the Deputy Administrator of HCFA.

Senator RIEGLE. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Mr. Mitchell, you were here during the testimony of the Governors' Association representative. The illustration that you gave in your testimony on page 3, the non-profit hospital borrowing from the bank, now that is clearly a shell game. But at the same time, you heard Senator——

Mr. MITCHELL. That was not really the shell game, Senator. There is one even more shell than that.

Senator CHAFEE. All right. However we want to classify it, it is a way of milking the Federal Government. But at the same time, you heard the Governors, and Senator Bond, and Senator Graham, and the head of the Governors' Association, the Executive Director, discuss what they are doing.

So that these things are not all clear-cut. And, indeed, some of them seem to me to have a good deal of legitimacy to them. Now, what is the solution here? I just do not think that we can set criteria and adjust individual programs.. What do you suggest?

Mr. MITCHELL. Well, our recommendations were recommendations of process, if you will. We believe that the issuing of the regulation which you just finished discussing will provide an opportuni-

ty to develop criteria by which programs can be developed that are within the bounds.

We also believe, though, that you are going to have to go beyond the regulation that is going to be issued and have the administration propose and the Congress enact legislation that will set the boundaries which establish the criteria for the type of programs that can be utilized.

Senator CHAFEE. Well, I do not want to be harsh, but is that not putting a whale of burden on the Congress? How the dickens are we ever going to set these boundaries? We are always accused of micro-managing around here, and it seems to me that would be the ultimate of it, would that not? We have got to give you folks some leeway.

Mr. MITCHELL. Well, I might point out, Senator, that I am not an administration witness here. I am from the Office of the Inspector General. And we are auditors, and we have to have standards to audit against. And we have got to have some standards.

It seems to me that the States need guidelines. In the jargon of the day, there has to be some bright lines so that people on both sides will know what are acceptable financing mechanisms. You can look at the one that Senator Graham described this morning, which seems very rational and compare it to one that has been put in place in a State not too far from here that is a complete paper accounting exercise. So, clearly, if we cannot devise criteria that handle every situation, it seems to me that the administration and the Congress working together can devise criteria that will narrow the gap much more than it is today and give the States considerably more guidance than they have today.

Senator CHAFEE. Mr. Lieberman, could you give a—by the way, are you from OMB?

Mr. LIEBERMAN. Yes, sir; I am.

Senator CHAFEE. Could you pull the mike closer please? In any event, my view is—and I will throw it out for what it is worth—is that this is something that has really got to be negotiated between the National Governors' Association and Mr. Mitchell or HCFA. And that it is an impossible thing for Congress to draw up the exact details lines. And maybe it has to be on sort of a waiver.

In other words, it is forbidden except where waivers are granted, and then you give your waivers based on reviewing each situation. I do not know. Do you have any thoughts, Mr. Lieberman?

Mr. LIEBERMAN. I agree, it is a very difficult line to draw. As Mr. Mitchell indicated in his testimony, about 15 or 18 months ago the estimate for fiscal 1991 was that the tax donation schemes nationwide would cost less than half a billion dollars. Two months ago the estimate was, I think, on the order of the $2.5 billion.

Senator CHAFEE. Billion?

Mr. LIEBERMAN. Billion. It went up five-fold, sir. And then in their most recent report of today, they are estimating it has gone up to $3.8 billion in this fiscal year, and projecting that it would reach $12 billion in 1993. There has been a clear acceleration in the resort to these approaches.

One of the pieces of work that was done by the recent joint HHS/OMB review team was we commissioned an independent actuary, Gordon Tractnell, to take a look at some of the trends. And

he went on at some length to point out that his actuarial prediction, in effect, was that unless the Congress changed the rules, that every State would be using these.

And I think the point that you and Senator Durenberger had previously made is quite appropriate in that what has happened analytically is that while the Congress has done absolutely nothing to change the nominal matching rate which remains at roughly 57 cents as the nationwide average, the effective matching rate—that is, the amount that the States are getting, if you would, on their net expenditures, not the gross ones that they are claiming against—will skyrocket, and will skyrocket well over 60 percent, so that the State share will have changed without getting to the question of whether all the uses are truly legitimate, or not.

Clearly, the money is not being wasted. The States are spending the money, whether it is to close their deficit, or whether it is to pay for uncompensated care.

And interestingly, in one of the States we went and looked at—Alabama—I believe the explicit goal of the program is to have what had formerly been a non-Federally paid responsibility for uncompensated care was to have the full cost of uncompensated care be paid through the Federal Medicaid match.

And, in fact, Alabama had something on the order of over 350 percent increase in their in-patient hospital expenditures in 1991, and about a 90 percent increase in their, if you would, claimed expenditures for 1991. So, the point that I would make, sir, is that what is going on—as Senator Durenberger was suggesting—is a significant shift in the degree to which the Federal Government is financing health costs through the Medicaid program. And, as Mr. Mitchell pointed out, without going through a detailed audit, you do not know where all the money trickles to at the end of that. But the simple fact is the effect of Federal share has changed enormously while the nominal share, the statute, if you would, has not changed at all.

Senator CHAFEE. Well, let me just say this in conclusion. Mr. Chairman, you were talking about getting Governors together to share their experiences. I will tell you one thing that every Governor will agree. One, they are all caught short with money. Two, every Governor goes off to the National Governors' Conference meetings, and they hear what the others are doing.

And there would not be a self-respecting Governor who would not jump on this program and come home and claim with some justification that he has developed something ingenious and is going to save his State a lot of money, and they will plunge into it. So, I believe Mr. Lieberman's projections absolutely. If it is costing $3 billion now, and some have not caught onto it, the rest will catch onto it pretty quickly. No one has ever called Governors dumb bells. They will catch on to these programs. I can remember when I was Governor, the Director of Social Welfare came and told me how we could shift expenditures to the Federal Government, and I thought they were wonderful and adopted every one of them. [Laughter.]

And so, I agree with your predictions, Mr. Lieberman. Something has to be done.

Senator RIEGLE. It is interesting, Senator Chafee. I think I am right on this. You may know, because it is closer to home for you than to me, but I think the State of Massachusetts is struggling very much to try to close its budget deficit. Mr. Lieberman, you may know the answer to this. Did one of the States government officials not figure out how to close the deficit by the use of this particular approach?

Mr. LIEBERMAN. Yes, sir; they did. In fact——

Senator RIEGLE. And got an award for it?

Mr. LIEBERMAN. Yes. In fact, HCFA will pay for half the cost of that award, as the ultimate irony. [Laughter.]

But that is——

Senator CHAFEE. And that fellow will be the lead speaker at the next National Governors' Conference. [Laughter.]

Senator RIEGLE. It was a woman.

Mr. LIEBERMAN. A woman.

Senator RIEGLE. It was a woman that was skillful enough to find that, I think, if I remember it right from the stories.

Mr. LIEBERMAN. Yes, sir.

Senator RIEGLE. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, let me ask a question of Mr. Lieberman.

Was Mike Hudson the other co-leader?

Mr. LIEBERMAN. Yes, sir.

Senator DURENBERGER. On what?

Mr. LIEBERMAN. On April 30, Director Darman and Secretary Sullivan appointed a special management review team, in effect, to ask the question of why had Medicaid estimates been so badly wrong.

And, as I think Ray Scheppach testified a few moments ago, the Medicaid costs have been going up quite dramatically; 20 percent, even over 30 percent. Just in the period between May 1990 and May 1991, the State estimates upon which HCFA relies in making the estimates for the Federal budget had increased in each of the fiscal 1991 and 1992 estimates in that 12-month period by over $8 billion. And that in a 15 to 16-month period, the 1992 estimates had increased by $15 billion.

So, Mike and I were asked to pull together a group of people to have a concentrated look at why were the estimates wrong; what needed to be done to fix the estimating process.

That is really what we focused on, and we went to nine States and tried to work with the Governors' Association, the National Council of State Legislatures, and National Association of State Budget Officers to get a better idea of how to make this Federal/State partnership work better.

Senator DURENBERGER. I want to make an observation to the chairman and the Ranking Member of this subcommittee that I think this is an explosive issue, and I think it has been much neglected. And we do laugh about it, and you are right; in Seattle on the 17th of August, the speakers will be there and everything is going to be trotted out. But they are also going to have somebody from OMB there, I will bet you, to explain this interim regulation, and there will be a lot of fighting and arguing back and forth. And I do not know what will come from it.

By way of making a suggestion to both of you, I really do think that this subcommittee should carve out for itself some kind of a role to see if there is not an interim legislative solution to this that the House could be persuaded to go along with, because the Governors need it. The legislatures need it. Somebody does need some sense of direction.

I do not think the solution is the one that I suggested, which is stop the cost-shifting, eliminate all of this. I think that may come in a few years. But I do not think we know exactly how these different donation or tax systems work. I do not think we know exactly who is paying it.

The way the formula works, it works on per capita income. So, the District of Columbia is going to get the least of it, because as I recall, they are still at high per capita income. They get 50 percent here, and Mississippi still is at 83 percent, or something like that. So, it flows across that. Who within the State is getting the benefit? Is the money spent to fulfill Federal mandates? Is it meant to expand eligibility? Is it used to get new benefits? Is it used to increase provider payments? What is going on out there? I think that also is a very important part of the analysis and may go beyond what OMB and HHS have in mind when they put those regulations together.

How you use the money is probably as important or significant as how it is raised. And because of these dollars, as John Chafee said, you have got no reason to doubt an estimate. They usually come in here low rather than high.

It strikes me this is a pretty significant piece of work that maybe the subcommittee ought to carve out for itself, and maybe Mr. Mitchell, Mr. Lieberman, Mr. Hudson, and others can provide you with some information that you need to do it.

Senator RIEGLE. You know, if you would yield, it seems to me that absent a fundamental overhaul of the health care system—and we are trying to do that. We have been working for some years now to develop a way to come in and re-engineer the health care system and make it more efficient; get the costs down, get people covered in some form, and deal with the problem of cost-shifting and uncompensated care. It seems to me the basic issue underneath all of this is if you have got poor people who are sick and who need health care, who provides the money? We are one country, there are 240 or 250 million of us. On that issue, should that be something that local governments foot the bill for? Should it be something that State governments foot the bill for?

Is it something that the Federal Government should foot the bill for, or, if we are going to divide it up, how do we assign the costs in some reasonable way off the taxing capacity? I mean, some tax has to come from somewhere to pay these bills.

That question, it seems to me that right now we are doing so much off-loading of mandates and shrinking money that the Federal Government had previously made available.

Revenue sharing is one example, but there is obviously an effort now to move into this area. The Governors are obviously working to try to offset that from a policy point of view because they find this as a way to get these bills paid. But it seems to me that the basic question is if we are going to provide health care to poor

people, how do we collect the money and how do we pay these bills? I would like to do it in the most efficient and competent way that we can, just in terms of how the health care system works. That is a whole tangle that needs untangling. But who should pay?

Senator DURENBERGER. Well, just so we leave this with an understanding of how this program works, and the only way I can do it is to relate to this area.

If we lived here in an SMSA rather than in two States and a District of Columbia, the simple way—as Bob Graham explained to us—that this system works is you tax the Arlington Hospital and the hospitals in McLean and up in Montgomery County, and places like that.

You tax the people who go in there, and bring the money into the District of Columbia to help out here in the District of Columbia. That is sort of a macro way of looking at how the whole system is designed to work.

And what it does then is gives an excuse for the folks out in the suburbs to see more people, prescribe more procedures, add more to the insurance bill. And without some utilization constraint, you have got a money-generator out there paid for by third party payors, or something like that, bringing money downtown, and you are not doing anything to restrain the overall costs in the system. That is why I argue that this cost-shifting business, or taxing the rich to pay the poor, so to speak, is a very poor way of going about it. It just happens to be right now one of the only ways that a lot of States seem to have.

The same thing goes on in the nursing home business. You have got private pay patients versus Medicaid patients, what do you do? You tax, or get voluntary contributions from the private pay patients and bring it in here.

Senator RIEGLE. But let me ask you this, if you would just yield on this point.

Senator DURENBERGER. Yes.

Senator RIEGLE. You have given it a lot of thought, and I ask it as a rhetorical question that I, myself, am pondering, and probably Senator Chafee is, too. And that is, whether you take the inefficient health care system we have now, or we could hypothesize a revised and more efficient health care system. The question is, who picks up the cost, who pays the bill for the poor person that needs health care and cannot pay for it themselves? And as we divide that cost up between—there is really three levels of government: the local level, State level, and the Federal level, as taxing authorities.

How do we decide which level of taxing authority is going to raise the money to pay for that health care for the poor person, whether in today's inefficient system, or tomorrow's more efficient system? How do we divide that up? I would really be interested in knowing this. I would also be interested, John, in your thoughts on that.

Senator CHAFEE. Well, obviously this is a tremendous, broad topic, and we have got another panel. But let me just say this. The problem is as follows: Rightly or wrongfully we have arrived through Medicaid at a system of paying for health care for the poor, and that system is based on per capita, on income. The for-

mula is arrived at, so that Rhode Island pays 48 percent, and Mississippi pays 14 percent, and Michigan pays maybe 50 percent; I do not know. But this formula has been arrived at that is acceptable. We have not changed it.

Now what is happening is, as Mr. Lieberman pointed out, is that the formula is not being observed through these techniques, whereas in State A, the Federal Government was to pay 52 percent, and the local government was to pay 48. Suddenly the whole thing shifted, if I understanding your presentation. So, the percentages are changed all around. What did you call it? The actual percentage is different from the—what was the term?

Mr. LIEBERMAN. I used the term nominal and effective, sir.

Senator CHAFEE. Nominal and effective. So, that has distorted what we believe is a fair formula here. But the Governors are smart enough to game this system and change the formula dramatically. And there is some poor Governor who is asleep somewhere and has not caught on, but he will get it pretty quickly.

Mr. LIEBERMAN. Two things, if I could. When some of my colleagues were out visiting State budget officials and so on in the nine States, one State budget official said I should be shot. He said I should be fired if I did not use these approaches, and literally, that was his quote.

The other point is, as you have indicated, sir, the effect on a State like Alabama or Mississippi, which has a very high Federal match, the multiplier effect of this is quite different from a State that has a 50-50 match.

So, the consequences of the formula are exacerbated. The question of whether that is an appropriate distribution or not is not what I am addressing. Just as a technical issue, it does have that very confusing effect.

Senator RIEGLE. Gentlemen, thank you very much. We appreciate your testimony. It is helpful to us.

Let me invite our last witnesses to the table. We have appearing for Families USA, we anticipated that Ron Pollack, the executive director would be with us. They have been following this issue for a long time, and I appreciate their outstanding work on this program. We are going to welcome today Lucia DiVenere, who is going to be making the presentation for that organization. Also, Dr. Reed Tuckson, who is the senior vice president for programs of the March of Dimes Birth Defects Foundation; and he is accompanied by Kay Johnson, who is the senior health policy advisor at the March of Dimes, and they will be testifying as well.

So, let me welcome you. I know this has been a long morning, and I appreciate your patience. We will try to move ahead here. We will make your formal presentations a part of the record, and we will hear Ms. DiVenere. Am I pronouncing that right?

STATEMENT OF LUCIA DiVENERE, PUBLIC POLICY ASSOCIATE, FAMILIES USA FOUNDATION, WASHINGTON, DC

Ms. DiVENERE. It is Lucia DiVenere. You did better than most, Senator. Good job.

Senator RIEGLE. All right. Very good. Let us hear from you first.

Ms. DiVENERE. Thank you. I appreciate it very much. My name is Lucia DiVenere. I am Public Policy Associate with Families USA. I appreciate the opportunity to discuss the many failures surrounding the Qualified Medicare Beneficiary Program, as well as your proposal to address these issues.

We strongly support your proposal, the Medicare Enrollment Improvement and Protection Act of 1991; and Senator Chafee, your legislation to provide prescription drug coverage to QMB's.

We see your legislation as a crucial element that will help make this important benefit a reality for the more than 2 million low-income seniors eligible but not receiving the benefits.

I bring with me today a letter signed by 13 national organizations supporting your legislation, and I would like to request that a copy of this letter, plus our full report, "The Secret Benefit," be included in the record with my testimony. Thank you.

Senator RIEGLE. Without objection.

[The letter and report appear in the appendix.]

Ms. DiVENERE. Thank you. The administration and the State governments have not taken the steps necessary to make the benefit a reality for the majority of poor beneficiaries.

As a result, just over half of those eligible are without the buy-in benefits to which they are entitled, and are paying Medicare cost-sharing that they should not have to pay. Families USA received more than 1,000 phone calls from people all over the country following release of our recent report.

The message in nearly every one of these calls was that Federal and State officials have simply failed to give many persons appropriate information about the buy-in benefit.

The application process for the benefit also is not simple. In many States, individuals must apply at a local welfare office. The application is difficult to read, understand, and complete, and the applicant must produce extensive documentation.

Your legislation will ensure that the buy-in reaches beneficiaries in the following ways: as long as individuals are required to apply for the benefit at the Medicaid or welfare offices, participation in the program will be low.

There is strong consensus among senior advocates that it is crucial for beneficiaries to be able to apply buy-in benefits at Social Security offices. Your bill would significantly address this most basic barrier to access by requiring Social Security offices to take QMB applications, and making other important improvements.

HHS should send effective notices to low-income Social Security beneficiaries informing them of the program and how to apply. The administration should also include information about the buy-in on the notice all Social Security beneficiaries receive towards the end of the year announcing the Part B premium for the next calendar year.

New Social Security beneficiaries should be expressly informed about the buy-in and allowed to apply as they apply for their Social Security benefits. Your legislation would help accomplish all these goals. The most critical time to provide information about buy-in assistance is at the time a beneficiary incurs medical expenses. Physicians and hospitals that treat Medicare patients should be required to inform beneficiaries about the buy-in and how to apply.

Your legislation would have the Secretary supply these notices about the QMB program to Medicare-participating hospitals and physicians. Millions of poor seniors should not suffer financial hardship when they had no way of knowing they were entitled to assistance.

Buy-in benefits should be provided retroactively to the beginning of 1991, and in the future, QMB benefits should also be available retroactively for 3 months from the date of application, as is the current formula for other Medicaid beneficiaries. Your legislation fully addresses both these important issues.

Your bill also includes important provisions to establish outreach and counseling activities around the QMB program, as well as to establish a toll-free hotline for centralized information.

This legislation would help turn the QMB program from a secret benefit that holds great promise, but little real protection, into a benefit that people know about, can count on, and that measures up to Congress' expectations.

Thank you.

[The prepared statement of Ms. DiVenere appears in the appendix.]

Senator RIEGLE. Thank you very much. I appreciate your strong support, both for my legislation and the legislation that you referenced that Senator Chafee is sponsoring, that is very helpful to us.

Mr. Tuckson, we would be pleased to hear from you now.

STATEMENT OF REED V. TUCKSON, M.D., SENIOR VICE PRESIDENT FOR PROGRAMS, MARCH OF DIMES BIRTH DEFECTS FOUNDATION, WHITE PLAINS, NY

Dr. TUCKSON. Thank you, sir. My name is Dr. Reed Tuckson, the senior vice president of the March of Dimes. It is a pleasure to appear before you, and also in front of-Mr. Chafee today.

I will submit our testimony for the record, but let me summarize by reminding us of the state of infant health in America, which remains of serious concern, and ought to be a source of embarrassment for our Nation.

We know the numbers; I will not recite them. But you are well aware of the deplorable survival statistics for the infants who are born in this country. As such, it is of extreme importance that attention be focused on every aspect of the health care delivery system for pregnant women and for children, including—as you are today—examination of issues relevant to the administration and financing of Medicaid and Title V.

Recent experience has shown that when the Congress initiates thoughtful expansions in Medicaid and the Maternal and Child Health Block Grant good things happen. More women receive prenatal care, and infant mortality rates start to improve.

We all know by now that by increased expenditures for prevention on the front end have real payoffs on the long run, both in enhancing infant survival, decreasing pain and suffering, and reducing health care expenditures.

Other witnesses have mentioned the relationship between the dollars spent on preventive care and the $3 we save in neonatal intensive care costs.

We at the March of Dimes are a national voluntary, community-based organization concerned with the scientific and access issues related to improving the health of our Nation's babies, and we are, like you, concerned about both of the major executive administrative proposals under discussion today that could adversely affect infant survival.

First, the new Administration for Children and Families. We appreciate, as does the Secretary, the importance of providing comprehensive coordinated services to America's children and families.

The creation of this new administration reflects this goal. However, while the intention is good, we think much, much more thought and discussion must occur prior to any decision to effect such a reorganization.

To move Title V programs, the core of our Federal and State efforts designed to protect the health of pregnant women and children, from the public health system to the new Administration on Children and Families causes concern for three reasons.

First, currently, the three priority programs aimed at decreasing infant mortality are located together at the Health Resources Services Administration in the Public Health Service. The new Healthy Start Initiative has been added to the Maternal and Child Health Block Grant, and the Community Health Centers' perinatal care program. These efforts, important in and of themselves, would benefit greatly by a unified vision and close administrative coordination within HRSA, and, indeed, within the larger public health system.

Second, any scheme that de-links Federal and State Title V activity would necessarily result in inefficiencies and administrative confusion for years to come. We cannot afford this disruption—not now—unless, it would yield overwhelmingly compelling benefits, none of which I have heard expressed by the administration proponents today.

Third, placement of just one piece of a comprehensive health program into an essentially Social Service agency will not, in our opinion, accomplish the overall goal of ensuring a comprehensive system.

In fact, the Block Grant Program would only be 3 percent of the budget for the new Administration on Families and Children. The risk of this small program being gobbled up does not seem to justify the potential benefits.

The only good that perhaps could come would be if, in fact, it resulted over the long run in increased expenditures for the health of children, and we have heard no evidence to suggest that in testimony presented by the administration today.

Therefore, we urge the Secretary to conduct a formal review of this strategy, with consultation from knowledgeable experts both within and outside the Federal Government, to seek the best means of accomplishing the objective of providing comprehensive department-wide support for pregnant women and children. We further urge the Secretary to prepare for Congress a report that describes the structure and mechanisms by which the Healthy Start Initiative, the Comprehensive Perinatal Care Program, and the Maternal and Child Health Services Block Grant will be inte-

grated and coordinated within the Department of Health and Human Services.

Let me now turn very quickly to the issue of voluntary contributions to Medicaid, and the administration's recent efforts to prohibit this activity through regulation.

At a time when at least 10,000 of the 40,000 babies that are born, die as infants in this country every year; at a time when our infant mortality rate is 22nd in the world, at a time when one out of four of our pregnant women receive no prenatal care in the first trimester; in a time when we are the only industrialized country, save South Africa, without guaranteeing universal access to health insurance for pregnant women and children; at a time when States and local governments are experiencing severe financial constraints limiting their capacity to deliver health services to poor and medically indigent women and children; and when our babies are dying because they do not have access to care, it seems inconceivable that attempts would be made to limit public, private, and voluntary efforts to expand financial access to health care for poor people in this country.

We at the March of Dimes recognize and appreciate the responsibility and tne necessity for community-based volunteerism and corporate support, and have actively supported State Medicaid infant mortality initiatives through voluntary contributions.

Until we can achieve universal access to insurance, we must do all that we can to expand and support Medicaid, especially given that two-thirds of the recipients are women and children.

Therefore, in conclusion, we urge Congress to first enact legislation to permit States to use voluntary contributions to finance Medicaid program activities aimed at giving poor women and children an opportunity to get access to lifesaving health care.

Second, the Secretary of HHS should develop clear guidelines for appropriate use of voluntary contributions that permit opportunities for public/private partnerships, but that would also enable the executive branch to better estimate the true Medicaid costs.

And finally, if an agreement on legislation cannot be reached before the end of this session, we urge continuation of the moratorium, as you in Congress have done every year since 1988.

Mr. Chairman, it has been a pleasure to appear before you today, and I hope that what does not get lost in the discussion is the reality that every day in this country, hundreds of babies are dying unnecessarily because they do not have access to care, and we have a responsibility to do all that we can to make good on our moral responsibility.

[The prepared statement of Dr. Tuckson appears in the appendix.]

Senator RIEGLE. Thank you very much. Senator Chafee, do you have any questions?

Senator CHAFEE. Just one question of Dr. Tuckson. When you say 100 babies die a day, what is a baby? Is that a live birth? Is that where you look?

Dr. TUCKSON. Yes, sir.

Senator CHAFEE. That is where your work is. In other words, if somebody who loses a child in the third or fourth month of pregnancy, that is not included in your figure?

Dr. TUCKSON. It is a live-born baby that dies at the time of birth. That figure is the infant mortality rate broken down by day.

Senator CHAFEE. Yes, I see. Well, I heard your arguments about permitting donations, and you have been sitting here and listening to the discussion back and forth. We have just got a difficult problem here. The question is are we going to stick to the formulas for the payment that have been worked out, right or wrong, or are we going to have what, in some instances, could be extremely artificial ways. And I think it is fair to use the word "gaming the system" that you heard also described here today. And I do not think that putting an end to the most egregious forms of gaming the system necessarily means that the Medicaid benefits are necessarily going to disappear.

Dr. TUCKSON. Well, I certainly appreciate, first of all, the complexity of the issue. I understand, and I hope that you are right in the comment that you have made.

The reality that I am just aware of, sir, is that it is so very difficult in the real world that we live in—in urban America, in rural America—to provide the range of services that Medicaid ought to be able to provide. It is so hard to get people enrolled in Medicaid. It is so hard to get the transportation systems. It is so hard to provide the child care, and on and on. These are things that make a difference in whether or not American babies live or die.

So that when States, who are constrained financially, try to find ways of getting other people involved—we have got this great national commitment for the American people to do all that they can; we have voluntary contributions being made—you would think that given the overwhelming, compelling nature of whether or not babies will live or die, that we would do everything in our power to encourage that, not, in fact, do things to discourage it. The reality—and I think that the chairman got to it in his questions earlier—has to do with what happens if we do not accomplish this. While we may be concerned about some of the administrative gaming that goes on, the thing that we have to be more concerned about is that American babies will die if we cannot provide these services.

Senator CHAFEE. Well, I think that you make your points very well, and the objective is to provide the care. But at the same time, I think we either want to stick with a system of prorating the costs, or not. I mean, maybe the system we have got is wrong, and that should be examined.

Ms. DiVenere, is that the correct pronunciation?

Ms. DIVENERE. DiVenere, Senator.

Senator CHAFEE. DiVenere. In the recommendations you had in how to get the information about to these QMB's, you think the recommendations you made will do the trick? In other words, do you think we will get most of them?

Ms. DIVENERE. Well, I think it is important to try. We know that what has gone on in the past clearly has not done the trick at all in one way or another, and I think some of the things that are outlined in the bill that both you and Senator Riegle are introducing today would go a long way towards doing it.

I think the idea of having beneficiaries be able to apply for these benefits in Social Security offices is probably the most important

thing you can do to increase the participation rate. You have to remember that the Part B premium is being deducted from people's Social Security checks to begin with, and so it is very natural for them to think of the Social Security offices as the first place to go to correct that wrongful deduction.

Some of the other kinds of notifications that are talked about in your proposal and that we support include more targeted notification, more frequent mailings, and simplified application forms. I think all of those things together would go a long, long way toward getting the participation rates up to more acceptable levels, which would approach 100 percent.

Senator CHAFEE. I was not here, I had to go absent for a few minutes, but it is my understanding that one of the witnesses pointed out the difference and great variation within some States; some are seeing 83 percent of the eligibles in Maine. What do they do in those States? How do they do such a good job?

Also, I am aware of some States where they make a particular effort not to notify, because they are in such a financial jam they just do not want to take on any more burdens, if you would.

Ms. DIVENERE. That is right. We suspect that that goes on a lot, too. We have not looked specifically at the activities that each State undertakes in order to arrive at whatever effective participation rates they have in the States, but I would draw your attention to a request that was made by Senators Riegle, and Pryor, and a number of other members to the GAO at the end of last month, which requests GAO to do a number of things looking at the QMB program, one of which is to look specifically at activities taken in States that have high participation rates to see exactly what does work and how participation rates could be increased. That report is expected to be reported to Congress on September 10 of this year. So, I am hoping that could help shed some light on this question.

Senator CHAFEE. That is going to look at the States?

Ms. DIVENERE. That is right; the States that are doing a good job, and to see exactly what they are doing that is effective in those areas.

Senator CHAFEE. All right. Well, the chairman had to step out one moment to take a call, but he will be right back. I have completed my questions, but I would appreciate if you folks could just stand by, stay right where you are, and I am confident he will be right back. So, just relax, and you can say we are in recess. Thank you very much. I appreciate your testimony.

Dr. TUCKSON. Thank you, sir.

Ms. DIVENERE. Thank you.

Senator RIEGLE. I apologize for having to step out. I had a call from another colleague that was quite urgent, and I had to take it.

Actually, I have no further questions, but I do want to say how much I appreciate the testimony and the work being done by the organizations that you represent. It is very helpful to us to have your testimony today.

I particularly appreciate the strong support from Families USA for the legislation that we have proposed, and we want to continue to work with you and we thank you both for your testimony today.

The committee stands in recess.

[Whereupon, at 1:08 p.m. the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF JO ANNE BARNHART

Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to appear before you this morning to discuss the Administration's decision to provide a health component within the newly organized Administration for Children and Families (ACF).

In the early 1900s, at the first White House Conference on Children, government officials acknowledged that the medical, social, and financial circumstances of children and families are closely, and perhaps inseparably interwoven. These linkages between poverty and health are widely accepted. And yet our attempts to improve conditions for poor families most often occur separately. The needs of families call us to find ways to link our programs together, in fact they demand that we work together if people are our priority rather than programs.

It is important that we forge a strong link between social programs and health programs that serve low income families. The Maternal and Child Health block grant (MCH) provides that link. MCH is committed to the health needs of women and children, particularly low income women and children.

The announcement in the Federal Register which gave ACF the responsibility for administering the Maternal and Child Health block grant reflects Secretary Sullivan's strong commitment to integrating medical and social services. We intend to carry out his plans for reorganization in such a way that it will not disrupt the current administration of MCH grants at the State and local level.

All the resources necessary to effectively administer the Maternal and Child Health block grant will be within ACF. We will continue to work closely with the Public Health Service to maintain the necessary health expertise and to ensure that MCH activities remain an integral part of the full range of public health efforts at Federal, State, and local levels.

The Administration for Children and Families will be the focal point for HHS efforts toward children and families. And, we want to ensure that those efforts address all aspects of what are truly complex problems. Through the inclusion of MCH in ACF we will begin to bridge the gaps between the delivery of social and health services to vulnerable children and families.

Any transition to a new organizational structure is difficult. Yet, when the difficulties associated with transition pass, that which remains will better serve the needs of our most vulnerable citizens.

Before the exact organizational details are final, we will be in touch with you and your staffs. We are committed to maintaining the integrity and improving the effectiveness of what is already a valuable block grant for children and families.

[SUBMITTED BY SENATOR CHRISTOPHER S. BOND]

U.S. SENATE,
Washington, DC, July 18, 1991.

Hon. RICHARD G. DARMAN,
Office of Management and Budget,
Old Executive Office Building,
Washington, DC.

Dear Mr. Darman: We understand that the Office of Management and Budget is inclined to score spending associated with states' use of voluntary contributions for state Medicaid funds as "new" spending, rather than having no budget impact. We strongly believe that to score this program as additional spending is incorrect since it is the continuation of an ongoing program.

As you know, the voluntary contribution option is possible for states under final regulations published by the Health Care Financing Administration (HCFA) in 1985, specifying the acceptable sources of state funds for a state's share of payment under Medicaid. A major provision of the rule states that public and private donations may be used as a state's share of financial participation in any facet of the Medicaid program. Prior to 1985, according to HCFA regulations, such donations could be used only for training expenditures. Federal courts have upheld states' rights to use voluntary contributions under this regulation. As you are aware, in 1990, when HCFA issued a proposed rule raised through provider donations, Congress placed a moratorium on issuance of final regulations until December 31, 1991.

We believe that, should voluntary Medicaid contribution programs be allowed to continue as in current law, they should not be scored as a budget spending item. We support developing appropriate criteria that would allow states to continue using voluntary contributions at a reasonable level and we have offered to work with HCFA in developing these criteria in a separate letter to Dr. Wilensky. (copy enclosed)

Thank you for consideration of our views.

Sincerely,

CHRISTOPHER S. BOND, *U.S. Senator.*
JOHN C. DANFORTH, *U.S. Senator.*
WILLIAM L. CLAY, SR., *Member of Congress.*
JOAN KELLY HORN, *Member of Congress.*
RICHARD A. GEPHARDT, *Member of Congress.*
IKE SKELTON, *Member of Congress.*
ALAN WHEAT, *Member of Congress.*
E. THOMAS COLEMAN, *Member of Congress.*
MEL HANCOCK, *Member of Congress.*
BILL EMERSON, *Member of Congress.*
HAROLD L. VOLKMER, *Member of Congress.*

U.S. SENATE,
Washington, DC, July 18, 1991.

GAIL WILENSKY, PH.D., *Administrator,*
Health Care Financing Administration,
200 Independence Avenue, S.W.,
Room 390-G,
Washington, DC.

Dear Dr. Wilensky: We understand that the Health Care Financing Administration (HFCA) is preparing interim final regulations for issuance next month on states' use of voluntary contributions as Medicaid funds for purposes of generating the federal Medicaid match. We write to urge you to consider the perspective of states such as Missouri as you develop these regulations.

Missouri, as well as many other states, is facing tremendous fiscal challenges as a result of mandates to expand Medicaid coverage and due to the increasing numbers of eligible beneficiaries brought about by a weak economy. In an effort to meet the demands of the Medicaid programs, states have made great efforts to raise the necessary state Medicaid dollars that would trigger federal Medicaid matching dollars.

The State Medicaid agency and Missouri hospitals have worked in partnership since 1989 to use voluntary contributions as a temporary means of maintaining a responsive Medicaid program within this difficult fiscal context. The Missouri voluntary contributions program has significantly enhanced the effectiveness of the Medicaid program and its ability to serve at-risk children and women. This public/private partnership has been used successfully to implement a network of on-site eligibility workers; to avoid hospital program reductions of approximately $32 million at a time of state revenue shortfall; to implement important child health prevention

programs; to offset, in part, Missouri hospitals' provision of uncompensated care; and to offset the contractual allowance providers incur in treating Medicaid patients. Missouri's leadership in forging this type of private/public partnership should be encouraged.

We hope you will understand our grave concern about the negative effect an outright ban on voluntary contributions will have on the State of Missouri. We understand the Administration's concerns about voluntary contributions, but we strongly believe that states should be permitted to continue voluntary contribution programs at a reasonable level. We ask you to consider establishing criteria for the use of donated funds, rather than prohibiting the practice. We will welcome the opportunity to work with you in developing such criteria.

We believe the most prominent health care initiative of the Bush Administration has been the expansion of the Medicaid program. It seems only appropriate now as states labor under revenue shortfalls and the urgency of complying with Medicaid mandates that they retain a great deal of flexibility to generate funds as they can. As states attempt to follow through on the health care priorities set by Congress and the Bush Administration, federal policy must support them in their efforts.

Thank you for your consideration of our views.

Sincerely,

CHRISTOPHER S. BOND, *U.S. Senator.*
JOHN C. DANFORTH, *U.S. Senator.*
WILLIAM L. CLAY, SR., *Member of Congress.*
JOAN KELLY HORN, *Member of Congress.*
RICHARD A. GEPHARDT, *Member of Congress.*
IKE SKELTON, *Member of Congress.*
ALAN WHEAT, *Member of Congress.*
E. THOMAS COLEMAN, *Member of Congress.*
MEL HANCOCK, *Member of Congress.*
BILL EMERSON, *Member of Congress.*
HAROLD L. VOLKMER, *Member of Congress.*

PREPARED STATEMENT OF SENATOR BILL BRADLEY

The Subcommittee on Health for Families and the Uninsured is meeting today to discuss a series of issues about which Congress has made its intent and commitment clear. Addressing the plight of the poor and vulnerable segments of our society led to the creation of the Medicaid program almost 30 years ago and, more recently, the Maternal and Child Health Block Grant program. The rising cost of health care, a depressed national economy, shameful national infant mortality statistics, increasing numbers of uninsured, increasing numbers of children living in poverty, and an aging society, have served as the impetus in the last few years to expand the federal role in providing greater access for these vulnerable segments of American society to health care services through Medicaid expansions. Because the Medicaid program is a partnership between the states and the federal government, these mandates necessarily placed an increasing financial burden on states.

In order to fulfill federal Medicaid expansions at a time when the national recession is driving up the need for public assistance and driving down general tax revenues, many states have implemented innovative programs to raise the necessary matching funds required to comply with the mandates. The states have needed flexibility in financing plans to provide the mandated services to the poor, elderly, and disadvantaged. Congress rejected the Administration's attempts to deny states the flexibility represented by voluntary contributions and provider taxes in 1988, 1989, and 1990. Although Congress supports the states in their efforts to comply with federal mandates for Medicaid expansions, we would discourage gaming of the system which would compromise the federal-state partnership for shared funding.

In order to deliver the services supported by the Maternal and Child Health block grants, coordination with other public health service programs has been necessary and encouraged. The planned shift of the MCH programs away from Public Health Service to the newly established Administration for Children and Families in the Department of Health and Human Services may compromise the linkages and coordination of health services which have been so successful in addressing the needs of poor women and children. I question the benefits to be gained by isolating these services at a time when we have begun to see improvement in national Infant Mortality statistics.

Another issue which this hearing will address is an issue in which I have been actively involved, provision of health benefits and improved access to health care for our elderly poor. It concerns me that the benefits established by Congress in the

Qualified Medicare Beneficiaries legislation is not reaching the population for which it was established.

I hope that the hearing today will shed some light and answer some questions about the programs that Congress has worked hard to establish for the more than 26 million persons on Medicaid. Cost containment concerns of Medicaid will require comprehensive restructuring of the health care delivery system. However, the over 13 million children who receive health care with Medicaid coverage and millions more pregnant women and elderly poor cannot wait for comprehensive reform.

PREPARED STATEMENT OF LUCIA DIVENERE

Mr. Chairman, I am Lucia DiVenere, Public Policy Associate of Families USA. Thank you for the opportunity to discuss with you today the abysmal failures of the Administration and the state governments to provide Medicare buy-in benefits, also known as qualified Medicare beneficiary (QMB) benefits, to the majority of poor seniors, as well as your proposal to address these problems. We greatly appreciate your continued leadership on this issue and your determination to protect low income seniors and disabled individuals from the heavy cost-sharing burdens of the Medicare program.

Families USA strongly supported creation and expansion of the QMB program from its inception and has worked closely with Congress and through our research efforts so that millions of low income seniors and persons with disabilities can benefit from this program.

We strongly support your proposal, the Medicare Enrollment Improvement and Protection Act of 1991, as a crucial element that will finally help make this important benefit a reality for the more than 2 million low income seniors eligible, but not receiving the benefits.

Before discussing the specifics in your bill, I would like to give an overview of the findings of Families USA Foundation's recent report, "The Secret Benefit," as well as to share with you the reaction our report has received from the public and from the Administration to date. I also request that a full copy of our report be entered into the hearing record along with my testimony.

2.2 to 2.3 million poor seniors, just over half of those eligible, are without the buy-in benefits to which they are entitled and are paying Medicare costs that they should not have to pay. Their Social Security checks are also being wrongfully deducted by $29.90 each month.

Since Families USA Foundation publicized its report on the large number of poor seniors who are not receiving buy-in protection, our office has been deluged with phone calls. We have heard the same from local press and social services offices. Based on this experience, we have no doubt that it is possible—and imperative—to reach large numbers of low income seniors and their relatives with information about this benefit.

The crucial question, Mr. Chairman, is how do we explain to senior citizens that the federal government can take money they shouldn't *out* of their checks, but can't do anything to stop those wrongful deductions?

BACKGROUND

Medicare beneficiary premiums and deductibles have escalated very rapidly over the past decade. Since 1980, the Part A deductible for each hospitalization increased 249 percent, from $180 to $628. The Part B premium increased 244 percent, from $104.40 to $358.80 annually. The Part B deductible increased 67 percent, from $60 to $100 annually.

Out-of-pocket costs in 1991, for Medicare beneficiaries with one hospitalization, are at least $1,086.80—not including the copayments required by Medicare (and also not including the costs of the services uncovered by Medicare, such as prescription drugs, long term care and numerous others). In fact, the Part A deductible and the Part B premium and deductible alone constitute approximately one-sixth of the annual incomes of individuals with incomes below poverty—their entire income for two months.

CONGRESSIONAL ACTION

Congress has taken important steps in recent years to prevent the extreme financial hardships that such cost-sharing requirements create for low-income beneficiaries. In the Medicare Catastrophic Coverage Act of 1988, Congress created the QMB program when it required the Medicaid program, beginning in 1989, to "buy-

in" to Medicare low-income seniors and persons with disabilities eligible for Medicare.

As of January 1, 1989, Congress required buy-in coverage for Medicare beneficiaries with incomes at or below 85 percent of the federal poverty guideline and resources of up to $4,000 for an individual and $6,000 for a couple (excluding the home, car, personal effects, life insurance and burial spaces). Under the law enacted in 1988, the income eligibility standard for the buy-in increased to 90 percent of the poverty guideline in 1990 and was scheduled to increase to 95 percent of the poverty guideline in 1991 and 100 percent in 1992.

As the legislation was being debated in June 1988, a number of Members of Congress, including Members of this Subcommittee, emphasized the importance of the new financial assistance the legislation provided to poor Medicare beneficiaries.

In Fall 1990 when Congress increased Medicare cost-sharing amounts as part of its deficit-reduction package, Congress also acted to protect low-income beneficiaries from these increases. Congress accelerated the buy-in requirement for all poor Medicare beneficiaries with limited resources to 1991, rather than 1992, and added buy-in requirements for Medicare beneficiaries with incomes up to 110 percent of the poverty guideline in 1993 and 120 percent of the poverty guideline in 1995. Medicare beneficiaries with incomes between 100 and 120 percent of the poverty guideline will be eligible for Medicaid payment of Medicare premiums, but not for Medicaid payment of other Medicare cost-sharing.

Congress also provided Medicare buy-in benefits to the relatively small number of seniors and persons with disabilities who did not work long enough to qualify for hospital coverage under Part A of Medicare. For individuals without a sufficient work history, Medicare hospital coverage is only available if they pay a monthly premium of $177—an amount that is unaffordable for the poor. The law requires Medicaid to buy low-income seniors and persons with disabilities into Medicare Part A. This is an important benefit—even for those who previously qualified for Medicaid coverage. Medicare hospital benefits are sometimes more comprehensive than Medicaid hospital benefits because some states impose strict limits on the number of hospital days covered under Medicaid.[1] In addition, the Medicare payment rate is often more generous than Medicaid hospital payment rates, and Medicare therefore offers better access to hospitals.

KEEPING THE BUY-IN BENEFITS A SECRET

Despite Congress's clear intent that poor Medicare beneficiaries receive immediate financial assistance, the Medicare buy-in has remained a secret benefit. The Administration and the state governments have not taken the steps necessary to make the benefit a reality for the majority of poor beneficiaries.

Impoverished Medicare beneficiaries, who previously were ineligible for or did not receive Medicaid, have no way of knowing about the buy-in benefit. They have no way of knowing that their Social Security checks are wrongfully being deducted by $29.90 per month (or $59.80 for couples). They have no way of knowing that they do not have to pay the $628 deductible for each hospitalization. And they have no way of knowing that they do not have to pay the $100 physician care deductible, or the various other copayments they may be making. And if they do learn about the benefit, they also learn that applying to get the benefit is often no simple matter.

In the Spring of 1989, Families USA Foundation issued a report that was critical of the Administration's and the state governments' implementation of the buy-in legislation. (At the time that report was issued, the buy-in eligibility requirement was 85 percent of poverty—not 100 percent of poverty as required today.) In response to that report, the Administration, in July 1989, sent a notice informing half of all Social Security beneficiaries that they may be eligible for buy-in assistance. Since that time, the income eligibility for the benefit has increased significantly, but the Administration has refused to send any additional notices—and has failed to initiate any other outreach to low-income eligible persons.

An additional and important issue involves coverage of the Medicare Part A premium. As of the end of May 1991, there were approximately 138,000 poor seniors and persons with disabilities for whom Medicaid was buying Medicare hospital (Part A) benefits. However, the Health Care Financing Administration can identify approximately 529,000 seniors and persons with disabilities nationwide who do not

[1] In the following states Medicaid hospitalization benefits are more limited than Medicare hospitalization benefits according to the latest state plan information in Commerce Clearing House's, *Medicare and Medicaid Guide:* Alabama, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia and West Virginia.

have Medicare hospital benefits, but are receiving Medicaid. Approximately 391,000 readily identifiable persons, therefore, are not getting the Medicare hospital coverage to which they are entitled.

Poor seniors receiving buy-in benefits only (and not other Medicaid benefits) were most explicitly targeted by Congress for QMB protection. Three out of four (74 to 75 percent) of these eligibles are not receiving this benefit.

GETTING THE BENEFIT TO POOR SENIORS

Families USA received more than 1,000 phone calls from people all over the country—poor seniors and their adult children hearing about the benefit for the first time—following release of our recent report. The message in nearly every one of these calls was that federal and state offices have simply failed to give many persons appropriate information about the buy-in benefit, even in response to an inquiry.

One woman from New Jersey told us that she made 20 phone calls before she was able to find someone in the state welfare office who knew about the benefit. Another individual in Texas told us he spent a full day tracking down information on behalf of his elderly mother. He wondered how many elderly individuals would have the stamina and courage to keep persevering. Yet a third individual from Maryland told us he had been trying for two weeks to get information on the QMB program for a disabled friend of his. Caseworker after caseworker either didn't know what he was talking about or gave him incorrect information.

Some Social Security and social services employees have said they never heard about such a benefit. In some cases, very low income Medicare beneficiaries have inquired about Medicaid benefits and been told that they were ineligible without any hint that they might be eligible for the buy-in, either immediately or in the future.

The application process for the buy-in benefit also is not simple. Even those low income beneficiaries who now know about the buy-in must overcome significant obstacles before they actually receive the financial protection to which they are entitled. In many states, individuals must apply in person at a local department of social services. For an older person in poor health or a younger person with disabilities, this can mean an arduous trip on public transportation to an unsafe neighborhood, and then a long wait in a physically uncomfortable setting. Even if the state allows applications to be mailed, the application is difficult to read, understand and complete without professional assistance. Finally, the applicant must be able to produce the documentation required to substantiate the information on the application

Congress has been struggling with the Administration, since the program began, to turn the QMB program into a reality. Since 1988, no fewer than 8 letters have been sent to the Secretary of Health and Human Services urging immediate action to inform Medicare beneficiaries of the program and to increase outreach activities. A total of 21 Senators and 125 Representatives have voiced their strong concern about these matters, many of them more than once.

There are a number of steps the Administration and the state governments can and must take to ensure that low-income Medicare beneficiaries receive the buy-in benefits to which they are entitled. We were disheartened that the Health Care Financing Administration responded to our recommendations by expressing a clear intention to rely primarily on private sector volunteers for outreach. Only the federal government has the capability of launching an outreach campaign that will achieve the results Congress expected. Private efforts may supplement federal efforts to make potentially eligible individuals aware of the benefit, but only the federal government can assume responsibility for making sure that it is easy for such individuals to actually get the benefit.

Steps that the Administration must take to reach poor Medicare beneficiaries eligible for buy-in assistance include:

• *Take Applications at Social Security Offices*

Thirty-one states and the District of Columbia currently accept SSA eligibility determinations for Medicaid purposes, through what are known as Section 1634 agreements. In these cases, low-income seniors and persons with disabilities can apply for Medicaid at the same time as they apply for SSI In states where SSI beneficiaries have to apply separately for Medicaid benefits, a significant number of beneficiaries do not do so. SSA refuses to allow Section 1634 agreements to cover applications for the buy-in.

Medicare beneficiaries are accustomed to applying for Social Security benefits at Social Security offices. Taking buy-in applications at Social Security offices is likely

to increase participation in the buy-in very significantly, both for new and current Social Security beneficiaries.

At a meeting with HHS officials last week, there was a strong consensus among senior advocates that it is crucial for beneficiaries to be able to apply for buy-in benefits at Social Security offices. There are a variety of ways this can be accomplished and we will be happy to discuss these with you and representatives of the Department at any time. Congress must support this effort by providing sufficient resources to accomplish this task.

The Medicare Eligibility Improvement and Protection Act will significantly address this most basic barrier to access of the QMB program. As long as individuals are required to apply for the benefit at the Medicaid or welfare offices, participation in the program will be low. Your bill addresses this problem by requiring that trained HCFA or Social Security staff be placed in Social Security offices to take QMB applications. The legislation also extends current Section 1634 contracts to the QMB program; requires the Secretary to develop a simplified application form, with consultation of consumer advocates and states; and requires the Secretary to periodically send notices, as well as application forms, to low income Social Security beneficiaries, enabling these individuals to apply for the program by mail.

• *Notification*

The Department of Health and Human Services (HHS) must assume responsibility for identifying beneficiaries eligible for the buy-in. HHS should send notices to low-income Social Security beneficiaries informing them of the buy-in benefit, eligibility criteria, how to get additional information, and how to apply. These notices should be designed to attract the attention of the reader. When we met with HCFA Administrator Gail Wilensky, following the release of our report, she was opposed to sending out such notices, on the grounds that it would cost $2-3 million and that the phone calls generated would "clogup" the system with inquiries from many beneficiaries who are not eligible for the buy-in.

The cost of this undertaking could be much lower if the notice is enclosed with a Social Security check. There are also a number of ways a mailing could be designed to target beneficiaries most likely to be eligible and could minimize the number of phone calls into the system at one time. We would be happy to work with HCFA to address this problem.

The Administration should also include information about eligibility for the buy-in on the notice all Social Security beneficiaries receive toward the end of each year announcing the Part B premium for the next calendar year.

New Social Security beneficiaries should be expressly informed about the buy-in and given the opportunity to apply as they apply for their Social Security benefits.

HHS should also seek out and provide buy-in benefits to the very low-income persons who are not getting any Social Security benefits. The Social Security Administration (SSA) is currently supporting a number of efforts to improve participation in the Supplemental Security Income (SSI) cash benefit program for seniors and persons with disabilities. These kinds of efforts should be used to make sure that eligible persons get buy-in benefits as well.

Your legislation will help accomplish these goals by requiring DHHS to notify all new Medicare beneficiaries of the QMB program at the time they apply for Medicare coverage. Additionally, your bill requires the Secretary to mail information about the program annually to Social Security beneficiaries whose benefits make it likely that they would be eligible for this benefit.

• *Providers Distribute Applications*

The most critical time to provide information about buy-in assistance is at the time a beneficiary incurs, or' is about to incur, medical expenses—at a doctor's office or in a hospital. Physicians and hospitals that treat Medicare patients should be required to inform beneficiaries about the buy-in and how to apply. Hospitals, in particular, have staff that can assist beneficiaries with the application process.

Your legislation would have the Secretary supply notices about the QMB program to Medicare participating hospitals and physicians. These notices should be placed conspicuously in the waiting rooms and other key areas, and medical personnel should be required to inform beneficiaries about the program.

• *Presumptive Eligibility*

Congress has created special procedures within the Medicaid program to facilitate participation by pregnant women. Under these procedures, at a state's option, providers may make a preliminary determination that a pregnant woman seeking treatment is potentially eligible for Medicaid coverage and the state is obligated to cover pregnancy-related services provided for up to 45 days or until the state com-

pletes an eligibility review, whichever is earlier. The individual has until the last day of the month after the month that presumptive eligibility was made to file for Medicaid and coverage is guaranteed to that date in the case of a woman who fails to apply. Presumptive eligibility should be extended to seniors and the disabled under the QMB program as well.

Your bill would extend presumptive eligibility, at a state's option, to QMBs as well.

• *Part A Enrollment*

The Health Care Financing Administration (HCFA) can identify almost 400,000 individuals who do not have Medicare hospitalization benefits and are entitled to have Medicaid pay their premiums. There is no excuse for not providing these individuals with the benefits to which they are entitled. HHS has insisted that individuals must submit the necessary applications themselves. Instead, HHS should automatically enroll these individuals in Part A and bill the Medicaid program for the premiums. The Social Security Administration should allow states to enroll poor seniors and persons with disabilities in Medicare Part A just as the states do with Part B.

Your bill fully addresses this serious loophole in the benefit by requiring the Secretary to automatically enroll these individuals and directly bill the state Medicaid plans for the cost of the Part A premiums. Your bill also addresses the current limitations in Part A enrollment by allowing states, without penalty, to enroll individuals in Part A throughout the year, rather than just in the first three months of the year.

• *Retroactivity*

Millions of poor seniors and persons with disabilities should not suffer financial hardship when they had' no way of knowing that they were entitled to assistance. In conjunction with an aggressive notification effort this year, buy-in benefits should be provided retroactively to the beginning of 1991.

In the future, QMB benefits should be available retroactively for three months from the date of application. This is especially important because many beneficiaries are likely to learn about the buy-in benefit at the time they are incurring major medical expenses. Other Medicaid beneficiaries are eligible for Medicaid benefits for three months retroactively. Buy-in beneficiaries should be treated no differently.

Your legislation fully addresses both these important issues.

• *Spenddown for QMBs*

Currently, states have the option to allow individuals to qualify for medically needy (and categorically needy coverage in 209(b) states) by subtracting the cost of their incurred medical expenses from their income before the eligibility determination is made. States have been instructed by HCFA however, that they may not allow spenddown in determining whether an individual meets the QMB income levels.

Individuals under the QMB program should be given the same protections as other individuals under the Medicaid program, and should be allowed to spenddown to determine QMB eligibility. Your legislation fully addresses this serious inequity.

• *Outreach*

Your bill also includes important provisions to establish outreach and counseling activities around the QMB program, as well as to establish a toll-free hotline that Medicare beneficiaries and their representatives can use as a central, knowledgeable place for QMB information and referral.

Your grants proposal would authorize $30 million annually, $15 million to states and state agencies on aging and $15 million to not-for-profit and private organizations and networks, to accept and begin to process applications for QMBs in locations other then welfare offices. These programs would also have to provide either one-on-one counseling or public educational efforts to inform individuals about the program and help them access the benefits.

CONCLUSIONS

It is our strong belief that this benefit will become a reality for those eligible only if there is a concerted effort within HHS to identify and reach eligible individuals and enroll them in the program. This means that, in addition to efforts to notify potentially eligible individuals, the Department must take steps to ensure that the application itself is as simple as possible to complete and that poor beneficiaries can apply as many ways as possible—over the phone, in their homes, at senior centers,

and at Social Security offices. We look forward to working with the Department to design such an effort.

Your legislation will help turn the QMB program from a phantom benefit that holds great promise, but little real protection, into a benefit that people know about, can count on, and that measures up to Congress' expectations.

Thank you again for the opportunity to present our views and findings on the Medicare buy-in with you.

July 25, 1991.

Hon. DONALD RIEGLE,
U.S. Senate,
Washington, DC.

Dear Senator Riegle: We, the undersigned organizations, are pleased to lend our full support for your proposal, the Medicare Enrollment Improvement and Protection Act of 1991.

As longstanding supporters of the Qualified Medicare Beneficiary (QMB) program, the purpose of which is to shield low income beneficiaries from the high cost-sharing requirements of the Medicare program, we are deeply concerned more than half of all seniors eligible for the QMB benefits are not receiving the benefits. Aggressive outreach and notification efforts have not been mounted by the DHHS to find and enroll potentially qualified individuals. As a result, more than 2 million elderly individuals and couples with incomes below the federal poverty line have been wrongly billed for Medicare premiums, copays, and deductibles since the program began more than three years ago.

Two critical areas of needed improvement are that beneficiaries must be able to enroll in the program through their local Social Security offices and the DHHS must actively notify beneficiaries, on an ongoing basis, about the program. Your bill would fully address these issues, as well as others of vital importance.

We appreciate your leadership in this pressing issue and look forward to working with you to make the QMB program a reality for the millions in need.

Sincerely,

AMERICAN ASSOCIATION OF HOMES FOR THE AGING.
AFSCME RETIREE PROGRAM.
ASOCIACION NACIONAL PRO PERSONAS MAYORES.
FAMILIES USA.
NATIONAL ASSOCIATION FOR FAMILIES CARING FOR THEIR ELDERS.
NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING.
NATIONAL ASSOCIATION OF FOSTER GRANDPARENTS PROGRAM DIRECTORS.
NATIONAL ASSOCIATION OF OLDER AMERICAN VOLUNTEER PROGRAM DIRECTORS.
NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES.
NATIONAL ASSOCIATION OF RSVP DIRECTORS.
NATIONAL ASSOCIATION OF STATE UNITS ON AGING.
NATIONAL CAUCUS AND CENTER ON BLACK AGED.
OLDER WOMEN'S LEAGUE.

June 17, 1991

Dear Senator:

A key element of last year's budget agreement that was intended to provide vital protections for millions of elderly and disabled individuals living below the poverty line has become a phantom benefit. The enclosed report, released today by Families USA Foundation, documents the problems with this program and the number of low-income people in each state who are not receiving the protection to which they are entitled.

Congress intended the Medicare buy-in benefit, also known as the Qualified Medicare Beneficiary (QMB) program, to protect low-income Medicare beneficiaries from the out-of-pocket costs of the Medicare program -- premiums, deductibles, and copays. These costs alone can amount to more than a sixth of the annual income for an elderly person living in poverty.

And yet, because the federal and state governments have failed to notify the poor about the this benefit, fewer than half of those entitled are actually receiving the benefit. As a result, low-income seniors are having $29.90 per month ($358.80 per year) deducted from their Social Security checks even though Congress intended to stop these deductions.

I hope you find the information in this report helpful. Please feel free to contact Lucia DiVenere of my staff with any questions or for additional information.

Sincerely,

Ronald F. Pollack
Executive Director

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Formerly The Villers Foundation

The Secret Benefit

The Failure to Provide the Medicare Buy-in to Poor Seniors

A Report By

Families USA Foundation
1334 G Street, NW
Washington, DC 20005
(202) 628-3030

June 1991

Introduction

The Medicare buy-in is a benefit designed by Congress to protect low-income beneficiaries from heavy Medicare out-of-pocket costs. This report outlines the potential of this benefit; the federal and state governments' failures to make this benefit a reality for poor seniors; and steps that can be taken to ensure that low-income seniors and persons with disabilities get the benefits Congress intended.

As of May 1991, an estimated 2.2 to 2.3 million poor seniors nationwide were eligible for the Medicare "buy-in," also known as the Qualified Medicare Beneficiary (QMB) program, but were not receiving the benefits.[1] Over half the seniors eligible for this benefit are not receiving it. These low-income seniors are very poor: individuals with incomes below $6,620 a year and less than $4,000 in assets, and couples with annual incomes below $8,880 and less than $6,000 in assets.

For these seniors, the federal government continues to deduct Medicare premiums ($29.90 per month for individuals, $59.80 per month for couples) each and every month out of their Social Security checks, even though they are entitled to have those premiums paid by the Medicaid program. These impoverished seniors are also paying substantial portions of their incomes on physician and hospital bills even though by law they are not responsible for these costs.

Background—Medicare Cost-Sharing

The Medicare program requires substantial out-of-pocket payments from beneficiaries. In 1991 these cost-sharing requirements are: the premium for physician coverage (Part B of Medicare), $29.90 per month (or $358.80 per year); the Part B deductible, $100 per year; copayments of 20 percent for all physician charges above the $100 annual deductible; physician costs that exceed Medicare's billable rate[2]; a hospital (Part A) deductible of $628 for each hospitalization; substantial copayments for hospitalizations in excess of 60 days; and substantial copayments for skilled nursing care stays longer than 21 days.

Beneficiary premiums and deductibles have escalated very rapidly in the past decade. A comparison of the 1980 and 1991 costs is illustrative:

	1980	1991	Percentage Increase
Part A Deductible	$ 180.00	$ 628.00	+ 249
Part B Premium	104.40	358.80	+ 244
Part B Deductible	60.00	100.00	+ 67
TOTAL	$ 344.40	$1,086.80	+ 216

Out-of-pocket costs in 1991, for Medicare beneficiaries with one hospitalization, are at least $1,086.80—not including the copayments required by Medicare (and also not including the costs of the services uncovered by Medicare, such as prescription drugs, long term care and numerous others). In fact, the Part A deductible and the Part B premium and deductible alone constitute approximately one-sixth of the annual incomes of individuals with incomes below poverty—their entire income for two months.

Recent Congressional Action

Congress has acted in recent years to prevent the extreme financial hardships that such cost-sharing requirements create for low-income beneficiaries. In the Medicare Catastrophic Coverage Act of 1988, Congress required the Medicaid program, beginning in 1989, to "buy-in" to Medicare low-income seniors and persons with disabilities eligible for Medicare.[3] The law required that Medicaid pay the Medicare premiums and deductibles for low-income seniors and persons with disabilities eligible for Medicare, and these low-income persons are not responsible for any out-of-pocket costs for Medicare-covered services.

As of January 1, 1989, Congress required buy-in coverage for Medicare beneficiaries with incomes at or below 85 percent of the federal poverty guideline and resources of up to $4,000 for an individual and $6,000 for a couple (excluding the home, car, personal effects, life insurance and burial spaces).[4] Under the law enacted in 1988, the income eligibility standard for the buy-in increased to 90 percent of the poverty guideline in 1990 and was scheduled to increase to 95 percent of the poverty guideline in 1991 and 100 percent in 1992.

In Fall 1990 when Congress increased Medicare cost-sharing amounts as part of its deficit-reduction package, Congress also acted to protect low-income beneficiaries from these increases. Congress accelerated the buy-in requirement for all poor Medicare beneficiaries with limited resources to 1991, rather than 1992, and added buy-in requirements for Medicare beneficiaries with incomes up to 110 percent of the poverty guideline in 1993 and 120 percent of the poverty guideline in 1995. Medicare beneficiaries with incomes between 100 and 120 percent of the poverty guideline will be eligible for Medicaid payment of Medicare premiums, but not for Medicaid payment of other Medicare cost-sharing.

The Medicare buy-in also provides protection for the relatively small number of seniors and persons with disabilities who did not work long enough to qualify for hospital coverage under Part A of Medicare. For individuals without a sufficient work history, Medicare hospital coverage is only available if they pay a monthly premium of $177 -- an amount that is unaffordable for the poor. The law requires Medicaid to buy low-income seniors and persons with disabilities into Medicare Part A. This is an important benefit -- even for those who previously qualified for Medicaid coverage. Medicare hospital benefits are sometimes more comprehensive than Medicaid hospital benefits because some states impose strict limits on the number of hospital days

covered under Medicaid.[5] In addition, the Medicare payment rate is often more generous than Medicaid hospital payment rates, and Medicare therefore offers better access to hospitals.

Keeping The Buy-In Benefits A Secret

The federal and state governments have kept the Medicare buy-in benefits a secret. Impoverished Medicare beneficiaries, who previously were ineligible for or did not receive Medicaid, have no way of knowing about the buy-in. They have no way of knowing that their Social Security checks are wrongfully being deducted by $29.90 per month (or $59.80 for couples). They have no way of knowing that they do not have to pay the $628 deductible for each hospitalization. And they have no way of knowing that they do not have to pay the $100 physician care deductible, or the various other copayments they may be making.

In the Spring of 1988, Families USA Foundation issued a report that was critical of the federal and state governments' implementation of the buy-in legislation. (At the time that report was issued, the buy-in eligibility requirement was 85 percent of poverty -- not the 100 percent of poverty standard required in 1991.) In response to that report, the federal government, in July 1988, sent a notice informing Social Security beneficiaries that they may be eligible for buy-in assistance. Since that time, the income eligibility for the benefit has increased significantly, but the federal government has refused to send any additional notices -- and has failed to initiate any other outreach to low-income eligible persons.

Nationally 2.2 to 2.3 million poor seniors are without the buy-in benefits to which they are entitled and are paying Medicare costs that they should not have to pay. Their Social Security checks are also being wrongfully deducted by $29.90 each month. (The 2.2 to 2.3 million estimate is a range rather than a precise figure because it is not possible to determine the exact number of Medicaid beneficiaries whose incomes fall below the poverty guideline.) Table 1 provides national and state-by-state estimates.

- *The following states have the highest potential numbers of poor seniors eligible for buy-in benefits but not receiving them: California (225,453); New York (161,765); Florida (135,459); Texas (131,613); Georgia (130,011); Pennsylvania (125,588); North Carolina (123,009); Illinois (102,415); Ohio (101,534); and Michigan (83,615).*

- *The following states have the highest potential percentages of poor seniors eligible for buy-in benefits but not receiving them: Alaska (98%); California (89%); Hawaii (87%); Kansas (85%); Indiana (80%); Michigan (75%); Rhode Island (75%); Ohio (73%); North Dakota (73%); Nebraska (71%); and the District of Columbia (71%).*

The estimates in Table 1 were derived by comparing estimates of poor elderly persons eligible for the buy-in who are living in the community with comparable estimates of the numbers of poor seniors with buy-in benefits. The estimates of poor seniors with buy-in benefits are based on state-by-state numbers of buy-ins provided by the Health Care Financing Administration. (See the Technical Appendix for a complete explanation of the estimates.)

Table 2 presents information from the Health Care Financing Administration on the numbers of poor seniors and persons with disabilities who are getting Medicare hospital (Part A) buy-in benefits. There are approximately 138,000 such persons. However, the Health Care Financing Administration can identify approximately 529,000 seniors and persons with disabilities nationwide who do not have Medicare hospital benefits but are receiving Medicaid. Hence, approximately 391,000 readily identifiable persons are not being bought-in to Medicare hospital coverage.

The first appendix, Estimates of Elderly Poor Persons Without Medicaid or Buy-in Benefits, presents the data on buy-in participation from a slightly different perspective. The table in this appendix looks at the percentage of poor seniors not receiving Medicaid who are eligible for the buy-in. This was the group most explicitly targeted by Congress for buy-in protection. As the table illustrates, three out of four (74 to 75 percent) of these eligibles are not receiving their entitlements.

Getting The Benefit To Poor Seniors

The federal and state governments, which have joint responsibility for administering Medicaid and the Medicare buy-in, can take a number of steps to ensure that low-income Medicare beneficiaries receive their buy-in benefits. These include:

- **Notification**

The Department of Health and Human Services (HHS) must assume responsibility for identifying beneficiaries eligible for the buy-in. HHS should send notices to low-income Social Security beneficiaries informing them of the buy-in benefit, eligibility criteria, how to get additional information, and how to apply. Such notices should be designed to attract the attention of the reader. Similar information should go to new Social Security beneficiaries as they apply for Social Security benefits. The federal government should also send a notice to all low-income Social Security beneficiaries toward the end of each year when beneficiaries are sent a notice announcing the Part B premium for the next calendar year.

HHS should design a notice that is sent periodically to low-income Social Security beneficiaries that asks beneficiaries to return a completed form. The completed form should be designed to enable HHS to determine whether the individual is likely to be eligible for the buy-in. HHS should then follow up with the beneficiary

to get the information necessary to make an actual eligibility determination, or should arrange for such follow-up with the appropriate state.

HHS should also seek out and provide buy-in benefits to the very low-income persons who are not getting any Social Security benefits. The Social Security Administration (SSA) is currently supporting a number of efforts to improve participation in the Supplemental Security Income cash benefit program for seniors and persons with disabilities. These kinds of efforts should be used to make sure that eligible persons get buy-in benefits as well.

- **Take Applications at Social Security Offices**

Thirty states currently contract with the Social Security Administration to determine eligibility for Medicaid. (The contracts are known as "Section 1634 agreements" because they are authorized by Section 1634 of the Social Security Act.) In these cases, low-income seniors and persons with disabilities can apply for Medicaid at the same time as they apply for SSI. In states where SSI beneficiaries have to apply separately for Medicaid benefits, a significant number do not do so. In the past, the Social Security Administration refused to allow Section 1634 agreements to cover applications for the buy-in. This means that, even in states where Social Security offices take applications from seniors and persons with disabilities applying for SSI and Medicaid, they cannot accept applications for the buy-in.

Medicare beneficiaries are accustomed to applying for Social Security benefits at Social Security offices. Taking buy-in applications at Social Security offices is likely to increase participation in the buy-in very significantly, both for new and current Social Security beneficiaries.

- **Providers Distribute Applications**

The most critical time to provide information about buy-in assistance is at the time a beneficiary incurs, or is about to incur, medical expenses -- at a doctor's office or in a hospital. Physicians and hospitals that treat Medicare patients should be required to inform beneficiaries about the buy-in and how to apply. Hospitals, in particular, have staff that can assist beneficiaries with the application process.

- **Part A Enrollment**

The Health Care Financing Administration (HCFA) can identify almost 400,000 individuals who do not have Medicare hospitalization benefits and are entitled to have Medicaid pay their premiums.[6] There is no excuse for not providing these individuals with the benefits to which they are entitled. HHS has insisted that individuals must submit the necessary applications themselves. Instead, HHS should enroll these individuals in Part A and bill the Medicaid program for the premiums. The Social

Security Administration should allow states to enroll poor seniors and persons with disabilities in Medicare Part A just as the states do with Part B.

- **Retroactivity**

Millions of poor seniors and persons with disabilities should not suffer financial hardship when they had no way of knowing that they were entitled to assistance. In conjunction with an aggressive notification effort, buy-in benefits should be provided retroactively to poor beneficiaries from the date of their eligibility. This is especially important for beneficiaries who incurred major medical expenses that should have been covered by the buy-in.

Endnotes

1. Persons with disabilities eligible for Medicare who are poor are also entitled to buy-in benefits. It is not possible, however, to reliably estimate the number who are not getting benefits.

2. As of 1991 physicians may charge Medicare beneficiaries up to 140 percent of the Medicare allowed charge, and the beneficiary is solely responsible for the additional 40 percent of the charge.

3. Congress repealed most of the Medicare Catastrophic Coverage Act in 1989 but left in place the provisions requiring financial protection from Medicare out-of-pocket costs for low-income Medicare beneficiaries.

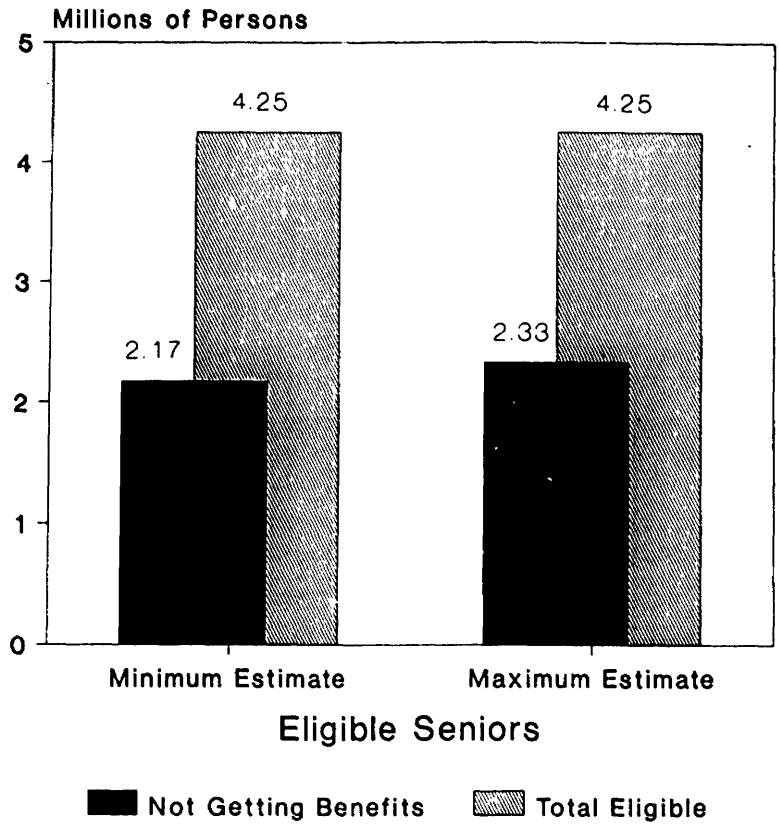
4. The law allowed six states, known as 209(b) states, to use an income eligibility standard five percent lower than the national standard for four years. As of 1991, four states (Illinois, Indiana, North Carolina and Ohio) set the income eligibility standard for the buy-in at 95 percent of the poverty guideline. These states are required to use an income eligibility standard for the buy-in of 100 percent of the poverty guideline as of January 1, 1992.

5. In the following states Medicaid hospitalization benefits are more limited than Medicare hospitalization benefits according to the latest state plan information in Commerce Clearing House's, **Medicare and Medicaid Guide**: Alabama, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia and West Virginia.

6. These are individuals whom Medicaid is buying into Part B and are identified as having no other insurance, i.e. Medicare Part A.

THE SECRET BENEFIT

Poor Seniors Without Buy-in Benefits



Source: Families USA Foundation

TABLE 1

ELDERLY POOR PERSONS WITHOUT MEDICAID BUY-IN BENEFITS

	Number of Non-Institutionalized Poor Seniors Meeting Buy-In Criteria	Number of Non-Institutionalized Buy-Ins[1]		Number of Eligible Non-Institutionalized Seniors Without Buy-In Benefits		Percent of Eligible Non-Institutionalized Seniors Without Buy-In Benefits	
		Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
UNITED STATES	4,246,363	1,915,811	2,076,846	2,169,517	2,330,552	51%	55%
Alabama	130,748	78,952	78,952	51,796	51,796	40%	40%
Alaska	3,526	81	81	3,445	3,445	98%	98%
Arizona	42,481	28,867	28,867	13,614	13,614	32%	32%
Arkansas	90,755	33,758	35,723	55,032	56,997	61%	63%
California	252,741	27,288	27,288	225,453	225,453	89%	89%
Colorado	34,403	19,190	19,190	15,213	15,213	44%	44%
Connecticut	43,789	19,000	19,000	24,789	24,789	57%	57%
Delaware	10,428	3,201	3,201	7,227	7,227	69%	69%
District of Columbia	15,824	4,579	7,088	8,736	11,245	55%	71%
Florida	231,401	95,942	122,427	108,974	135,459	47%	59%
Georgia	188,987	58,976	58,976	130,011	130,011	69%	69%
Hawaii	21,839	2,934	7,815	14,024	18,905	64%	87%
Idaho	12,606	4,616	4,616	7,990	7,990	63%	63%
Illinois	172,994	70,579	70,579	102,415	102,415	59%	59%
Indiana	64,968	13,190	20,633	44,335	51,778	68%	80%

TABLE 1

ELDERLY POOR PERSONS WITHOUT MEDICAID BUY-IN BENEFITS

	Number of Non-Institutionalized Poor Seniors Meeting Buy-In Criteria	Number of Non-Institutionalized Buy-Ins[1]		Number of Eligible Non-Institutionalized Seniors Without Buy-In Benefits		Percent of Eligible Non-Institutionalized Seniors Without Buy-In Benefits	
		Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
Iowa	41,300	15,648	16,366	24,934	25,652	60%	62%
Kansas	38,927	5,837	9,127	29,800	33,090	77%	85%
Kentucky	90,278	57,535	57,535	32,743	32,743	36%	36%
Louisiana	106,048	67,285	67,285	38,763	38,763	37%	37%
Maine	22,209	18,650	18,650	3,559	3,559	16%	16%
Maryland	67,875	38,547	38,547	29,328	29,328	43%	43%
Massachusetts	77,152	32,168	32,168	44,984	44,984	58%	58%
Michigan	111,016	27,401	40,467	70,549	83,615	64%	75%
Minnesota	55,718	31,763	31,763	23,955	23,955	43%	43%
Mississippi	105,243	67,633	67,633	37,610	37,610	36%	36%
Missouri	99,030	53,648	53,648	45,382	45,382	46%	46%
Montana	10,601	3,400	3,808	6,793	7,201	64%	68%
Nebraska	26,175	7,523	7,523	18,652	18,652	71%	71%
Nevada	10,880	6,948	6,948	3,932	3,932	36%	36%
New Hampshire	9,564	3,109	3,109	6,455	6,455	67%	67%
New Jersey	130,675	76,457	76,457	54,218	54,218	41%	41%
New Mexico	30,138	18,118	18,118	12,020	12,020	40%	40%

TABLE 1

ELDERLY POOR PERSONS WITHOUT MEDICAID BUY-IN BENEFITS

	Number of Non-Institutionalized Poor Seniors Meeting Buy-In Criteria	Number of Non-Institutionalized Buy-Ins[1]		Number of Eligible Non-Institutionalized Seniors Without Buy-In Benefits		Percent of Eligible Non-Institutionalized Seniors Without Buy-In Benefits	
		Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
New York	364,458	202,693	202,693	161,765	161,765	44%	44%
North Carolina	179,140	56,131	87,446	91,694	123,009	51%	69%
North Dakota	12,444	3,416	3,416	9,028	9,028	73%	73%
Ohio	138,551	37,017	61,000	77,551	101,534	56%	73%
Oklahoma	65,327	50,629	50,629	14,698	14,698	22%	22%
Oregon	32,982	15,910	15,910	17,072	17,072	52%	52%
Pennsylvania	219,293	93,705	93,705	125,588	125,588	57%	57%
Rhode Island	18,405	4,607	5,064	13,341	13,798	72%	75%
South Carolina	90,879	48,676	48,676	42,203	42,203	46%	46%
South Dakota	14,284	6,716	6,716	7,568	7,568	53%	53%
Tennessee	159,594	88,902	88,902	70,692	70,692	44%	44%
Texas	323,519	191,906	191,906	131,613	131,613	41%	41%
Utah	13,577	4,575	5,861	7,716	9,002	57%	66%
Vermont	8,023	6,611	6,611	1,412	1,412	18%	18%
Virginia	105,832	49,183	54,986	50,846	56,649	48%	54%
Washington	37,251	20,967	37,251	0	16,284	0%	44%
West Virginia	52,393	21,156	21,156	31,237	31,237	60%	60%

TABLE 1

ELDERLY POOR PERSONS WITHOUT MEDICAID BUY-IN BENEFITS

	Number of Non-Institutionalized Poor Seniors Meeting Buy-In Criteria	Number of Non-Institutionalized Buy-Ins[1]		Number of Eligible Non-Institutionalized Seniors Without Buy-In Benefits		Percent of Eligible Non-Institutionalized Seniors Without Buy-In Benefits	
		Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
Wisconsin	55,310	18,073	39,217	16,093	37,237	29%	67%
Wyoming	4,782	2,114	2,114	2,668	2,668	56%	56%

1. Ranges are presented because it is not possible to know which non-cash Medicaid recipients in states that buy-in these persons have income less than the poverty guideline. The range represents participation rates excluding all non-cash eligibles ("Minimum"), which assumes that all non-cash eligibles have income greater than the poverty guideline, and participation rates including all non-cash eligibles that states buy-in ("Maximum"). To "exclude" these two groups from the estimates of buy-ins, the percent of elderly non-institutionalized Medicaid recipients who receive payments on the basis of Medical Need and other non-cash eligibles who spend-down were calculated and subtracted from the buy-ins on a state-by-state basis.

SOURCES: See Technical Appendix.

TABLE 2

SENIORS AND PERSONS WITH DISABILITIES WITHOUT MEDICARE HOSPITALIZATION BENEFITS (PART A)

	Number Eligible for Part A Buy-In[1]	Number of Part A Buy-Ins	Number Not Receiving Part A Benefits[1]
UNITED STATES	528,547	137,762	390,785
Alabama		780	
Alaska		349	
Arizona		14	
Arkansas		4,913	
California		6,044	
Colorado		20	
Connecticut		301	
Delaware		0	
District of Columbia		577	
Florida		40,004	
Georgia		11,923	
Hawaii		567	
Idaho		297	
Illinois		1,605	
Indiana		2,744	
Iowa		753	
Kansas		51	
Kentucky		447	
Louisiana		3,574	
Maine		1	
Maryland		2	
Massachusetts		7,681	
Michigan		12	
Minnesota		1,724	

TABLE 2

SENIORS AND PERSONS WITH DISABILITIES WITHOUT MEDICARE HOSPITALIZATION BENEFITS (PART A)

	Number Eligible for Part A Buy-In[1]	Number of Part A Buy-Ins	Number Not Receiving Part A Benefits[1]
Mississippi		266	
Missouri		275	
Montana		290	
Nebraska		1	
Nevada		593	
New Hampshire		0	
New Jersey		184	
New Mexico		0	
New York		10	
North Carolina		300	
North Dakota		0	
Ohio		133	
Oklahoma		5,659	
Oregon		6	
Pennsylvania		13,179	
Rhode Island		1,303	
South Carolina		3	
South Dakota		656	
Tennessee		9,281	
Texas		13,887	
Utah		27	
Vermont		0	
Virginia		296	
Washington		13	
West Virginia		3,818	

TABLE 2

SENIORS AND PERSONS WITH DISABILITIES WITHOUT MEDICARE HOSPITALIZATION BENEFITS (PART A)

	Number Eligible for Part A Buy-In[1]	Number of Part A Buy-Ins	Number Not Receiving Part A Benefits[1]
Wisconsin		3,042	
Wyoming		157	

1. Data not available on a state level basis.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, May 29, 1991.

TABLE 3

ESTIMATES OF ELDERLY POOR PERSONS WITHOUT MEDICAID OR BUY-IN BENEFITS

	Number of Non-Institutionlaized Poor Seniors Meeting Buy-In Criteria	Number of Non-Institutionlaized Poor Seniors Eligible for Buy-In and Not Receiving Medicaid[1]		Number of Non-Institutionlaized Seniors Receving Buy-In Benefits Only	Percent of Eligible Non-Institutionlaized Seniors Without Medicaid or Buy-In Benefits	
		Minimum	Maximum		Minimum	Maximum
UNITED STATES	4,246,363	2,941,183	3,102,218	771,666	74%	75%
Alabama	130,748	66,188	66,188	14,392	78%	78%
Alaska	3,526	3,445	3,445	0	100%	100%
Arizona	42,481	15,351	15,351	1,737	89%	89%
Arkansas	90,755	58,720	60,685	3,688	94%	94%
California	252,741	252,741	252,741	27,288	89%	89%
Colorado	34,403	30,269	30,269	15,056	50%	50%
Connecticut	43,789	33,868	33,868	9,079	73%	73%
Delaware	10,428	7,719	7,719	492	94%	94%
District of Columbia	15,824	8,805	11,314	69	99%	99%
Florida	231,401	108,974	135,459	0	100%	100%
Georgia	188,987	153,465	153,465	23,454	85%	85%
Hawaii	21,839	14,713	19,594	689	95%	96%
Idaho	12,606	12,606	12,606	4,616	63%	63%
Illinois	172,994	172,994	172,994	70,579	59%	59%
Indiana	64,968	57,525	64,968	13,190	77%	80%
Iowa	41,300	40,582	41,300	15,648	61%	62%

TABLE 3

ESTIMATES OF ELDERLY POOR PERSONS WITHOUT MEDICAID OR BUY-IN BENEFITS

	Number of Non-Institutionlaized Poor Seniors Meeting Buy-In Criteria	Number of Non-Institutionlaized Poor Seniors Eligible for Buy-In and Not Receiving Medicaid[1]		Number of Non-Institutionlaized Seniors Receving Buy-In Benefits Only	Percent of Eligible Non-Institutionlaized Seniors Without Medicaid or Buy-In Benefits	
		Minimum	Maximum		Minimum	Maximum
Kansas	38,927	35,637	38,927	5,837	84%	85%
Kentucky	90,278	49,280	49,280	16,537	66%	66%
Louisiana	106,048	52,465	52,465	13,702	74%	74%
Maine	22,209	9,412	9,412	5,853	38%	38%
Maryland	67,875	67,875	67,875	38,547	43%	43%
Massachusetts	77,152	61,718	61,718	16,734	73%	73%
Michigan	111,016	70,549	83,615	0	100%	100%
Minnesota	55,718	50,442	50,442	26,487	47%	47%
Mississippi	105,243	37,610	37,610	0	100%	100%
Missouri	99,030	85,467	85,467	40,085	53%	53%
Montana	10,601	9,614	10,022	2,821	71%	72%
Nebraska	26,175	18,652	18,652	0	100%	100%
Nevada	10,880	10,880	10,880	6,948	36%	36%
New Hampshire	9,564	7,191	7,191	736	90%	90%
New Jersey	130,675	116,539	116,539	62,321	47%	47%
New Mexico	30,138	14,082	14,082	2,062	85%	85%
New York	364,458	180,613	180,613	18,848	90%	90%

TABLE 3

ESTIMATES OF ELDERLY POOR PERSONS WITHOUT MEDICAID OR BUY-IN BENEFITS

	Number of Non-Institutionlaized Poor Seniors Meeting Buy-In Criteria	Number of Non-Institutionlaized Poor Seniors Eligible for Buy-In and Not Receiving Medicaid[1]		Number of Non-Institutionlaized Seniors Receving Buy-In Benefits Only	Percent of Eligible Non-Institutionlaized Seniors Without Medicaid or Buy-In Benefits	
		Minimum	Maximum		Minimum	Maximum
North Carolina	179,140	147,825	179,140	56,131	62%	69%
North Dakota	12,444	9,028	9,028	0	100%	100%
Ohio	138,551	114,568	138,551	37,017	68%	73%
Oklahoma	65,327	65,327	65,327	50,629	22%	22%
Oregon	32,982	32,982	32,982	15,910	52%	52%
Pennsylvania	219,293	126,688	126,688	1,100	99%	99%
Rhode Island	18,405	13,762	14,219	421	97%	97%
South Carolina	90,879	60,296	60,296	18,093	70%	70%
South Dakota	14,284	11,166	11,166	3,598	68%	68%
Tennessee	159,594	104,635	104,635	33,943	68%	68%
Texas	323,519	179,120	179,120	47,507	73%	73%
Utah	13,577	12,291	13,577	4,575	63%	66%
Vermont	8,023	3,568	3,568	2,156	40%	40%
Virginia	105,832	66,821	72,624	15,975	76%	78%
Washington	37,251	0	16,284	0	0%	100%
West Virginia	52,393	40,088	40,088	8,851	78%	78%
Wisconsin	55,310	34,053	55,197	17,960	47%	67%

TABLE 3

ESTIMATES OF ELDERLY POOR PERSONS WITHOUT MEDICAID OR BUY-IN BENEFITS

	Number of Non-Institutionlaized Poor Seniors Meeting Buy-In Criteria	Number of Non-Institutionlaized Poor Seniors Eligible for Buy-In and Not Receiving Medicaid[1]		Number of Non-Institutionlaized Seniors Receving Buy-In Benefits Only	Percent of Eligible Non-Institutionlaized Seniors Without Medicaid or Buy-In Benefits	
		Minimum	Maximum		Minimum	Maximum
Wyoming	4,782	2,973	2,973	305	90%	90%

1. Ranges are presented because it is not possible to know which non-cash Medicaid recipients in states that buy-in these persons have income less than the poverty guideline. The range represents participation rates excluding all non-cash eligibles ("Minimum"), which assumes that all non-cash eligibles have income greater than the poverty guideline, and participation rates including all non-cash eligibles that states buy-in ("Maximum"). To "exclude" these two groups from the estimates of buy-ins, the percent of elderly non-institutionalized Medicaid recipients who receive payments on the basis of Medical Need and other non-cash eligibles who spend-down were calculated and subtracted from the buy-ins on a state-by-state basis.

Medicaid Eligibility Limits - Elderly Individuals Living in the Community, 1991

State	Categorically Needy			Medically Needy			OBRA 86			Buy-in Only		
	Income		Resources	Income		Resources	Income		Resources	Income		Resources
	Monthly Limit	Percent of Poverty (a)		Monthly Limit	Percent of Poverty		Monthly Limit	Percent of Poverty		Monthly Limit	Percent of Poverty	
Average	$423	78%	$1,984	$377	69%	$4,083	$565	100%	$3,691	$550	100%	$4,000
Alabama	$407	74%	$2,000	--			-			$552	100%	$4,000
Alaska (b)(d)	$756	109%	$2,000	--			$691	100%	$4,000	$691	100%	$4,000
Arizona	$407	74%	$2,000	--			$552	100%	$4,000	$552	100%	$4,000
Arkansas	$407	74%	$2,000	--			-			$552	100%	$4,000
California	$600	109%	$2,000	$600	109%	$2,000	(c)			$552	100%	$4,000
Colorado	$452	82%	$2,000	--			-			$552	100%	$4,000
Connecticut*	NA		$1,600	$473	86%	$1,600	-			$552	100%	$4,000
Delaware	$407	74%	$2,000	--			-			$552	100%	$4,000
D.C. (e)	$407	74%	$2,600	$426	77%	$2,600	$552	100%	$2,600	$552	100%	$4,000
Florida (d)	$407	74%	$2,000	$167	30%	$5,000	$552	100%	$4,000	$552	100%	$4,000
Georgia	$407	74%	$2,000	$317	57%	$2,000	-			$552	100%	$4,000
Hawaii* (b)(e)	$412	65%	$2,000	$396	63%	$2,000	$634	100%	$2,000	$634	100%	$4,000
Idaho	$477	86%	$2,000	--			-			$552	100%	$4,000
Illinois*	NA		$2,000	$283	51%	$2,000	-			$524	95%	$4,000
Indiana*	$407	74%	$1,500	--			-			$524	95%	$4,000
Iowa	$407	74%	$2,000	$483	88%	$10,000	-			$552	100%	$4,000
Kansas	$407	74%	$2,000	$407	74%	$2,000	-			$552	100%	$4,000
Kentucky	$407	74%	$2,000	$217	39%	$2,000	-			$552	100%	$4,000
Louisiana	$407	74%	$2,000	$100	18%	$2,000	-			$552	100%	$4,000
Maine (e)	$417	76%	$2,000	$416	75%	$2,000	$552	100%	$2,000	$552	100%	$4,000
Maryland	$407	74%	$2,000	$384	70%	$2,500	-			$552	100%	$4,000
Massachusetts (d)	$536	97%	$2,000	$522	95%	$2,000	$552	100%	$4,000	$552	100%	$4,000
Michigan	$438	79%	$2,000	$400	72%	$3,000	-			$552	100%	$4,000
Minnesota*	$420	76%	$3,000	$420	76%	$3,000	-			$552	100%	$4,000
Mississippi (e)	$407	74%	$2,000	--			$525	95%	$2,000	$552	100%	$4,000
Missouri*	$407	74%	$1,000	-			-			$552	100%	$4,000

State	Categorically Needy			Medically Needy			OBRA 86			Buy-in Only		
	Income		Resources	Income		Resources	Income		Resources	Income		Resources
	Monthly Limit	Percent of Poverty		Monthly Limit	Percent of Poverty		Monthly Limit	Percent of Poverty		Monthly Limit	Percent of Poverty	
Montana	$407	74%	$2,000	$400	72%	$2,000	–			$552	100%	$4,000
Nebraska* (d)	$431	78%	$2,000	$392	71%	$4,000	$523	95%	$4,000	$552	100%	$4,000
Nevada	$443	80%	$2,000	–			–			$552	100%	$4,000
New Hampshire*	$421	76%	$1,500	$421	76%	$2,500	–			$552	100%	$4,000
New Jersey (d)	$438	79%	$2,000	$350	63%	$4,000	$552	100%	$4,000	$552	100%	$4,000
New Mexico	$407	74%	$2,000	–			–			$552	100%	$4,000
New York	$493	89%	$2,000	$500	91%	$3,000	–			$552	100%	$4,000
North Carolina*	$242	44%	$1,500	$242	44%	$1,500	–			$525	95%	$4,000
North Dakota*	$345	63%	$3,000	$345	63%	$3,000	–			$552	100%	$4,000
Ohio*	$350	63%	$1,500	–			–			$524	95%	$4,000
Oklahoma*	$471	85%	$2,000	$284	51%	$2,000	–			$552	100%	$4,000
Oregon	$409	74%	$2,000	$395	72%	$2,000	–			$552	100%	$4,000
Pennsylvania (e)	$439	80%	$2,000	$425	77%	$2,400	$552	100%	$2,000	$552	100%	$4,000
Rhode Island	$471	85%	$2,000	$558	101%	$4,000	–			$552	100%	$4,000
South Carolina	$407	74%	$2,000	$225	41%	$4,000	$552	100%	$4,000	$552	100%	$4,000
South Dakota	$407	74%	$2,000	–			–			$552	100%	$4,000
Tennessee	$407	74%	$2,000	$183	33%	$2,000	–			$552	100%	$4,000
Texas	$407	74%	$2,000	–			–			$552	100%	$4,000
Utah	$413	75%	$2,000	$350	63%	$2,000	–			$552	100%	$4,000
Vermont	$472	86%	$2,000	$766	139%	$2,000	(e)			$552	100%	$4,000
Virginia*	$407	74%	$2,000	$250	45%	$2,000	–			$552	100%	$4,000
Washington	$435	79%	$2,000	$458	83%	$2,000	–			$552	100%	$4,000
West Virginia	$407	74%	$2,000	$200	36%	$2,000	–			$552	100%	$4,000
Wisconsin	$510	92%	$2,000	$510	92%	$2,000	–			$552	100%	$4,000
Wyoming	$407	74%	$2,000	–			–			$552	100%	$4,000

Medicaid Eligibility Limits - Elderly Couples Living in the Community, 1991

State	Categorically Needy			Medically Needy			OBRA 86			Buy-in Only		
	Income		Resources	Income		Resources	Income		Resources	Income		Resources
	Monthly Limit	Percent of Poverty (a)		Monthly Limit	Percent of Poverty		Monthly Limit	Percent of Poverty		Monthly Limit	Percent of Poverty	
Average	$638	87%	$2,998	$453	62%	$5,319	$754	103%	$5,273	$737	100%	$6,000
Alabama	$610	82%	$3,000	–			–			$740	100%	$6,000
Alaska (b) (d)	$1,120	121%	$3,000	–			$926	100%	$6,000	$926	100%	$6,000
Arizona (d)	$610	82%	$3,000	–			$740	100%	$6,000	$740	100%	$6,000
Arkansas	$610	82%	$3,000	–			–			$740	100%	$6,000
California	$934	126%	$3,000	$934	126%	$3,000	(c)			$740	100%	$6,000
Colorado	$904	122%	$3,000	–			–			$740	100%	$6,000
Connecticut*	NA		$2,400	$629	85%	$2,400	–			$740	100%	$6,000
Delaware	$610	82%	$3,000	–			–			$740	100%	$6,000
D.C. (e)	$702	95%	$3,000	$448	61%	$3,000	$740	100%	$3,000	$740	100%	$6,000
Florida (d)	$610	82%	$3,000	$225	30%	$6,000	$740	100%	$6,000	$740	100%	$6,000
Georgia	$610	82%	$3,000	$375	51%	$4,000	–			$740	100%	$6,000
Hawaii* (b) (e)	$619	73%	$3,000	$531	63%	$3,000	$851	100%	$3,000	$851	100%	$6,000
Idaho	$654	88%	$3,000	–			–			$740	100%	$6,000
Illinois*	NA		$3,000	$358	48%	$3,000	–			$703	95%	$6,000
Indiana*	$610	82%	$2,250	–			–			$703	95%	$6,000
Iowa	$610	82%	$3,000	$483	65%	$10,000	–			$740	100%	$6,000
Kansas	$610	82%	$3,000	$460	62%	$3,000	–			$740	100%	$6,000
Kentucky	$610	82%	$3,000	$267	36%	$4,000	–			$740	100%	$6,000
Louisiana	$610	82%	$3,000	$192	26%	$3,000	–			$740	100%	$6,000
Maine (e)	$625	84%	$3,000	$450	61%	$3,000	$740	100%	$3,000	$740	100%	$6,000
Maryland	$610	82%	$3,000	$425	57%	$3,000	–			$740	100%	$6,000
Massachusetts (d)	$893	121%	$3,000	$650	88%	$3,000	$740	100%	$3,000	$740	100%	$6,000
Michigan	$656	89%	$3,000	$533	72%	$3,000	–			$740	100%	$6,000
Minnesota*	$610	82%	$6,000	$524	71%	$6,000	–			$740	100%	$6,000
Mississippi (e)	$610	82%	$3,000	–			$703	95%	$3,000	$740	100%	$6,000
Missouri*	$610	82%	$2,000	–			–			$740	100%	$6,000

State	Categorically Needy			Medically Needy			OBRA 86			Buy-in Only		
	Income		Resources	Income		Resources	Income		Resources	Income		Resources
	Monthly Limit	Percent of Poverty		Monthly Limit	Percent of Poverty		Monthly Limit	Percent of Poverty		Monthly Limit	Percent of Poverty	
Montana	$610	82%	$3,000	$400	54%	$3,000	–			$740	100%	$6,000
Nebraska* (d)	$644	87%	$3,000	$392	53%	$6,000	$740	100%	$6,000	$740	100%	$6,000
Nevada	$684	92%	$3,000	–			–			$740	100%	$6,000
New Hampshire*	$611	83%	$1,500	$608	82%	$4,000	–			$740	100%	$6,000
New Jersey (d)	$635	86%	$3,000	$433	59%	$6,000	$740	100%	$6,000	$740	100%	$6,000
New Mexico	$610	82%	$3,000	–			–			$740	100%	$6,000
New York	$712	96%	$3,000	$717	97%	$4,300	–			$740	100%	$6,000
North Carolina*	$317	43%	$2,250	$317	43%	$2,250	–			$702	95%	$6,000
North Dakota*	$400	54%	$6,000	$400	54%	$6,000	–			$740	100%	$6,000
Ohio*	$610	82%	$2,250	–			–			$702	95%	$6,000
Oklahoma*	$674 (f)	91%	$3,000	$359	49%	$3,000	–			$740	100%	$6,000
Oregon	$605	82%	$3,000	$526	68%	$3,080	–			$740	100%	$6,000
Pennsylvania (e)	$659	89%	$3,000	$442	60%	$3,200	$740	100%	$3,000	$740	100%	$6,000
Rhode Island	$731	87%	$3,000	$600	81%	$6,000	–			$740	100%	$6,000
South Carolina	$610	82%	$3,000	$225	30%	$6,000	$740	100%	$6,000	$740	100%	$6,000
South Dakota	$610	82%	$3,000	–			–			$740	100%	$6,000
Tennessee	$610	82%	$3,000	$200	27%	$3,000	–			$740	100%	$6,000
Texas	$610	82%	$3,000	–			–			$740	100%	$6,000
Utah	$622	84%	$3,000	$430	58%	$3,000	–			$740	100%	$6,000
Vermont	$728	98%	$3,000	$766	104%	$3,000	(e)			$740	100%	$6,000
Virginia*	$610	82%	$3,000	$308	42%	$3,000	–			$740	100%	$6,000
Washington	[illegible]	85%	$3,000	$575	78%	$3,000	–			$740	100%	$6,000
West Virginia	$610	82%	$3,000	$275	37%	$3,000	–			$740	100%	$6,000
Wisconsin	$776	105%	$3,000	$592	80%	$3,000	–			$740	100%	$6,000
Wyoming	$610	82%	$3,000	–			–			$740	100%	$6,000

Notes: * 209(b) states; these states may use more restrictive criteria than the SSI standard to determine Medicaid eligibility.

– Option not available in state

NA - Information was not available for Connecticut and Illinois. Illinois determines eligibility by using many different geographic areas. Connecticut determines eligibility using individual specific criteria.

(a) The federal poverty level for 1991 is $6,620 for an individual and $8,880 for a couple.

(b) The federal poverty level for individuals in Alaska is $8,250 and $7,610 for Hawaii. The federal poverty level for couples for Alaska is $11,110 and $10,210 for Hawaii.

(c) OBRA group covered under medically needy.

(d) Eligibility limits are the same for both OBRA 86 and Buy-in Only populations, therefore all buy-in eligible persons get full Medicaid benefits as well as Medicare buy-in benefits.

(e) These states maintain a separate OBRA 86 program for persons at a lower resource level and for Nebraska and Mississippi a lower income level. The Buy-In Only population is eligible for Medicare cost-sharing only and the OBRA 86 population receives both Medicare cost-sharing and full Medicaid benefits.

(f) In Oklahoma, if one spouse is ineligible the categorically needy monthly income limit is $674. If both are eligible the monthly income limit is $738.

Definitions

Categorically Needy
For the elderly and disabled populations, categorically needy persons are persons who receive Supplemental Security Income (SSI). The federal SSI income level is set at $6,620 for an individual in 1991, 74% of the federal poverty guideline, and $8,880 for a couple, 82% of the federal poverty guideline. All states, except 209(b) states, must offer Medicaid coverage to SSI recipients; some states automatically enroll SSI eligible persons and some states require separate applications. SSI beneficiaries are allowed resources of $2,000 or less for an individual and $3,000 or less for a couple, excluding a home, car, personal effects, life insurance policies and burial spaces.

Medically Needy
Persons not eligible for SSI might be eligible for Medicaid under the state optional medically needy program. Medically needy persons incur medical expenses sufficient to reduce their income below the medically needy level. This level may be no higher than 133% of the state Aid to Families with Dependent Children (AFDC) income level. The resource standard may be at any level, and allows the same exclusions as for the categorically needy.

OBRA 86
OBRA 86 gave states the option to offer full Medicaid coverage or buy-in assistance only to elderly and disabled persons with incomes up to 100% of the federal poverty level. All states that chose this option offered full Medicaid coverage. Fifteen states chose to offer coverage, including California and Vermont which already covered this population under their medically needy option. Michigan eliminated its program effective April 1, 1991. Under OBRA 86, the resource standards could be no greater than the medically needy or categorically needy standards.

Buy-in
The Medicare Catastrophic Coverage Act of 1988 and OBRA 90 mandated states to provide buy-in coverage for all elderly and Medicare eligible disabled persons with incomes up to 120% of the federal poverty level. Persons eligible for this coverage are called Qualified Medicare Beneficiaries, or QMBs. Persons who receive buy-in benefits only are known as buy-ins only or QMBs only. All categorically needy and other Medicaid eligibles beneficiaries who meet the buy-in criteria are bought into Medicare by Medicaid and get additional Medicaid benefits not covered by Medicare. This mandate was phased-in, with full implementation to be achieved in 1995. Beneficiaries with incomes up to 100% of poverty will be covered in 1991; up to 110% of poverty in 1992 and 1994; and up to 120% of poverty beginning in 1995. For persons with incomes over 100% of poverty, states are required to pay only the Medicare premiums. 209 (b) states had the option of following a slower implementation; Illinois, Indiana, North Carolina, and Ohio chose to follow this slower implementation. The resource standard for Buy-in's Only is twice the national SSI resource standard.

TECHNICAL APPENDIX

This technical appendix presents the steps completed in order to estimate a participation rate for Medicare Buy-ins (known as Qualified Medicare Beneficiaries -- QMBs) by state. Two participation rates were estimated -- one for all non-institutionalized elderly persons bought into the Medicare program and one for persons who are buy-ins only, meaning they are not receiving other Medicaid benefits. To calculate participation rates, the eligible population and the number of buy-ins had to be estimated.

In the participation rate for all non-institutionalized elderly persons bought into Medicare, the numerator includes all non-institutionalized elderly persons who meet certain income and asset criteria who were bought into the Medicare program, including those receiving other Medicaid benefits, and the denominator includes all non-institutionalized elderly persons who meet the income and asset criteria. For the participation rate for buy-ins only, the numerator includes all non-institutionalized elderly persons who meet certain income and asset criteria who were bought into the Medicare program and are not receiving other Medicaid benefits and the denominator includes all non-institutionalized elderly persons who meet the income and asset criteria and do not receive other Medicaid benefits.

I. ELIGIBLE POPULATION

The first task was to estimate the population meeting the income and asset criteria for the denominators of the participation rates discussed above. State-by-state estimates of the number of non-institutionalized elderly persons with income below the poverty guideline in 1991 were estimated using data from a pooled data base of four years of March Current Population Survey (CPS) data. These estimates differ from the Bureau of the Census estimates of the number of individuals in poverty for two reasons:

- The income thresholds used in these estimates were based on the poverty guidelines published in the February 20, 1991 Federal Register. The poverty guidelines are a simplified version of the Federal Government's statistical poverty thresholds used by the Bureau of the Census to prepare its statistical

estimates of the number of persons and families in poverty. The poverty income guidelines are issued by the Department of Health and Human Services to be used for administrative purposes, such as determining whether a person or family is financially eligible for assistance or services under a particular Federal program. Unlike the poverty threshold used for statistical purposes, the poverty guidelines are not age dependent. The poverty guidelines for 1991 are $6,620 for single persons ($8,290 in Alaska and $7,610 in Hawaii) and $8,880 for two person families ($11,110 in Alaska and $10,210 in Hawaii). In comparison, the poverty thresholds in 1991 are projected to be approximately $6,520 for a single person age 65 and over and $8,220 for a couple age 65 and over. Also, four of the 209(b) states use 95 percent of the poverty guideline rather than 100 percent. Therefore, for these states, Indiana, North Carolina, Ohio, and Illinois, we estimated the number of non-institutionalized elderly persons below 95 percent of the poverty guideline.

- The definition of income used for these estimates differs from that used by the Bureau of the Census when they define income as a percent of the poverty level. The Census Bureau includes the income of all members of a family in determining income as a percent of the poverty level. In calculating income as a percent of the poverty guideline for these estimates, only the income of the spouses of a married couple where at least one member is age 65 or older and only the income for single individuals for persons age 65 and over were used.

In addition to an income criteria, buy-ins must meet an asset criteria: countable assets less than $4,000 for single persons and less than $6,000 for married persons. Using a national estimate of the percent of single and married persons below the countable asset criteria from the 1984 SIPP (adjusted to 1991), we adjusted the population below the poverty guideline for each state.

II. MEDICARE BUY-INS

Estimates of Medicare buy-ins were provided for May 1991 by the Health Care Financing Administration (HCFA) Bureau of Data Management and Strategy (BDMS). These estimates included certain groups not captured in the eligible population estimates discussed above. In order to estimate an accurate participation rate, some of the groups needed to be excluded from the buy-in estimates. Two groups that needed to be taken out were elderly buy-ins who are institutionalized and persons under age 65 who qualify for Medicare on the basis of a disability and have income less than the poverty guideline. Data from fiscal year

1989 Medicaid 2082 forms, the latest complete information available, were used to adjust the estimates of the number of buy-ins as discussed below.[1]

A. Institutionalized

In order to exclude the institutionalized persons from the buy-in estimates, the percentage of elderly Medicaid beneficiaries who use care provided in an Intermediate Care Facility other than one for the Mentally Retarded (ICF other) was calculated for each state[2] and the percentage subtracted from the number of buy-ins. Elderly persons receiving care from ICF Other care, rather than ICF/MR or SNF services, were used to approximate the percentage of Medicaid buy-ins who were institutionalized because this category would be less likely to double count persons moving in and out of facilities.

All institutional categorical eligibles receiving cash assistance were subtracted from the buy-in estimates. Other institutionalized non-cash beneficiaries were subtracted in states that also bought in non-cash recipients. Percentages by state were used, rather than actual numbers because the Medicaid data are for 1989 and the estimates are based on persons receiving Medicaid during the course of the year, not at one point in time.

B. Disabled Non-Elderly

In order to exclude the disabled non-elderly who are bought in, a national estimate of the number of under 65 disabled who are Medicare and Medicaid eligible and have income less than the poverty guideline was required. We assumed that all disabled persons under age 65 receiving Medicare and Medicaid have income less than the poverty guideline by virtue of the work-related disability requirements tied to SSI. Based on an estimate from

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[1]Adjustments were not made to buy-in data for Arizona because the state did not report Medicaid data from the 2082 forms for Fiscal Year 1989.

[2]The numerator and denominator for the percentage differed dependent upon whether a state buys-in its non-cash recipients. If non-cash recipients are bought in they were included in the numerator and the denominator and a further adjustment described in a later section was also performed.

HCFA's Office of Research and Demonstrations (ORD) (Medicaid Source Book: Background Data and Analyses, November 1988, p.142), we assumed that 20 percent of Medicaid disabled beneficiaries are also eligible for Medicare. 1989 estimates of Medicaid disabled beneficiaries from the 2082 data by state were used, multiplied by 20 percent and then updated to 1991. These estimates were subtracted from the buy-in estimates.

C. Others

Other groups of concern were those who may be bought into the Medicare program but have income that is greater than 100 percent of the poverty guideline; persons who qualify for Medicaid on the basis of being Medically Needy or other spend-down provisions. Because the denominator for the estimates of the number of persons eligible included only those with 100 percent or less of the poverty guideline, we did not wish to include buy-ins with income over the poverty guideline. A difficulty was that we could not positively identify these persons.

Our first task in dealing with this "other" group was to identify states that buy-in their non-cash recipients. Table A presents information provided by the Division of Entitlement Requirements, The Medicaid Bureau of HCFA on which states choose to buy-in non-cash recipients.

Since it is not possible to know which non-cash Medicaid recipients have income less than the poverty guideline a range of participation rates was calculated with the minimum participation rate excluding all non-cash eligibles who spend down in states that buy-in theses groups and the maximum including them all. To "exclude" these two groups from the estimates of buy-ins, the percent of elderly non-institutionalized Medicaid recipients who receive payments on the basis of Medical Need and other non-cash eligibles who spend-down were calculated and subtracted from the buy-ins on a state-by-state basis.

In three states, Alaska, California, and Massachusetts, the percent of Medicaid recipients who receive cash assistance were also excluded from the estimates of the number of buy-ins because the SSI payments, with state supplementation, for singles and couples is greater than the poverty guideline. In California, all Medically Needy recipients were excluded from the estimates of buy-ins because the medically needy income limit in those states is above the poverty guideline for both singles and couples. (Vermont also has medically needy income limits above the poverty guideline, but does not buy in its medically needy recipients.)

III. BUY-INS ONLY

The data from BMDS provided estimates of the number of persons who are buy-ins only. The denominator for a participation rate for buy-ins only is the population under the poverty guideline less our estimates of the number of buy-ins who are not QMBs only (all buy-ins minus buy-ins only). These calculations are also presented as a range because of the treatment of the Medically Needy and other non-cash eligibles who spend-down. For these estimates, we did not adjust the buy-ins only data for the institutionalized and the disabled populations. We did not adjust for institutionalized persons because if a nursing home resident meets the income and asset criteria to be bought in, he or she would also likely be receiving Medicaid payments and therefore would not be a buy-in only. Not adjusting for possible disabled beneficiaries under the age of 65 in the buy-in only estimates somewhat overstates the participation rate (understates the percent eligible but not bought in).

TABLE A
CATEGORIES OF MEDICAID RECIPIENTS BOUGHT INTO THE MEDICARE PROGRAM BY STATE, 1991

	Cash Assistance Recipients Bought In	Non-Cash Assistance Bought In
Alabama[1]	X	
Alaska[1]	X[2]	X
Arizona[1]	X	X
Arkansas	X	X
California	X[2]	X[3]
Colorado[1]	X	X
Connecticut	X	
Delaware[1]	X	
District of Columbia	X	X
Florida	X	X
Georgia[1]	X	X
Hawaii	X	X
Idaho[1]	X	X
Illinois	X	
Indiana	X	X
Iowa	X	X
Kansas	X	X
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	X
Massachusetts	X[2]	
Michigan	X	X
Minnesota	X	

TABLE A
CATEGORIES OF MEDICAID RECIPIENTS BOUGHT INTO THE MEDICARE PROGRAM BY STATE, 1991

	Cash Assistance Recipients Bought In	Non-Cash Assistance Bought In
Mississippi[1]	X	X
Missouri	X	
Montana	X	X
Nebraska	X	
Nevada[1]	X	X
New Hampshire	X	
New Jersey	X	
New Mexico[1]	X	X
New York	X	
North Carolina	X	X
North Dakota	X	
Ohio	X	X
Oklahoma	X	
Oregon	X	X
Pennsylvania	X	
Rhode Island	X	X
South Carolina[1]	X	X
South Dakota[1]	X	
Tennessee	X	
Texas[1]	X	
Utah	X	X
Vermont	X	
Virginia	X	X
Washington	X	X
West Virginia	X	

TABLE A
CATEGORIES OF MEDICAID RECIPIENTS BOUGHT INTO THE MEDICARE PROGRAM BY STATE, 1991

	Cash Assistance Recipients Bought In	Non-Cash Assistance Bought In
Wisconsin	X	X
Wyoming[1]	X	

1. State does not allow spenddown for regular non-institutionalized Medicaid services, according to Edward Neuschler, Medicaid Eligibility for Frail Elders, Commonwealth Fund Commission on Elderly People Living Alone, April 1988.

2. Excluded from participation rate calculation because SSI payments with State supplementation are greater than 100 percent of the poverty guideline for singles and couples.

3. Excluded from participation rate calculation because Medically Needy income limit exceeds 100 percent of the poverty guideline for singles and couples.

SOURCES: Division of Entitlement Requirements, Medicaid Bureau, Health Care Financing Administration; and Edward Neuschler, Medicaid Eligibility for Frail Elders, Commonwealth Fund Commission on Elderly People Living Alone, April 1988.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Thank you for holding this morning's hearing, Mr. Chairman. Your continued leadership in addressing the health care needs of low income children and families, particularly those lacking health insurance benefits, is to be commended.

Mr. Chairman, we are going to examine three important topics today: the proposed reorganization of the Maternal and Child Health Block Grant, the Qualified Medicare Beneficiary program, and Medicaid provider taxes and donations. Each of these topics could fill an entire hearing. In fact, on Wednesday there was a Senate Aging Committee hearing devoted entirely to the QMB program. The subject of the MCH block grant has been discussed in Labor and Human Resources, and I suspect that there will be more hearings forthcoming on the subject of Medicaid provider taxes and donations after the Administration releases its regulation.

Be that as it may, Mr. Chairman, I am pleased that we have an opportunity this morning to examine, however briefly, each of these programs. As I hope everyone here today knows and if not, let me tell them the MCH Block Grant is a program upon which I place great value. The MCH Block Grant encompasses 10 extremely important programs, among them the crippled maternal and child research program, the childhood lead based paint poisoning prevention program, and the sudden infant death syndrome information and counseling program. Today, the MCH Block Grant resides in the Health Resources and Services Administration within the Public Health Service.

Mr. Chairman, the Administration has proposed transferring the MCH block grant from the public health service into the new Administration for Children and Families, a move that I do not support. Quite frankly, there seems little to be gained by such a transfer and much to be lost. The MCH Block Grant Program provides a broad base of health services through coordination with other public health programs administered by the Public Health Service. It simply does not belong in an agency that is largely comprised of income maintenance programs.

I have personally discussed my concerns with Secretary Sullivan and Jo Anne Barnhart, Assistant Secretary, under whose very capable leadership the new children's administration resides. In addition, Mr. Chairman, I have initiated a joint letter to the Secretary about this matter, which is being circulated for signature.

Several of our Finance Committee colleagues have already agreed to sign the letter, which I hope to send by the end of the day.

Mr. Chairman, as an alternative to the transfer of the MCH Block Grant, our letter proposes the establishment of any interagency committee chaired by the Surgeon General. This committee would be charged with the collaboration of child education, social services and health programs. This committee would provide a strong structure to develop policies preceding an reorganization efforts, and I hope the Secretary will give it serious consideration.

Mr. Chairman, with respect to the QMB program, it is extremely discouraging to sit here this morning and realize that despite five years of Congressional efforts to protect very poor Medicare beneficiaries from out-of-pocket medical expenses, more than half of those eligible for assistance are not receiving it.

I am discouraged on two fronts. First of all, this is a problem that many of us, under your leadership, Mr. Chairman, contacted Secretary Sullivan about two years ago. Many of the identical issues raised In the Families, USA report that will be discussed this morning were raised in our letter of June 27, 1989. I am disappointed that we have been forced to hold hearings to resolve what should have been fixed two years ago.

Second, OMB Director Darman has suggested that Medicare is unsustainable in its present form due to the rapid rate at which the costs of this program are expanding. There is no doubt in my mind that Medicare will be forced to undergo substantial changes throughout the next five to 10 years, changes which may well raise out-of-pocket spending for Medicare services. I cannot emphasize how difficult it will be in the future to make adjustments to the level of cost sharing associated with the Medicare program—both in Part A and Part B—if we cannot guarantee the public that low income beneficiaries will be protected from those changes.

Finally, Mr. Chairman, I would like to briefly comment on the subject of the Medicaid provider taxes and donations. The most legitimate form of provider tax and donation programs is the Florida tax on net hospital revenue. As former Governor Graham pointed out, the tax was designed to benefit a small number of hospitals burdened by a disproportionate share of poor by capturing a part of the paying business in non-disproportionate share hospitals.

This is a classic medical cost shift. Instead of raising hospital charges for paying patients in disproportionate share hospitals, the Florida plan taxes all paying patients in other hospitals to offset the burden of disproportionate share hospitals.

Medicaid tax and donation plans in state long term care programs, especially nursing homes, have exactly the same effect. They tax—voluntarily or involuntarily by institution—but always involuntarily with regard to patients. They tax those who can pay to pay for those who cannot. That's our classic USA medical cost shift.

Is it legitimate? Why not? We've been doing it in doctors' offices and hospitals and nursing homes for years.

Is it cost efficient? NO WAY!

Should any plan to expand access to every American with greater productivity and reduced costs use cost shifting? No. Not unless it is done explicitly.

PREPARED STATEMENT OF KEVIN LYN ERBE

Mr. Chairman and Members of the Subcommittee: I am pleased to be here this morning to discuss the Qualified Medicare Beneficiary (QMB) program. I welcome this opportunity to describe the Health Care Financing Administration's efforts to ensure that beneficiaries who qualify receive the financial assistance provided by the QMB program.

The Department of Health and Human Services is committed to making low-income Medicare beneficiaries aware of the QMB program and to improving their access to it. Both HCFA and the Social Security Administration (SSA) are implementing public information campaigns to increase awareness, and are exploring new ways to identify potential eligibles for follow-up by the States. The Administration on Aging (AoA) is also planning to provide information on the QMB program to State and Area Agencies on Aging for distribution to senior centers and service providers.

Secretary Sullivan is personally concerned about the notification and enrollment of these vulnerable citizens. In fact, he has requested that this issue be on the summer conference agenda of the National Governor's Association Human Resources Committee to encourage State outreach efforts.

Last week, the Secretary sent letters to all Members of Congress indicating his concern that eligible QMBs receive the Medicaid cost-sharing coverage to which

they are entitled. In the July 16 letter, he stated his intent to utilize fully the resources of the Department to promote awareness of this benefit.

These efforts demonstrate the Department's clear intent to spread the word further on assistance available to financially vulnerable Medicare beneficiaries.

BACKGROUND

Under the QMB program States pay the Medicare premium, coinsurance and deductibles for indigent Medicare beneficiaries. States were first required to "buy-in" to Medicare for low-income seniors and persons with disabilities on January 1, 1989 through legislation enacted in the Medicare Catastrophic Coverage Act of 1988. The provision mandated that States phase in assistance for Medicare eligible individuals with incomes up to 100 percent of the federal poverty level (FPL) by January 1, 1992. Subsequent legislation accelerated the phase-in by one year and added buy-in requirements for beneficiaries with incomes up to 110 percent of the FPL by 1993 and 120 percent of the FPL by 1995 for part B premiums only.

OUTREACH

Immediately following enactment, HCFA moved to implement the new buy-in program. In October 1988, HCFA sent a letter to all State Governors and Directors of State Medicaid programs alerting them to the new QMB benefit and outlining Federal and State responsibilities to implement it. A State Medicaid Manual issuance in December 1988 contained comprehensive policy and systems instructions for the States.

To help States notify potentially eligible beneficiaries, HCFA provided the States with magnetic tape files of the names and addresses of Social Security beneficiaries whose incomes would likely qualify them for the QMB program.

States conducted outreach to provide information and notify potentially qualified beneficiaries of the QMB benefit. Several States launched comprehensive campaigns. For example, the States of Texas, Florida and New Jersey made an all out effort to notify potential eligibles through press releases, direct mailings a review of their Medicaid caseload, and a toll-free telephone number for QMB information.

HCFA directly notified beneficiaries of the new QMB benefit by providing information in the 1989 *Medicare Handbook.* This handbook was mailed to all Medicare beneficiaries. Information on the QMB benefit has since been included in the 1990 updated issue of the *Medicare Handbook.*

In the summer of 1989, HCFA made a special mailing of a one-page notice to approximately 14 million Medicare beneficiaries identified by the Social Security Administration as potentially. eligible for the QMB benefit. The notices included State-specific locations and telephone numbers for further inquiry.

In preparation for this targeted mailing, the Social Security Administration sent an information package to its 1,300 district offices describing the benefit. The package included a series of questions and answers district office workers could use in responding to beneficiary inquiries.

A QMB inquiry unit in HCFA's central office responded to over 15,000 written and telephone inquiries in a period of just six months.

BENEFICIARY RESPONSE

These efforts have taught us that Qualified Medicare Beneficiaries are difficult to identify. Of the large number of beneficiaries who responded to the direct mailing, only a small percentage actually qualified for the program. Many met the income requirement but had too many other assets to qualify.

ENROLLMENT ISSUES

Beyond notification, other issues relate to enrolling QMBs. Beneficiaries must apply at their State Medicaid or public assistance office. Many attach a negative stigma to going to the "welfare" office. Some beneficiaries fear that having Medicaid pay for Medicare premiums and copayments will cause them to have to change their personal physician.

Because an application for Medicaid must be made, it will always be necessary for States to make the final eligibility determination. We must also keep in mind that funding is not available to support an alternative application process, which could be quite expensive.

ADDITIONAL OUTREACH EFFORTS

While these perceptions may deter some from applying, there are still others who, despite our efforts at notification, have failed to learn of the QMB program. We are evaluating where our previous outreach efforts could have been more effective. There may be characteristics about the eligible population we can identify that help us guide our future efforts. We know that beneficiaries have heard about the QMB benefit. We need to target our message and deliver it in a way that will "sink in" with those most likely to benefit.

Any information disseminated should be as specific as possible with regard to the eligibility requirements. This would reduce the number of inquiries from people who do not qualify for the program. States currently do not have the resources to cope with large numbers of applicants, many of whom will not qualify for the QMB program.

We also must consider the cost-effectiveness of the outreach method selected. In the current budgetary environment, dollars must be spent wisely. Mass promotions and broad public information campaigns have been tried before at great expense and with poor results. For example, the direct mailing to 14 million potential beneficiaries in 1989 cost over $2.0 million resulted in few additional enrollees. Even if funds were readily available, which they are not, we have no reason to believe another mailing would be more effective than the one in 1989.

While some may argue that the costs of outreach activities should not be a factor, the current pressure on both State and Federal budgets demands we pursue only those methods that have the greatest promise of generating results.

Last week, senior officials from HCFA, SSA and AoA met with over two dozen consumer groups and representatives from the National Governors' Association and the American Public Welfare Association. The purpose of the meeting was to share ideas on how the government and private sectors can join forces to ensure that qualified beneficiaries receive the assistance to which they are entitled. Advocacy groups and organizations in the field are an essential component to making the QMB program a reality for needy beneficiaries.

We plan to work with these groups and use their resources to distribute materials about the QMB benefit through the aging network. We will also target public service announcements in areas with the largest concentration of potential QMB eligibles; develop a fact sheet for distribution to senior centers; and, write articles for senior publications and for use by others, perhaps by members of Congress.

CONCLUSION

The Health Care Financing Administration has done a great deal to inform Medicare beneficiaries of the QMB program. We have done considerable outreach and continue to explore ways to identify this population. More efforts are needed. It is a complex problem.

The question before us now is how best to target the unenrolled, eligible population. We look forward to hearing your suggestions and comments.

PREPARED STATEMENT OF SENATOR BOB GRAHAM

Mr. Chairman. Thank you for convening this hearing on provider taxes and voluntary contributions, a very important issue for Florida, and for allowing me to testify.

In 1984 while I was Governor, Florida passed landmark legislation creating the Public Medical Assistance Trust Fund (PMATF) to provide health care to the state's neediest citizens, primarily through the medicaid program. The PMATF is funded through a 1.5 percent assessment on the net operating revenues of all hospitals and through general state revenues.

It was a compromise agreed to by the state legislature, the hospital and insurance industry, and the business community—a unique demonstration of how all segments of the community could come together to achieve a common goal. The program was implemented in 1985.

The State's assessment was created for several reasons: (1) to level the playing field, alleviating the situation in which a few hospitals finance a large portion of the state's indigent care, (2) to allow the state medicaid program to improve and expand its available services, (3) to provide the state with revenues for its medicaid match during continuing anti-tax public opinion, and (4) to respond to an Administration directive asking states to utilize innovative mechanisms for its state medicaid match.

Florida's hospital assessment is based on all public and private hospital revenues, is required regardless of whether the hospital participates in medicaid and regardless of the extent of medicaid participation, and is not included as an allowable cost in the medicaid cost report.

This year, Florida's tax will garner $174 million in revenues for the state match. Last year, Florida spent most of the $147 million in revenues from the assessment on keeping up with just the new federal mandates from Congress. $30 million in revenues from the tax are used for non-medicaid indigent care purposes. And about $20 million in the PMATF is not generated from the hospital tax.

Congress has prohibited regulations which limit the use of provider taxes and donations since 1988 and most recently in OBRA 1990. The 1990 law also precludes the Secretary from limiting federal-matching funds for any type of state taxes. As a safeguard, the statute excludes provider-specific taxes from a provider's cost base for purposes of Medicaid reimbursement.

This year, Senator Fowler has introduced legislation to allow voluntary contributions which do not amount to more than 10 percent of the state's medicaid match or the participating hospital's general revenues. I am an original cosponsor of the bill.

Mr. Chairman, I would like to comment on the Administration's position on provider taxes and voluntary contributions.

On July 19, I received a response from Secretary Sullivan to my query regarding the Administration's interpretation of the provider tax provision of OBRA 1990, which I introduced.

Secretary Sullivan in his letter to me said, "The Administration's concern is with the recent escalation in certain provider-specific donation and tax programs. . . We are considering several regulatory and legislative proposals to restrain the growth of such programs."

I can not accept the Administration narrowing the scope of provider taxes through the regulatory process, which would violate the 1990 law.

As a former Governor, I am concerned that this also encroaches upon states' rights to raise revenues as necessary to meet federal mandates and provide quality health care to a needy population.

In a July report, the Administration claimed that state provider taxes and donated fund programs accounted for a large amount of medicaid program growth in FY 1991. Clearly, the medicaid program and for that matter all public and private health care spending is experiencing extreme growth in costs.

Florida's tax, however, will account for 9.4 percent of the State match this year, compared to 17.3 percent four years ago and 12.8 percent two years ago. The Florida assessment is a flat rate, with an 8 percent increase per year from revenues coming in on the tax, compared to a 27 percent annual increase, over four years, due to medicaid program growth.

In its report, the Administration also found that provider taxes and contributions increase the federal matching rate. In the case of Florida, however, the across the board tax represents state revenues, and does not skew the federal matching rate. The assessment even includes psychiatric hospitals which, by law, do not receive medicaid reimbursement for inpatient care.

Mr. Chairman, Florida is the only state with a mandatory tax on all hospital providers. About 23 states use either provider taxes or donated fund programs to accrue the state medicaid match.

If the Administration eliminates the states' ability to use provider taxes and voluntary contributions the effect would be devastating.

States would have to curtail many important programs. The Administration, instead, should evaluate various state provider tax and contribution programs, and allow reasonable programs to continue. The Administration also needs to remember that provider taxes and contributions are not used for deleterious purposes; they are utilized for needy mothers, infants and children.

The maintenance of the PMATF is critical to financing several medicaid programs in the State; the Congressionally mandated expansion to 150 percent of poverty for pregnant women and infants, the mandated QMB program which Florida supplements with full medicaid coverage, and the optional Medically Needy program for non medicaid-eligible persons with catastrophic expenses.

The State might drop the optional services if the PMATF fund and its corresponding federal revenues were disallowed. I urge the Subcommittee on Health to carefully examine the nuances of the Administration's contentions and the realities of legitimate state provider tax and donation programs.

Attachment.

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC.

Hon. BOB GRAHAM,
U.S. Senate,
Washington, DC.

Dear Senator Graham: I am responding to your letter concerning recent reports in the *New York Times* and the *Washington Post* about the Administration's position on provider-specific taxes and Voluntary contributions.

The policy regarding the use of donations and provider-specific taxes for the State's share of financial participation in the Medicaid program has been the subject of considerable ongoing discussion and controversy. We have received numerous comments in response to the notice of proposed rulemaking published in the *Federal Register* on February 9, 1990. Moreover, the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) extends until December 31, 1991, the moratorium on issuing a final rule on the use of donations to fund a portion of the State's share of Medicaid. It also prevents the Health Care Financing Administration (HCFA) from applying such a rule to provider-specific taxes.

The Administration's concern is with the recent escalation in certain provider-specific donation and tax programs designed merely to capture more Federal dollars. We are considering several regulatory and legislative proposals to restrain the growth of such programs. Please be assured that we will be cognizant of the concerns of the States and others as we proceed.

I hope the above information is responsive to your needs. A similar letter is being sent to Senator Connie Mack who consigned your letter.

Sincerely,

LOUIS W. SULLIVAN, M.D.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Mr. Chairman, thank you for calling this hearing on a matter which is very important to all of us.

Mr. Chairman, I have consistently supported physician payment reform. The Iowa physician community did also. For us a lot is riding on it.

We supported physician payment reform because we thought it was a good idea on the merits. We also thought it was a very good idea for the State of Iowa because it was going to help us to recruit, and keep, primary care physicians of the kind we need in our rural communities across the State but have a hard time finding.

At the present time, 170 communities in Iowa are seeking more than 200 doctors. I am also hearing from Medicare beneficiaries in the eastern part of Iowa that they are having trouble finding physicians who will add them to their case loads. This seems to reflect increasing frustration with the Medicare program on the part of physicians.

Part of our problem lies in our low Medicare reimbursement levels. Of the 240 Medicare payment areas around the country, the eight in Iowa rank 196th and lower in reimbursement.

Iowa is also a State with a great many Medicare beneficiaries. So any physician who practices in Iowa is likely to be very dependent on the Medicare program.

We believed, with everyone else, that Medicare physician payment reform was going to re-allocate money toward primary care practitioners and was going to more equitably allocate Medicare reimbursement around the country as well.

This we thought would help us considerably in finding and keeping physicians for our smaller communities.

Unfortunately, it doesn't look like the recently published rule is going to help us at all. It is true that Iowa does relatively well compared to other states according to the averages released by HCFA.

However, in year five of the reform Iowa will be losing four percent in charges per service compared to current law and two percent in outlays.

It appears that the gains which will be made by Iowa physicians compared to current law will be so modest that they will really not change our overall situation very much.

From this Senator's perspective this is just not acceptable. I sincerely hope we can work with the health care financing administration to make this payment reform a success.

If physician payment reform is widely seen by physicians as being prevented from fulfilling the purposes for which we created it, the problems we are currently experiencing with Medicare are going to be seriously compounded.

PREPARED STATEMENT OF GWENDOLYN S. KING

Mr. Chairman and members of the subcommittee: I am happy to be here today to discuss public information and outreach activities regarding the Qualified Medicare Beneficiary (QMB) program.

Let me say at the outset that we are very concerned about reports that suggest many Medicare beneficiaries are not receiving the additional financial support to which they are entitled under the QMB program. SSA stands ready to help in any way we can within our funding and workload limitations.

CURRENT SSA EFFORTS

Currently, SSA staff in field offices are providing, as they have since the beginning of the QMB program in 1989, basic information to the public concerning eligibility requirements and benefits. SSA field offices refer any individual we believe could be eligible or who wishes to apply for the QMB program to the State public assistance offices.

SSA is also working to increase public awareness of the QMB program. The June 1991 edition of the *Courier*, a monthly newsletter in English and Spanish to nearly 15,000 advocacy and intergovernmental groups, featured a QMB cover article, which I would like to insert for the record at this time, and the July edition will contain a reproducible flyer on QMB for use by external organizations and advocacy groups.

Our July monthly information package to SSA's field offices contains several public information materials on QMB eligibility, and we will display posters in English and Spanish in our field offices. We also will make these posters available to other organizations such as the Administration on Aging and legal aid offices. We believe these public information vehicles will assist in reaching audiences of potential eligibles.

NEW INITIATIVES

We are seeking to enhance even further our public information on the QMB program. We are revising 12 of our current program pamphlets and leaflets to include QMB program information. In addition, we are providing our field offices with fact sheets on the QMB provisions that can be given to anyone who inquires about the program.

I should point out, however, that there is a statutory prohibition against use of trust fund resources for non-Social Security title II OASDI work such as QMB activity, which is a title XIX Medicaid activity. To deal with this limitation, SSA and the Health Care Financing Administration (HCFA) would have to establish a memorandum of understanding and reimbursable agreement for SSA to do any specialized non-Social Security work.

In addition to funding, the hardest issue for SSA regarding QMB-related work is how to avoid further deterioration in areas for which we have direct responsibility such as disability claims processing, where a rising tide of initial applications in the last year has caused disabled people to have to wait far longer for their claims to be processed than is acceptable.

CONCLUSION

Mr. Chairman, let me repeat my concern that each eligible individual receives the important benefits of the QMB program. No eligible low-income individual should pay unnecessarily for expenses that this program would cover. In addition to the activities I have described, the Social Security Administration stands ready to help, within our funding and workload limits, find better ways to identify those who are eligible for QMB program assistance.

PREPARED STATEMENT OF BRYAN B. MITCHELL

Good morning I am Bryan B. Mitchell, Principal Deputy Inspector General, Department of Health and Human Services.

With me is George Reeb, the Assistant Inspector General for Health Care Financing Audits. We welcome this opportunity to appear before you this morning to dis-

cuss some of the work the office of inspector general has done relative to Medicaid provider tax and donation programs that have been implemented by several States.

BACKGROUND

As intended by Congress at the inception of the Medicaid program, the Federal Government and the States share in the cost of providing medical care to Medicaid recipients. The Federal matching rates for States range from 50 to 83 percent, depending upon each State's relative per capita income.

In the past, States have used general tax revenues to finance their share of Medicaid expenditures. Recently, some States have begun using what we call creative financing techniques to meet their statutorily mandated Medicaid expenditures by implementing provider tax and donation programs. Under these programs, revenue is generated through increased taxes and donations and is used as the States' share of Medicaid expenditures to claim federal matching funds.

The majority of these provider tax and donation programs involve Medicaid payments made to hospitals servicing a disproportionate number of law-income people with special needs. Under current law, States are required to make additional Medicaid payments, over and above the usual fee for service payments, to these hospitals. The Secretary is prohibited from limiting the amount of these disproportionate share payments.

Some States, recognizing the opportunity this situation presents, have orchestrated their provider tax and donation programs to encourage providers to submit to taxes or make donations. The encouragement comes in the form of increased disproportionate share payments to the providers that are at least equal to and sometimes more than the taxes or donations received from the same providers. States then claim the increased disproportionate share payments for federal matching funds.

Let me give you a very real example of a State's provider donation program associated with disproportionate share hospitals. This State had a Medicaid hospital budget shortfall of $208 million. To eliminate this budget deficit, the State orchestrated a provider donation program under which:

1. Hospitals formed a non-profit corporation and borrowed $365 million from a bank.
2. The non-profit corporation donated the $365 million to the State.
3. The state increased the hospital's disproportionate share payments from a maximum of 2.5 percent of Medicaid reimbursement to over 53 percent. Using this play, the State returned the $365 million to the hospitals in the form of disproportionate share payments.
4. The State claimed the $365 million in disproportionate share payments for Federal matching and was reimbursed $208 million by the Federal Government.

This example demonstrates very clearly how through use of a carefully crafted provider donation program, a State can acquire federal funds to eliminate a State budget deficit.

The same thing can be accomplished through provider tax programs. One State proposed a tax program which was described by a July 15, 1991 Washington Post editorial as being quote "a shell game" unquote. The editorial noted that the program's only result was quote "that the feds were paying more of the same bill and the State less" unquote. And that is certainly true.

Under the tax program, the State increased fees to providers (other than hospitals) and then deducted the increase as a tax before making the provider payments. In other words, the providers were paid the same amount that they were paid prior to the tax program but the State planned to claim the total providers' fee, including the tax, for Federal matching. This scheme was designed so that the State not only did not pay anything as its share of the Medicaid cost, but actually made a profit on Medicaid claims.

The HCFA denied Federal participation in this tax program and the State is expected to appeal. The HCFA, however, was not

The only ones uncomfortable with this tax plan. One physician complained to the inspector general that the State quote "might have been committing fraudulent acts by reporting untrue amount of payments made to health care providers to the Federal Government in order to get much more Federal reimbursements than it actually pays to health providers . . . " unquote. An office manager for a group of physicians complained to her congressional representative about the State's efforts to use the tax to quote "inflate the Federal Government's spending on Medicaid" unquote.

The HCFA was concerned about the financial effect that proliferation of provider tax and donation programs was having on the Medicaid program. In 1989, there were less than 10 major provider tax and donation programs. In 1991, this number

is up to 32 and growing. The HCFA was concerned with this proliferation and requested that the Office of Inspector General perform a survey of States' actual and planned use of these programs.

WORK DONE BY THE OFFICE OF INSPECTOR GENERAL

Prior to making the request to the OIG, HCFA published on February 9, 1990 a notice of proposed rule making aimed at controlling provider tax and donation programs. In October 1990, we issued a survey report to HCFA in which we estimated that provider tax and donation programs would generate for the States about $497 million annually in Federal matching funds; consequently increasing Federal budget outlays by that amount. We recommended that HCFA proceed with its proposed rulemaking which was scheduled for completion after December 31, 1990. The Omnibus Budget Reconciliation Act of 1989 established this date as the date that the congressional moratorium prohibiting publication of the final regulations was to expire. The Omnibus Budget Reconciliation Act of 1990 extended this moratorium to December 31, 1991.

We continued to monitor the spread of provider tax and donation programs and, on May 10, 1991, we issued a second report to HCFA. We reported that, since our initial survey, the growth of provider tax and donation programs appeared to be spiraling further. In our May 1991 report, we identified 18 States that had provider programs and another 18 plus the District of Columbia that were contemplating their use. We estimated that the cost of these programs to the Federal Government was approximately $2.5 billion in fiscal year 1991, over five times the estimated cost of just 6 months previously.

We repeated our recommendation that HCFA expedite the processing of its regulation to curb provider donation programs. We also recommended that HCFA propose legislation to control provider tax programs.

OUR LATEST REPORT

We are issuing today to the HCFA our third report on this issue. We now estimate the cost of provider tax and donation programs to the Federal Government to be $3.8 billion, an increase of about 51 percent from May 1991. By the end of fiscal year 1993, we estimate that provider programs implemented by 30 States will cost the Federal Government about $12.1 billion. We believe that our estimate is conservative since many of the 30 States did not report costs for fiscal years 1992 and/or 1993. Nor does it take into account other States that may now be planning a provider tax or donation program.

Although the specifics of tax and donation programs differ among States, there are some commonalities among them. Medicaid recipients are generally unaffected, and continue to receive the same level and quality of care that they received providers are generally unaffected as well. The tax that they pay or the donation that they make is generally returned to them in the form of increased reimbursements, usually through disproportionate share payments. The State, however, is a winner in that they can reduce their share of Medicaid costs and force the Federal Government to pay significantly more.

SUMMARY

In summary, Mr. Chairman, we continue to believe that provider tax and donation programs must be brought under control to safeguard the Federal/State financial partnership in the Medicaid program and to avoid possible bankruptcy of the Medicaid program. One State health official summed up the lack of Federal constraints on these programs quite clearly when, in referring to the size of his State's provider program, stated quote "we chose the level of $35 million very carefully—we could have chosen $200 million to show how bizarre this could get—but that would raise the risk of prompting outrage" unquote.

In our opinion, therein lies the threat to the Medicaid program. The State official is correct. The State's profit and the Federal Government's loss could easily have been $200 million instead of the $35 million estimated in FY 1991. We continue to recommend that the congress and HCFA take action to bring these programs into proper balance.

PREPARED STATEMENT OF SENATOR WILLIAM V. ROTH, JR.

Mr. Chairman, I commend you for holding this hearing on three very important matters effecting Senior citizens and children.

I was tremendously pleased to see in March when Secretary Sullivan named Jo Anne Barnhart as the Assistant Secretary in charge of the new agency under the Department of Health and Human Services bringing together all child and family related programs under the same roof. The transfer of Maternal and Child Health Block Grant from the Public Health Service to the Administration on Children and Families is not a simple process, and much is being said both for and against this change. While some may have concerns that MCH will lose prominence in the Administration on Children and Families, I have full confidence in Assistant Secretary Barnhart's leadership as the Administration's advocate for children and families. I know she cares. In view of the consolidation, it is important to note it is not just the Federal Government that is moving towards better coordination of services for children and families, but many States have established new agencies to emphasize this focus.

In regards to the next matter on the Committee's agenda—the Qualified Medicare Beneficiaries—I opposed passage of Catastrophic and worked to repeal the bill, but I supported the provision establishing the Medicaid buy-in for Qualified Medicare Beneficiaries (QMBs). It is regrettable that today we find ourselves learning of the States and the Federal Government shirking the responsibility to let those eligible low-income Seniors know that they could find financial relief in enrolling in the QMB program. My office and I have tried to spread the word regarding this benefit since 1988. My staff has worked hard to inform potential QMB participants of their benefits. I sent out statewide mailings and posted information in Senior centers in attempt to help. Yet, even in my small State of Delaware, the QMB program falls far short of meeting its goals.

As for the third topic on the agenda, experts are indicating that the Medicaid program costs to the Federal Government are leaping upward because of "loopholes" in Federal authority. Under current conditions, the price of Medicaid is skyrocketing, largely due to the schemes employed by many States to acquire federal funds without spending any matching State outlays. Right now, there is no legislation—and there are no regulations—controlling the States' use of financing systems which, in my view, go beyond the bounds of the original mission of the Medicaid program. I am aware of the fiscal constraints facing many States, but in some cases, this manipulation of federal assistance appears to be abusive and almost fraudulent.

I look forward to today's testimony. Again, Mr. Chairman I commend you for holding this hearing.

PREPARED STATEMENT OF RAYMOND C. SCHEPPACH

Good morning, Mr. Chairman and members of the committee. I appreciate the opportunity to appear before the committee today on behalf of the nation's Governors on a very important issue—the urgent need to protect the authority of states to raise the revenue necessary to pay Medicaid program costs using donated funds, provider-based taxes, or other revenue sources. I will also address issues concerning Qualified Medicare Beneficiaries.

Since Medicaid's inception in 1965 as a federal-state program to provide health insurance to women and children eligible for Aid to Families with Dependent Children (AFDC), its responsibility has expanded to meet the health care needs of many diverse populations. As a result, by 1995, Medicaid will be larger than any other federal or private health insurance program. It will cover almost 27 million people—half of whom are children. It is becoming the safety-net health care program for all Americans.

As a result of these expansions, Medicaid expenditures have increased dramatically. In fiscal 1970, total Medicaid expenditures were only about $5 billion. They reached $26 billion in fiscal 1980 and $71 billion in fiscal 1990. By 1995, Medicaid spending is projected to reach $150 billion.

The impact of such growth on states is significant. Medicaid is now the fastest-growing portion of state budgets. In fiscal 1990, state spending on Medicaid increased 19 percent and is increasing by more than 25 percent this year.

The main reasons for the growing financial demands of the program include:

- Optional and mandated federal expansions that increase eligibility and services;
- State efforts to streamline administration, making participation in the program more attractive to providers and enrollees;
- The recession, which has resulted in an increased demand for public assistance; and
- A medical inflation rate that is double the rate of general inflation.

States have been able to keep pace with Medicaid's growth and swelling budgetary demands only because when establishing the program, the federal government—in cooperation with the states—fully recognized state authority to raise revenue. To support Medicaid as we know it today, states must retain the right to raise revenue through voluntary contributions and provider-based taxes for the following reasons:

First, states have the constitutional right to raise revenue without federal restriction. This right was recognized in statute and regulation when Medicaid was established in 1965 and subsequently reaffirmed in regulation and by acts of Congress. Legislative history indicates that Congress expressly and purposely gave states the right to finance their share of Medicaid costs through any type of tax and allowed states to use donated funds as part of their share of Medicaid spending.

Second, the use of donated funds and provider-based taxes has enabled states to further federal policy and to achieve the historic purpose of the Medicaid program. States use the funds to increase payment to hospitals that serve a disproportionate number of poor patients, expand access to pregnant women and children, and conduct outreach efforts. All are priority initiatives expressly encouraged, and in some cases mandated by Congress, and eligible for federal matching funds as long as the state provides funds to meet the federal match. Particularly in a time of economic distress, states should be encouraged to pursue financing strategies to help meet the shared federal-state commitment to the nation's poor.

Third, in view of the states' reliance on federal regulations permitting the use of donated funds and provider-based taxes when implementing programs, it is unfair to change the rules that determine what is acceptable for a federal match. If the federal government denies or restricts the states' authority to use donated funds or provider-based taxes, a number of successful health care programs will not have the funds to continue.

Here are some examples of such programs:

- The Alabama Mothers and Babies Trust Fund. Created in 1987, the Trust Fund uses donations to fund hospital disproportionate share adjustments for indigent care. It increases coverage for adult inpatient days from 12 to 14 days per year, and it removes limits on extended hospitalization for diagnosis and treatment of newborn infants. Restriction of state funding sources could necessitate program reductions injuring pregnant women, children, the elderly, and persons with disabilities.
- The Hill Hospital in York, Alabama. This small hospital serves primarily poor people in an economically distressed area of the state. No one is turned away due to inability to pay, and a large majority of the patients have no health insurance. Hill Hospital has been able to operate through local taxes and disproportionate share Medicaid payments. The expected new regulation on the use of donated funds would cripple Hill Hospital and possibly require it to close. It is the only hospital in Sumpter County.
- Our Lady of the Way Hospital. A small rural health care facility in Kentucky, this hospital specializes in obstetrical services. Twenty percent of their total inpatient services and more than 72 percent of delivery room charges are attributable to Medicaid patients. The hospital is already faced with an average loss of $178.35 per day for Medicaid patients. With increased loss from Medicaid as proposed by expected Health Care Financing Administration (HCFA) regulations, the hospital's survival is questionable.
- Vanderbilt University Medicaid Center. This center is the largest non-public provider of Medicaid services in Tennessee. It is the region's designated Level I burn center, and the Level III perinatal center. It provides high risk obstetrical care for the region and operates the only tertiary pediatric facility in the region. Many of its programs are possible only because of voluntary contributions. Because it provides a significant amount of uncompensated care, it has been designated as a disproportionate share provider for purposes of Medicare and Medicaid reimbursement. Without the options of provider specific taxes or voluntary contributions, there is no doubt that this successful program will be forced to reduce benefits and services.
- Maryland's Kidney Dialysis Program. Maryland provides coverage to 3,000 low-income people with end-state renal disease. The program pays for kidney dialysis, Medicare deductibles and coinsurance, prescription drugs, and supplies related to kidney disease. Low-income kidney transplant patients can rely on the program to cover the cost of expensive drugs needed to prevent organ rejection. If Maryland's provider-based tax program terminated, the state will have no choice but to cut this vital program.

These programs are consistent with congressional intent and represent the gains made in providing care to pregnant women and children and long-term care to the elderly and disabled.

The Office of Management and Budget (OMB), however, takes the position that because the Medicaid budget is increasing, the use of donated funds should no longer be permitted and provider-based taxes should be severely restricted. The basis of their arguments for eliminating the use of such funds is questionable.

First, OMB contends that donated funds and provider-specific taxes are directly responsible for unanticipated increases in Medicaid expenditures. This contention is dubious. Medicaid has experienced substantial cost increases in all states regardless of whether they use provider taxes or donated funds. The cost of expansions in both services and populations as well as the effects of downturns in the national economy that resulted in increased demand for Medicaid assistance are more likely reasons for unanticipated Medicaid expenditures.

Second, OMB contends that states' use of donations and provider taxes could change their match rate and eventually turn Medicaid into a program financed fully by the federal government. This is simply not true. The states continue to meet their obligation to raise general revenue funds to match federal dollars. Since Medicaid's inception, states have had the authority to use all sources of state-generated revenues, including voluntary contributions, to support the provision of medical care to the poor. This was a practice accepted without objection until Medicaid costs began to escalate rapidly. States use these funds to supplement—not supplant—state spending.

Third, the Administration contends that provider taxes are acceptable only if applied to all health care providers of a particular service. This is a clear violation of state authority. It is the states' constitutional right to determine state taxing policy.

Fourth, the Administration contends that denying states the use of donated funds and provider-taxes is necessary to bring Medicaid program costs under control. Again, this is a dubious contention. In fiscal 1992, only five percent of state Medicaid spending came from donated funds or provider taxes. If states are denied federal match dollars for donations and specific taxes they will have to cut Medicaid services and benefits.

The Governors are not alone in maintaining that the states have the right to raise revenue through voluntary donations and provider-based taxes. A diverse coalition consisting of state organizations, children and elderly advocacy groups, health care providers, and organizations representing business and labor have joined the Governors on this issue.

With the Chairman's permission, I would submit a letter signed by members of this coalition to be inserted into the hearing record. Signers of the letter include the National Conference of State Legislatures, American Hospital Association, National Association of Public Hospitals, Children's Defense Fund, National Association of Manufacturers, Families United for Senior Action, U.S. Chamber of Commerce, and the AFL-CIO.

It is our understanding that the Administration plans to issue interim final regulations that would severely restrict the use of provider taxes immediately and ban the use of donated funds. These regulations are expected to be released on the day before Congress adjourns for August recess. If Congress allows the Administration to restrict the states' use of donated funds and provider-specific taxes to operate their Medicaid programs, the result would deny billions of dollars to a program that is virtually the only source of health coverage for the neediest of our citizens.

Medicaid's budgetary problems are a symptom of a much larger problem that requires a comprehensive solution. Until the nation address the problems inherent throughout our health care system such as skyrocketing health care inflation and gaps in our system that leave an estimated 34.4 million people uninsured each year, Medicaid's role as the payor of last resort will continue to grow. In the absence of a consensus on how to reform the entire system, no change in federal policy that limits the states' ability to meet the demands placed on Medicaid should be tolerated. The program was built on one set of rules and the rules must not be changed. The most vulnerable populations should not suffer because we do not have a solution to the larger question of health care reform.

We need your support to stop regulations that attempt to lower federal Medicaid spending by forcing states to undertake severe program cuts.

Before concluding my remarks, I will briefly address concerns about using Medicaid resources to pay cost sharing for low-income Medicare beneficiaries.

States share the committee's concern that enrollment rates by Qualified Medicare Beneficiaries (QMBs) is lower than anticipated. When Congress enacted legislation in 1988 and 1990 to require Medicaid payment for Medicare cost sharing for certain

low-income Medicare beneficiaries, states conducted outreach efforts to reach potential eligibles through public service announcements, press releases, and targeted mailings. Yet enrollment rates remained low.

The QMB enrollment problems exemplify the concerns the Governors had when Congress initially proposed to extend Medicaid payment for low-income Medicare beneficiaries.

First, the Governors continue to strongly believe that it makes more sense for Medicare to pay cost sharing for those low-income seniors not otherwise eligible for Medicaid. Medicare is a federal program designed to protect the elderly regardless of their income and it is better situated to ensure seniors get needed assistance.

Second, the Governors believe that the Social Security Administration and Medicare should be responsible for determining eligibility for the Medicaid subsidy. Low-income senior QMB eligibles are Medicare beneficiaries, not Medicaid beneficiaries. Medicaid simply pays the cost-sharing for those determined eligible.

Based on previous state efforts at outreach, we recognize the difficulties targeting information to those likely to be eligible. We believe that in the absence of Medicare reform that provides assistance to low-income elderly to pay cost-sharing, the Social Security Administration should be responsible for conducting outreach and determining eligibility. We stand ready to assist the federal government in designing effective outreach strategies.

Thank you for the opportunity to present the Governors' views on these important Medicaid issues. I am happy to answer any questions.

July 26, 1991

Dear Member of Congress:

We, the undersigned organizations, strongly urge you to protect the authority of states to raise the revenue necessary to pay Medicaid program costs.

Since Medicaid's inception in 1965, as a federal-state program to assist poor families to obtain health care, it has become larger than any other federal or private health insurance program. Today, it serves almost 27 million people -- half of whom are children. Medicaid pays for a broad array of services ranging from prenatal and well-child care for pregnant women and children, through long-term care for persons who are elderly or disabled. The number of people Medicaid serves is projected to increase by 25 percent between 1989 and 1995. As a result, Medicaid spending reached almost $71 billion in fiscal 1990, and is projected to reach $150 billion by 1995.

Medicaid is now the fastest growing portion of state budgets. In fiscal 1990, state spending on Medicaid increased 19 percent and is increasing by more than 25 percent this year. The growing financial demands of the program result from federal expansions, uncontrolled health care inflation, and the effects of the national economic recession.

To finance the increasing costs that accompany this growth, it is essential that states maintain maximum flexibility to raise the funds to meet their share of federal matching requirements. This is particularly true now, as states struggle with hardships of economic downturns and increased demand for public assistance.

In a time of fiscal constraints and Medicaid expansions, it is critical that states retain the right to raise revenue through voluntary contributions and provider-based taxes -- permitted since the program began and codified in federal regulation in 1985 and by acts of Congress -- to meet the shared federal-state commitment to the nation's poor. Federal limits on state revenue-raising authority could force states to reduce existing Medicaid eligibility and service levels for millions of low-income individuals and families.

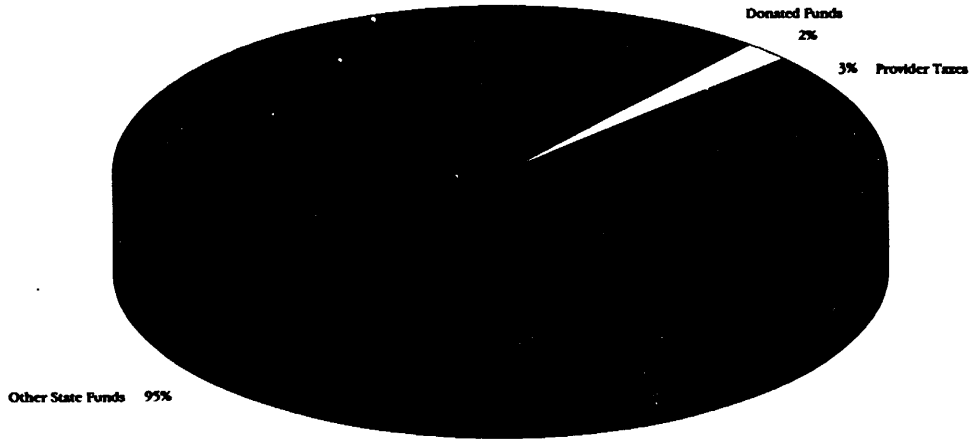
Please join us in supporting state flexibility to finance Medicaid.

Sincerely,

American Academy of Pediatrics
American Association of University Affiliated Programs for Persons with Developmental Disabilities
AFL-CIO
AFL-CIO Public Employee Department
American Federation of State, County, and Municipal Employees
American Group Practice Association
American Hospital Association
American Nurses Association
American Osteopathic Hospital Association
American Public Health Association
American Public Welfare Association
Association for Retarded Citizens
Association of American Medical Colleges
Association of Maternal and Child Health Programs
Association of State and Territorial Health Officials
Child Welfare League of America
Children's Defense Fund
Families United for Senior Action
Gray Panthers
Health Insurance Association of America
International Union, UAW
March of Dimes Birth Defects Foundation
National Association of Children's Hospitals and Related Institutions
National Association of Community Health Centers
National Association of Counties
National Association of Home Care
National Association of Manufacturers
National Association of Public Hospitals
National Association of Rehabilitation Facilities
National Association of State Budget Officers
National Association of State Units on Aging
National Conference of State Legislatures
National Council of Community Hospitals
National Council of Senior Citizens
National Governors' Association
National League of Cities
National Perinatal Association
Service Employees International Union
Southern Regional Project on Infant Mortality
U.S. Catholic Conference
U.S. Conference of Mayors
U.S. Chamber of Commerce

cc: John H. Sununu, Chief of Staff to the President
Richard G. Darman, Director, Office of Management and Budget
Louis W. Sullivan, M.D., Secretary of Health and Human Services

Provider Taxes & Donated Funds as a Percent of State Medicaid Funding FY92

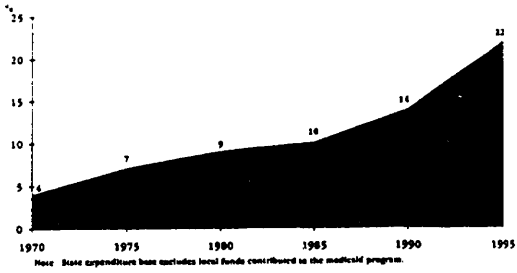


FY92 State Medicaid Spending $48.5 billion

FY92 proposed & implemented donated funds $1.1 billion and provider taxes $1.4 billion, totalling $2.5 billion

Information compiled by the National Association of State Budget Officers with information from the American Public Welfare Association & the Health Care Financing Administration, June 13, 1991.

Figure 1
Medicaid Spending as a Percent of State Budgets



Note: State expenditure base includes local funds contributed to the medicaid program.

Figure 2
State Medicaid Spending
($ in billions)

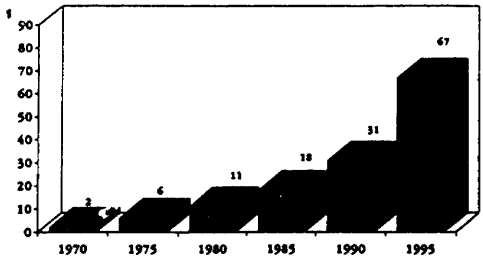
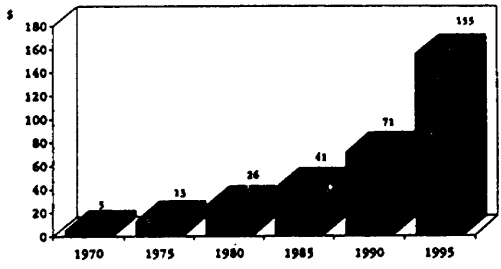


Figure 3
Total Medicaid Spending
($ in billions)



PREPARED STATEMENT OF REED TUCKSON

Mr. Chairman and Members of the Committee: On behalf of the March of Dimes Birth Defects Foundation, we want to thank you for this opportunity to appear before this committee. The March of Dimes mission is the prevention of birth defects and infant mortality through research, education, advocacy, and community services. For over 50 years, we have dedicated our resources to improving the health of America's mothers and children.

In the interest of time, we will briefly summarize our testimony today. However, we would like to submit a complete written statement for the record.

We commend you, Mr. Chairman, for holding this hearing today to focus attention on key administrative issues of importance to improving the health of pregnant women and infants. Medicaid, the nation's largest publicly financed health program serving women and children, and the Title V Maternal and Child Health (MCH) Block Grant have been key to ensuring access to health care for women and children and rightfully have been central to our national infant mortality reduction strategy. For example, recent expansions have made approximately one million pregnant women eligible for Medicaid, and in some states as much as half of all births were paid for by Medicaid last year. Recent improvements in the Title V program have complemented Medicaid expansions by making providers available to Medicaid recipients and other medically indigent pregnant women and children. However, even with these recent expansions, hundreds of thousands of eligible pregnant women and children have not received Medicaid benefits.

The nation cannot afford, economically or morally, to neglect the health care needs of mothers and babies. I'm sure that the members of the committee are as pained as I am about the tragedy of infant mortality. As you are well aware:

- Each night, in this country, 100 women cry themselves to sleep over the loss of their babies who died that day.[1]
- Each year, nearly 40,000 infants die before their first birthday. Yet one-quarter of these deaths could be prevented with the knowledge and technology now available.[2]
- Our infant mortality rate places us in a tie for last place among our industrialized peers and ranks us 19th worldwide on infant survival.[3]
- Birth defects contribute to one out of every five infant deaths.[4] Many conditions leading to birth defects could be detected and treated through timely, comprehensive prenatal care, saving this country hundreds of millions of dollars in health care costs.
- Each infant death takes both a human and fiscal toll. The estimated cost to the nation in lost productivity is $380,000 per infant death.[5]

Many factors contribute to our nation's excess number of infant deaths. Among the most important is limited access to prenatal care. In a landmark report on prenatal care, the Institute of Medicine reported that financial barriers were the most important obstacles faced by women who received insufficient prenatal care.[6] Financial barriers, combined with non-financial barriers such as insufficient numbers of providers and lack of governmental leadership, mean that prenatal care use is low in the United States.

- The nation made no progress in improving early prenatal care use between 1979 and 1988. One-quarter of all pregnant women receive no prenatal care in the critical first three months of pregnancy.
- Each year, approximately 70,000 babies of all colors are born without benefit of any prenatal visits—this means that their mothers did not see a health provider before they arrived at the hospital to give birth.[7]

Program expansions have been enacted by Congress and the state to reduce these financial barriers to maternity care and early evidence suggests that Medicaid reforms have had a positive effect on reducing financial barriers and improving prenatal care access.

- The U.S. General Accounting Office found that between two-thirds and three-quarters of targeted pregnant women enrolled were in Medicaid within two years of expansions.[8]

Recent reforms in Medicaid and the MCH Services Block Grant aimed at pregnant women and infants are an investment in the health of our children. The nation can save $3 for every $1 spent on prenatal care for low income pregnant women by improving the health of their infants and reducing high cost neonatal care. However, an initial investment of resources is required for such a return.

I. ENSURING AN EFFECTIVE ADMINISTRATIVE STRUCTURE TO SUPPORT THE TITLE V MCH SERVICES BLOCK GRANT

In April 1991, the Secretary of Health and Human Services, Dr. Louis Sullivan, announced the formation of a new Administration for Children and Families. This administration combines the programs of: the Family Support Administration (including Aid to Families with Dependent Children—AFDC, JOBS, child care, Low Income Housing Energy Assistance and child support programs); the Office of Human Development Services (including Head Start, Child Welfare, Child Abuse and Youth, Social Services Block Grant but not the Office of the Administration on Aging); and the Title V MCH Services Block Grant. While the March of Dimes and other members of the Maternal and Child Health Coalition support the goals of this reorganization, we oppose the transfer of the Title V program to this new administration (See attached letter, Appendix B).

The Administration is proposing to move only the Block Grant program to the Administration for Children and Families. The Maternal and Child Health Bureau, along with several categorical maternal and child health programs (including the Healthy Start initiative) will remain within the HRSA in the Public Health Service. A move of this nature would prove to have detrimental effects on maternal and child health care programs throughout the country.

Since 1935, the programs structured under Title V of the Social Security Act have been the core of maternal and child health activities in the United States. Over the years, Title V programs have ensured the availability of health providers for prenatal care, public health nurses to give immunizations, physicians to deliver specialized services to children with chronic illnesses or disabilities, and professionals to provide genetic counseling to families. Title V has been the anchor for innovative efforts to combat infant mortality, train professionals, and develop more family-centered care.

Every state and territory has a maternal and child health unit within its health department, and states have traditionally been required to match Title V funds. States often use the bulk of their allocations to support local health department services.

In addition, throughout the history of the program, certain maternal and child health activities, particularly those which are most effectively administered through a central office, have been conducted through a federal agency. Currently the Bureau of Maternal and Child Health, within the Health Services and Resources Administration (U.S. Public Health Service, Department of Health and Human Services) serves as that central federal agency. Through the Bureau, annual budgets are prepared and funds are allocated. In addition, smaller grant programs such as those for training maternal and child health professionals or for funding Special Projects of Regional and National Significance (SPRANS) are managed by the Bureau.

During the 1980s, the Title V program underwent two dramatic changes. In 1981, 10 programs (see Appendix A) were combined into a block grant program with at least 85% of federal appropriations to be allocated to states and the remaining 15% of funds to be retained at the federal level. In 1989, the Title V statute was substantially revised to add new accountability requirements for states and to clarify the program's role in assuring maternal and child health services and reaching the nation's health goals for the year 2000. The 1989 amendments also added a second federal set aside for innovative projects such as: rural maternal and child health; home visiting; one-stop shopping; and perinatal projects in community hospitals. Because implementation of the 1989 amendments has just begun this year, any change now would disrupt and negate this innovative work for possibly several more years.

The current MCH Services Block Grant program provides prenatal care for nearly one-half million pregnant women and primary and specialized care to millions of children. In addition to funding clinical services, states' MCH programs set standards for care, develop state maternal and child health plans, coordinate Medicaid and other activities, and monitor progress.

Given the nature and purposes of the Title V program, major concerns have been raised about the proposal to move the MCH Services Block Grant into the newly formed Administration on Children and Families. These concerns can be grouped into three areas, including:

1. The nation's three priority programs aimed at reducing infant mortality currently are located in the Health Resources and Services Administration (HRSA). With the creation of the Healthy Start targeted infant mortality initiative and the infant mortality reduction activities undertaken through the Community Health Centers' Comprehensive Perinatal Care Programs, the importance of HRSA in co-

ordinating and integrating these efforts should not be underestimated. Interactions and systems at the federal, regional, state, and local level all would be directly affected. Without a unified vision and close coordination, the nation cannot hope to achieve its infant mortality reduction goals.

2. The federal and state activities of the program must remain unified to be effective. The MCH Services Block Grant must have an administrative office at the federal level. The role of the Bureau of Maternal and Child Health includes more than the administration of special grant programs. The Bureau has an equally important role to play in providing technical assistance and guidance to states, as well as planning and development activities for the entire program. This technical assistance is a vital component of the federal-state relationship which gives programs the capacity to provide essential health care services to populations that otherwise have no access to care. The expertise and experience of professionals in the Public Health Service is important to fulfilling this role. Moreover, a unified program may be best located in the Public Health Service given that Title V programs typically are located in state health agencies—not state welfare agencies.

3. Moving one relatively small health program does not achieve balance within the Administration for Children and Families. The March of Dimes and many other organizations concerned with the health of mothers and children agree with the goal of improving coordination and integration of programs to meet a range of family needs. For years, these organizations have advocated for creation of an agency with the breadth and mission of the original Children's Bureau. However, placement of one relatively small health program in the midst of an agency with several large welfare and social services agencies would not be likely to accomplish this goal. In addition, since the Title V program resources would represent less than 3% of the total budget of the Administration for Children and Families, the program would never be in a position to compete for attention and resources within the new administration.

II. THE ROLE OF VOLUNTARY CONTRIBUTIONS IN IMPROVING MEDICAID

The March of Dimes is extremely concerned that Medicaid programs for pregnant women and children be adequately funded and administered. Well-functioning Medicaid programs are especially important since an estimated two-thirds of Medicaid beneficiaries are women and children.[10] Our mission—to prevent birth defects and infant mortality—can be achieved only if there is an ongoing commitment of effort to improve access to maternity and infant health care. To that end, March of Dimes chapters have supported Medicaid expansion by encouraging corporate support for infant mortality initiatives and by making voluntary contributions to Medicaid programs in several states. We believe that public-private partnerships are essential to success. As a voluntary health organization, the March of Dimes has supported a variety of proposals by the Bush Administration to encourage the use of charitable contributions in solving complex national problems through our 134 chapters and millions of volunteers.

The Administration has now proposed regulations designed to deny states the use of voluntary contributions and donated funds as "countable" revenues for purposes of federal financial contributions in Medicaid. Sixteen organizations that we work closely with are also very concerned about the health of mothers and children (See attached letter, Appendix C) and oppose the administration's position because it would reduce access to care for these vulnerable populations. We believe that the Administration's position regarding voluntary contributions to Medicaid does not give due consideration to several key factors.

1. State Medicaid programs have sought additional revenues to provide services to which low income pregnant women and children were entitled. In other words, the money was spent according to federal law for needed care. When Medicaid eligibility and benefits were expanded it was clear that new revenues would be needed. Many states have made preventive maternal and child health services a priority. Now the Administration seeks to limit care for low income pregnant women and children indirectly by denying states federal matching funds for entitlement services. Don't the Administration and Congress instead want to continue to encourage preventive investment?

2. States have sought to reduce barriers to enrollment. Not only have recent reforms expanded eligibility and benefits, they also have reduced administrative barriers to programs enrollment. This means that more families are able to complete the application process and receive Medicaid financed care. In Florida, the March of Dimes has contributed funds to ensure the ongoing availability of outreach programs for pregnant women. In several states, such as Alabama and Utah, increased

demand for services generated by award winning, new prenatal outreach programs has required use of non-governmental revenue sources to pay for services. And in Missouri, donated funds have been used to expand Medicaid for important services such as perinatal case management. Some of these states stand to lose hundreds of millions of federal dollars if the use of donated funds if prohibited. This translates into higher infant mortality rates and increased economic hardships on the people who need it most.

In other states, such as Texas, voluntary contributions have been used to locate eligibility workers outside of welfare offices, in hospitals and clinics (commonly known as "outstationing"). States are required by federal law to outstation eligibility workers in Federally Qualified Health Centers and in hospitals serving a disproportionate share for medically indigent and Medicaid patients. In most cases, the salaries for such workers currently are paid under "shared cost arrangements"— with the health facility paying the states' share of the cost of the worker's salary. These important arrangements create "one-stop shopping", locations for families with Medicaid-eligible pregnant women and children—a coordinated, cost-efficient management approach that the Administration and Congress are trying to promote. The question is how do we continue to improve the efficiency of the health care delivery system through innovation, not how do we stifle it.

3. There is an inadequate supply of providers to deliver prenatal services to Medicaid-covered pregnant women. As the pool of obstetrical providers has grown smaller, fewer providers are available to serve pregnant women on Medicaid. Additional revenues have been used to encourage provider participation. For example, Georgia has used voluntary contributions to create incentives for providers to serve Medicaid-covered pregnant women early (in the first three months of pregnancy). It should be noted that many of the states now using special revenue mechanisms are southern or rural states, where provider shortages often are most severe, where the states have the least amount of money for health care services and where many minorities reside.

4. In many states, provider payments had been insufficient to meet federal requirements and attract providers to Medicaid. States' obligations have recently been clarified by Congress or by the courts. Federal law now requires that Medicaid payment levels be sufficient to attract a supply of providers equivalent to that in the community-at-large. Moreover, a provision known as the "Boren Amendment" requires adequate payments for hospitals. several states have improved provider reimbursement levels with voluntary contributions or donated funds in a good faith attempt to respond to Congressional and Administration pressures. The question now is whether federal level policymakers are seriously committed to the goal of attracting more providers to the Medicaid program.

5. States have used additional revenues to enhance prenatal care services. To be successful and cost-effective, prenatal care must be of a minimum frequency and content. Over 20 states have used the option to enhance prenatal benefits. In Georgia, for example, voluntary contributions have been used to extend home visits, childbirth and parenting classes, and case management services to high risk pregnant women. Given the cost savings to be achieved through early and comprehensive prenatal care, can we really afford not to provide these services by any reasonable means?

There also are strong legal arguments for protecting states' rights to raise revenues through voluntary contributions, as well as through provider taxes. From its inception in 1965, the federal Medicaid statute assumed that funds other than states' general revenues—such as county and city revenues or local charitable contributions—would be used to finance Medicaid. Section 1902(a)(2) of Title XIX provides "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.* In addition, federal law specifies that federal financial participation be determined on the "total sum expended" (Section 1903(a)(1)), rather than some net amount from which certain revenues have been subtracted.

This month, the Office of Management and Budget (OMB) and Department of Health and Human Services (DHHS) released a report on *Better Management for Better Medicaid Estimates.* This report emphasizes the role of voluntary contributions and provider-specific taxes in the unanticipated increases in Medicaid costs. However, even by the Administration's own account, these revenue sources are only one of the numerous reasons for costs that exceeded states' estimates (provider payment increase following "Boren Amendment" type court decisions and dramatic cost inflation also were cited). In addition, the role of economic downturns in states was not well explained. For example, the Administration for Children and Families

has estimated that between July 1989 and April 1991 the number for AFDC cases rose by 18% nationwide and by more than one-quarter in 18 states.

The report does, however, reveal important weaknesses in the current federal administrative structure for Medicaid. We agree that the Health Care Financing Administration needs to expand its capabilities and assume a leadership role in relation to its responsibilities. The OMB/DHHS report found that lack of sufficient qualified staff, inadequate knowledge of and familiarity with state plans, and poorly designed data collection systems leave HCFA in a poor position to make federal estimates or to assist with state estimates. These limitations also affect efforts to provide guidance and leadership in the implementation of Medicaid reforms.

The key point is that states need and have a right to flexibility in raising revenues to cover the cost of Medicaid expansions. At a time of severe budget constraints, when they are faced with declining revenues and increased demand for public assistance, states have used voluntary contributions and provider taxes to generate additional revenues for essential services to which pregnant women and children are entitled under federal law. If Congress permits the Administration to take away states' ability to use voluntary contributions and provider taxes—while leaving them with no financing alternative and no proposal for comprehensive health care reform—it will be the very poor who will suffer, the pregnant women and children whom Congress has sought to protect in recent years through enactment of critically needed Medicaid expansions. Undoubtedly, the progress we are beginning to make in reducing our country's infant mortality rate will be impeded if not reversed.

Until the nation makes a commitment to reform of the entire health care system and make health insurance available to all Americans, Medicaid must function well to fill the gaps. Among other things, the Pepper Commission and the National Commission on Children found that the urgent and immediate need for health care coverage among pregnant women and children should be a national priority. Policymakers should not now pull back from their commitment to provide basic coverage to low income pregnant women and children through Medicaid. National leadership from both the Congress and the Administration are essential to reaching the nation's health objectives for the year 2000.

III. RECOMMENDATIONS

The issues raised in today's hearing are somewhat complex and technical—thus they may not seem easy to resolve. However, the goal of this effort should be to reach policy decisions that are both fiscally responsible and responsive to the needs of vulnerable populations. To reach this goal, policymakers must have an understanding of programs and a vision of what the nation's priorities should be. Based on the facts and arguments presented in our testimony, the March of Dimes recommends the following:

- **Congress should enact legislation to permit states to use voluntary contributions to finance Medicaid program activities.** Current law provides protection for funds raised through provider specific taxes. However, voluntary contributions also should be protected by statute.

Permitting states maximum flexibility would provide opportunities to provide services to the maximum number of eligible persons. In particular, the role of voluntary contributions may be especially important in the case of outstationed workers, outreach workers and other administrative costs (relatively low cost and very important). At a minimum, voluntary contributions should be available for use in financing these and other similar administrative activities.

If necessary to contain and better predict costs, a cap on voluntary contributions should be considered. If setting a cap is the compromise necessary, the amount of the cap should be determined on the basis of states' current experience with voluntary contributions so that Medicaid services and eligibility would not be reduced in the process. A 10% cap on voluntary contributions as a percent of the total Medicaid program and as a percent of an individual hospital's gross revenue (excluding federal Medicaid or Title V monies) has been proposed in pending legislation. However, a cap of a higher amount may be more practical and realistic if states are to avoid service cutbacks.

- **If an agreement on legislation cannot be reached before the end of this session of Congress, we urge enactment of legislation to extend the current moratorium on regulatory activity.** An extension of the moratorium would permit HCFA and Congress to more thoroughly consider alternative mechanisms to refinance basic services to vulnerable populations. While we recognize that such a decision may have a budget impact of up to $160 million, we cannot believe that

Congress would have states cutback or eliminate services to pregnant women and children in order to avoid finding this small amount of revenue through the federal budget process. The long term cost savings alone economically justify such a decision.

- **Congress should enact legislation aimed at improving the accuracy and reliability of Medicaid information.** The OMB/DHHS report makes some valid criticisms of HCFA and state Medicaid agencies. The Medicaid Bureau should assume greater responsibility for managing Medicaid. This would include: hiring more qualified staff; assisting states with program implementation; routinely collecting and analyzing state plans and amendments; and revising data collection systems. HCFA should exercise leadership and forge a new partnership with state Medicaid agencies.
- **Congress should protect the integrity of the Title V program by requiring that the federal office and its activities funded through "set-aside" funds remain unified with the block grant funds to be allocated to states.** The state block grant program cannot function well without direct support of the professional expertise contained in the federal office. No bifurcation of the program is acceptable. For example:

—Location of the federal bureau in HRSA with transfer of the block grant funds to the Administration on Children and Families would not be appropriate.
—An interagency agreement for transfer of funds from the Administration on Children and Families to the Bureau would not be sufficient protection for the program nor would it be adequate to ensure smooth functioning of the Title V program.

- **The Secretary of Health and Human Services should conduct a formal review of the decision to move the Title V program,** with input from key MCH policy experts inside and outside of government, as well as state and MCH officials (one approach would be to assemble a technical assistance or advisory group to work with the transition team). The Secretary's own stated goals are to: (ii) promote collaboration and eliminate program isolation; (ii) facilitate communication and joint administration with states; (iii) spur new ideas; and (iv) provide a base for enhance coordination. There are practical, alternative ways to achieve these goals. We urge that neither the Title V program funds or staff be moved or restructured without such a review.
- **The Secretary of Health and Human Services should prepare for Congress a description of the structures and mechanisms by which the Healthy Start initiative, Comprehensive Perinatal Care Program, and the MCH Services Block Grant will be integrated and coordinated.** These programs each have a major role to play in reducing infant mortality in the United States. The Administration has a responsibility to plan for and manage the coordination and integration of these efforts. Success depends on setting achievable goals, developing a long-range vision for action, careful planning, and systematic implementation. In the battle to assure infant survival, America cannot afford to do less.

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Attachment.

Appendix A

MCH Services Block Grant

The MCH Services Block Grant combined ten programs:

Crippled Children's Services
Maternal and Child Health Research
Maternal and Child Health Services
Maternal and Child Health Training
Childhood Lead Based Paint Poisoning Prevention
Sudden Infant Death Syndrome Information and Counseling
Comprehensive Hemophilia Diagnostic and Treatment Centers
Genetic Disease Testing and Counseling Services
Adolescent Pregnancy Prevention Services
Supplemental Security Income -- Crippled Children Portion

Appendix B

April 24, 1991

The Honorable Louis Sullivan
Secretary
Department of Health and Human Services
200 Indopendence Avenue, SW
Washington, D.C. 20201

Dear Dr. Sullivan:

As the leading maternal and child advocates in America, we applaud, on the one hand, your creation of the new Administration for Children and Families, but must raise serious objections to the transfer of the Maternal and Child Health Block Grant into this new social-welfare system. We believe that this transfer is ill-advised and urge that you revoke this decision.

Removal of the Maternal and Child Health Block Grant from its position in the Public Health Service is a barrier to the essential interaction between it and other public health programs, including CDC, ADAMHA, Family Planning, Migrant and Community Health Centers. This forced separation is inconsistent with the President's emphasis on increased immunizations, substance abuse prevention and infant mortality. The segregation from other related key agencies addressing the health needs of children and families will also be an impediment to the new MCH health directives which are critical to the implementation of the Year 2000 goals.

Programs under the MCH Block Grant are health, rather than welfare, oriented and are located in state health departments. Traditionally, these programs have attracted the participation and cooperation of health professionals, dedicated to program excellence and the delivery of high

quality health services. It should also be noted that while many of these services have been directed at low income families, services are not necessarily income related. Simply put, the goals, objectives and organization of these services are not compatible with the new administrative structure.

The proposed separation of the so-called SPRANS portion of the MCH BLock Grant is similarly ill-advised. Separation from mch services severs the information lifeline that serves as the focus for SPRANS grantees - that of assuring that health services for mothers and children are responsive to current needs and problems and that they are cost-effective and efficient.

Obviously, as this nation moves to develop and initiate an effective maternal and child health policy, deliberate attention will need to be focused on the interrelationships between health, education, nutrition, environment and social services. Such a sweeping reorganization will require a thorough debate and and discussion to ensure minimal disruption and that such a move would truly strengthen our national commitment to mothers and children.

Again, we urge you to reconsider and modify your current directive.

Sincerely yours,

Alan Guttmacher Institute
Ambulatory Pediatrics Association
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of University Affiliated Facilities
American Pediatric Society
American Public Health Association
Association of Maternal and Child Health Programs
Association of Medical School Pediatric Department Chairmen
Association of Schools of Public Health
Association of State and Territorial Health Officials
National Association of Children's Hospitals and Related Institutions
National Foundation March of Dimes
Pediatric Section, American College of Rheumatology
Society for Pediatric Research

cc: James Mason, M.D.
Robert Harmon, M.D.
Vince Hutchins, M.D.
The Honorable Henry Waxman
The Honorable William Dannemeyer
The Honorable Lloyd Bentsen
The Honorable Bob Packwood

Appendix C

Maternal and Child Health Advocates That Support State Flexibility in Medicaid Financing

June 26, 1991

Dear Member of Congress:

As advocates for federal Medicaid reforms to expand public assistance for health care for pregnant women and children of low income families, we support continued state flexibility to finance Medicaid programs, consistent with federal law and regulation over the past decade.

Medicaid is the nation's largest public program for children's access to health care. About half of the 27 million Medicaid recipients are children. Millions more are pregnant women.

In recent years, bipartisan leadership has persuaded Congress to improve Medicaid eligibility and benefits for women and children for two reasons. There has been mounting evidence of high infant mortality rates and poor health status among children of low income families -- the same families who are disproportionately represented among the growing numbers of uninsured. There also has been strong evidence that Medicaid for children is one of the most cost effective public investments.

In order to fulfill federal Medicaid expansions at a time when a national recession is driving up the need for public assistance and driving down general tax revenues, many states are using voluntary contributions and special taxes from health care providers to supplement their general revenue financing of their Medicaid programs. These funds enable states to qualify for federal Medicaid matching dollars, which they have used to implement Congress' Medicaid expansions for women and children.

Congress was correct in 1988, 1989, and 1990 to reject the Administration's attempts to deny states the flexibility to use voluntary contributions and provider taxes as part of their Medicaid financing. The experience of today's recession makes it all the more imperative that states improve access to health care for children who will be so important to tomorrow's economy.

We urge Congress to continue to reject the Administration's efforts to deny state flexibility in financing Medicaid. It is critical to maternal and child health for millions of Americans.

(See next page for list of organizations)

Maternal and Child Health Advocates That Support State Flexibility in Medicaid Financing

American Academy of Pediatrics

American Association of University Affiliated Programs for Persons with Developmental Disabilities

American Lung Association

American Public Health Association

American Nurses Association

American Speech-Language-Hearing Association

Association of Maternal and Child Health Programs

Association of Minority Health Profession Schools

Association of State and Territorial Health Officials

California Children's Hospital Association

Children's Defense Fund

March of Dimes Birth Defects Foundation

National Association of Children's Hospitals and Related Institutions

National Association of Community Health Centers

National Perinatal Association

Sudden Infant Death Syndrome Alliance

MAJOR ORGANIZATIONS IN OPPOSITION TO THE TRANSFER OF THE MATERNAL AND CHILD HEALTH BLOCK GRANT TO THE "NEW" ADMINISTRATION FOR CHILDREN AND FAMILIES

ALAN GUTTMACHER INSTITUTE
AMBULATORY PEDIATRICS ASSOCIATION
AMERICAN ACADEMY OF PEDIATRICS
AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION
AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED FACILITIES
AMERICAN COLLEGE OF OBSTETRICS AND GYNOCOLOGY
AMERICAN HOSPITAL ASSOCIATION
AMERICAN MEDICAL ASSOCIATION
AMERICAN NURSES ASSOCIATION
AMERICAN PEDIATRIC SOCIETY
AMERICAN PUBLIC HEALTH ASSOCIATION
AMERICAN SOCIETY FOR HUMAN GENETICS
ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS
ASSOCIATION OF MEDICAL SCHOOL PEDIATRIC DEPARTMENT CHAIRMEN
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH
ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
COALITION ON ALCOHOL AND DRUG DEPENDENCY IN WOMEN (70 GROUPS)
NATIONAL ASSOCIATION OF WIC DIRECTORS
NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS
NATIONAL ASSOCIATION OF COUNTIES
NATIONAL ASSOCIATION OF WIC DIRECTORS
NATIONAL FOUNDATION MARCH OF DIMES
PEDIATRIC SECTION, AMERICAN COLLEGE OF RHEUMATOLOGY
SOCIETY FOR ADOLESCENT MEDICINE
SOCIETY FOR PEDIATRIC RESEARCH

NUMEROUS INDIVIDUAL LETTERS/CALLS FROM STATE HEALTH DEPARTMENTS

COMMUNICATIONS

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association (AHA), on behalf of its member institutions, welcomes this opportunity to provide a statement for the record of the Subcommittee on Health for Families and the Uninsured of the Senate Committee on Finance regarding the reorganization of the Maternal and Child Health Services Block Grant Program (MCH).

The AHA represents nearly 5,500 hospitals, which includes hospitals with a commitment to programs in maternal and child health. Specifically with regard to women and children, the Association relies on guidance from 1,300 hospitals who are members of the AHA Section for Maternal and Child Health. At the recommendation of the Section for Maternal and Child Health, the AHA has joined with many other maternal and child health organizations to oppose the transfer of the Maternal and Child Health Block Grant to the newly-created Administration for Children and Families. In a letter dated June 12, 1991, to Secretary Louis Sullivan, AHA urged that the current directive be reconsidered and that the administration of the Maternal and Child Health Block Grant be retained in the Public Health Service. A copy of that letter is provided for the record.

At this time, the AHA would like to reiterate for the members of the Subcommittee our principle objections to the transfer of the MCH Block Grant from its home in the Public Health Service:

> As health professionals and administrators, our members are seriously concerned that transfer of the MCH Block Grant program to the new social-welfare agency will significantly impede necessary coordination among public health programs, such as maternal and child health, hemophilia and genetic services, and community health centers. Maternal and child health clinics, including hospital-sponsored clinics, rely on monies from a number of these public health programs to meet the important preventive, well-child, and health service needs of low-income women and children. The MCH Block Grant program is an important cornerstone in this effort and, therefore, must not be removed from its roots in the Public Health Service.
>
> We applaud the Administration's current policies related to infant mortality, and immunizations, as well as other recent initiatives taken to elevated the importance of maternal and child health services through the recently-established Bureau of Maternal and Child Health. The new Bureau is a positive step in the integration of maternal and child health services and helps to underscore the Administration's commitment to programs for women and children. This is clearly not the time for any disruption in such programs. On the contrary, it is imperative that the emphasis on programs for women and children be maintained. We, therefore, question whether this can best be accomplished through a change in the administrative structure.
>
> Especially in these times of limited resources, grantees of the Maternal and Child Health Block Grant, such as hospitals, health departments, and not-for-profit health agencies, depend on the coordinated efforts of federal, state, and local public health programs to meet the increasing demands for services by women and families. We oppose this transfer of the MCH Block Grant from the Public Health Service on the basis that further disruption of a public health service mechanism jeopardizes our success as health care providers to maximize public and private resources to reach the greatest number of women and children who would otherwise go without certain maternal and child health services.

We urge you to consider the concerns brought before the Subcommittee in testimony and statements from the AHA and other maternal and child health professionals opposing the transfer and intervene, as appropriate, to preserve the existing and successful organization of the Bureau of Maternal and Child Health within the Public Health Service.

Attachment.

AMERICAN HOSPITAL ASSOCIATION,
Washington, DC, June 12, 1991.

Hon. LOUIS SULLIVAN, *Secretary,*
Department of Health and Human Services,
200 Independence Avenue, S.W.,
Washington, DC.

Dear Secretary Sullivan: The American Hospital Association (AHA), representing nearly 5,500 hospitals, commends you for your interest in maternal and child health and on the creation of the new Administration for Children and Families. This new agency can be a potent force in assuring that the welfare and social services necessary to assist needed families will be available and well coordinated. Nevertheless, the AHA, through its Section for Maternal and Child Health, which works directly with the 1,400 hospitals most active in providing health services to women and children, joins with the many other maternal and child health organizations to oppose the transfer of the Maternal and Child Health (MCH) Block Grant to this new agency.

As health professionals and administrators, our members are seriously concerned that transfer of the MCH Block Grant to the new social-welfare agency will significantly impede necessary coordination among public health programs, such as maternal and child health, hemophilia and genetic services, and community health centers. Maternal and child health clinics, including hospital-sponsored clinics, rely on monies from a number of these public health programs to meet the important preventive, well child and health service needs of low-income women and children. The MCH Block Grant is an important cornerstone in this effort and, therefore, must not be removed from its roots in the Public Health Service.

We applaud the Administration's current policies related to infant mortality, immunizations, and so forth, as well as other recent initiatives taken to elevate the importance of maternal and child health services through the recently established Bureau of Maternal and Child Health. The new Bureau is a positive step in the integration of maternal and child health services and helps to underscore the Administration's commitment to programs for women and children. This is clearly not the time for any disruption in such programs. On the contrary, it is imperative that the emphasis on programs for women and children be maintained. We therefore question whether this can best be accomplished through a change in the administrative structure.

Especially in these times of limited resources, grantees of the Maternal and Child Health Block Grant, such as hospitals, health departments, and not-for-profit health agencies, depend on the coordinated efforts of federal, state, and local public health programs to meet the increasing demands for services by women and families. We oppose this transfer of the MCH Block Grant from the Public Health Service on the basis that further disruption of a public health service mechanism jeopardizes our success as health providers to maximize public and private resources to reach the greatest number of women and children who would otherwise go without certain maternal and child health services.

We urge you to reconsider and modify your current directive.

Sincerely,

PAUL C. RETTIG, *Executive Vice-President.*

WYCHE FOWLER, JR.
GEORGIA

COMMITTEE ON APPROPRIATIONS
COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY
COMMITTEE ON ENERGY AND NATURAL RESOURCES
COMMITTEE ON THE BUDGET

United States Senate
WASHINGTON, DC 20510-1003

July 15, 1991

Mr. Richard G. Darman
Director
Office of Management and Budget
Executive Office Building
Washington, D.C. 20503

Dear Mr. Darman:

We, as members of the Georgia Congressional delegation, are writing you today on behalf of the Georgia Department of Medical Assistance, disproportionate share hospitals throughout our state, and the thousands of low-income women and children currently in need of health care services.

There is increasing concern that HCFA is going to eliminate the use of voluntary contributions as a means of increasing the federal Medicaid match. We recognize that some restrictions must be placed on the use of contributions, but to eliminate them completely would put Georgia's Medicaid budget in jeopardy and most likely close many rural hospitals.

Georgia's Indigent Care Trust Fund was created in 1990 to financially assist numerous hospitals in the state that provide care to a disproportionate number of indigent patients. The program receives voluntary donations from contributing hospitals and utilizes the funds generated to help pay for indigent care throughout the state. Sixty-five hospitals are currently participating in the program, which provides valuable services such as perinatal case management and postpartum home visits for impoverished women and their children.

Should the use of these funds be eliminated many health care services for Georgia's impoverished and ill children will be in jeopardy. Forthcoming regulations from HCFA will effectively eliminate Georgia's Indigent Care Trust Fund which currently provides many important and vital services.

1. Hospitals which offer birthing and parenting classes to Medicaid eligible women will no longer receive payment through hospital outpatient programs.

2. Physicians will no longer receive incentive payments to begin prenatal care in the first trimester or to provide more than 10 antepartum visits.

3. Providers with experience in the delivery, prenatal and other child health services will no longer be reimbursed for two postpartum visits in the home.

4. The Perinatal Case Management program will not be expanded statewide.

5. Disproportionate share hospitals will no longer receive additional payment adjustments for primary care programs and services for Medicaid recipients and indigent citizens.

We understand that some states have adopted practices which bypass the intent of the Medicaid system; however, we feel that Georgia's use of voluntary contributions is exemplary and a proper model for other states. We urge you to carefully examine the Georgia Indigent Care Trust Fund when considering any regulations. HCFA cannot ignore what services these funds currently provide for our nation's poor women and children.

Should HCFA determine that regulations are necessary to control the use of voluntary contributions, we encourage you to implement guidelines which place caps on the amount of donated funds used by the states rather than completely eliminating current programs. We feel that by restricting the use of donated funds to not more than ten percent of the total state Medicaid match, HCFA can effectively separate the so-called "scams" from reasonable programs such as Georgia's.

States have, and must continue to maintain, the legal right to develop reasonable funding mechanisms to finance necessary indigent care and maternal and child health services.

Respectfully yours,

Wyche Fowler, Jr.
United States Senator

Sam Nunn
United States Senator

Lindsay Thomas
United States Congressman

Charles Hatcher
United States Congressman

Richard G. Darman
July 15, 1991
page three

Richard Ray
United States Congressman

Ben Jones
United States Congressman

John Lewis
United States Congressman

Doug Barnard, Jr.
United States Congressman

Buddy Darden
United States Congressman

J. Roy Rowland, M.D.
United States Congressman

Ed Jenkins
United States Congressman

COMMENTS PREPARED FOR THE CONSIDERATION OF THE SENATE FINANCE SUBCOMMITTEE ON HEALTH FOR FAMILIES AND THE UNINSURED PURSUANT TO THE SUBCOMMITTEE'S JULY 26 HEARING ON MEDICAID FINANCING ISSUES.

PETE WILSON, Governor

STATE OF CALIFORNIA

HEALTH and WELFARE AGENCY
OFFICE OF THE SECRETARY
1600 NINTH STREET, ROOM 460
Sacramento, California 95814
(916) 445-6951

JUL 30 1991

The Honorable Donald W. Riegle, Jr.
United States Senate
105 Dirksen Senate Office Building
Washington, D.C. 20510-2201

Dear Senator Riegle:

LOCAL GOVERNMENT FINANCIAL PARTICIPATION IN MEDICAID FUNDING

On behalf of Governor Pete Wilson, this letter is submitted to advise your (sub)committee of the vital nature of local government financial participation in the Medi-Cal program. We understand that testimony at a hearing on July 26, 1991, may not have fully described the importance of this historic and conventional funding mechanism for state Medicaid programs. In California, local government funding served as a significant element of the Medi-Cal program for most of the 1970's. Further, pursuant to current legislation know as Senate Bill 855 (SB 855), we anticipate that local government financial participation will be expanded as a critical funding source for Medi-Cal acute inpatient services.

A discussion paper regarding the background and history of local government financial participation in state Medicaid programs, as applied to SB 855, is enclosed for your consideration. In light of the increasing federal demands on states to provide eligibility and coverage for Medicaid services, it is imperative that available funding sources, especially historic sources such as local government financial participation, remain fully viable under federal law. We urge you and the members of your (sub)committee to resist strongly any efforts by federal agencies to undermine any current or historic Medicaid funding sources for the states.

Thank you for your consideration of these materials.

Sincerely,

RUSSELL S. GOULD
Secretary

Enclosure

LOCAL GOVERNMENT FINANCIAL PARTICIPATION IN MEDI-CAL UNDER SB 855

The California Legislature recently approved SB 855, and the bill was passed forward to Governor Wilson for signature. In brief, SB 855 establishes an augmented payment adjustment program for acute inpatient hospital services rendered by all Medi-Cal disproportionate share providers ("SB 855 program"). As discussed below, the State's financial share of the SB 855 program is funded through local government financial participation. Under the SB 855 program, public entities that are the licensees of disproportionate share hospitals will transfer specified amounts to a State-administered fund from which payment adjustments for inpatient hospital services will be made, as authorized by federal Medicaid statutes.

In adopting this local financial participation approach, the California Legislature has relied on federal Medicaid statutes and regulations authorizing the use of local financing as part of the State's share of Medi-Cal. Local government financial participation is a conventional and historic vehicle for financing state Medicaid expenditures and such programs are in place in about 15 states. This paper describes the local funding aspects of SB 855 and demonstrates that this funding approach is authorized under applicable federal law.

Federal Medicaid Statutory And Regulatory Background

Federal statutes have recognized local public entities as a legitimate Medicaid funding source since the inception of the Medicaid program in 1965. Section 1902(a)(2) of the Social Security Act (42 U.S.C. § 1396a(a)(2)) requires that each state's Medicaid Plan must:

> 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 with respect to which payments under Section 1903 are authorized by this title; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the Plan. . . .

Thus, under the Medicaid Act, Congress expressly authorized states to use funds derived from local government sources for up to 60% of the non-federal share of the program.

The legislative history of this Medicaid statutory provision reflects that Congress directly considered the involvement of local governments as a source of the non-federal share of Medicaid financing. As originally introduced in the House of Representatives, the Medicaid program would have required that all non-federal funds in support of the program come from state sources, rather than from state and local sources. As finally adopted, however, the statute includes a Senate amendment which allows the use of local funds for financing the non-federal share so long as the state is able to assure a consistent statewide program at a reasonable level of adequacy.1/ Thus, Congress considered and expressly rejected the opportunity to preclude states from using local funds to finance their Medicaid programs.

Section 1902(a)(2) of the Medicaid Act is implemented by regulations which currently appear at 42 C.F.R. § 433.33 and § 433.45. Section 433.33 sets forth the state plan requirement regarding state and local financial participation in the program. Essentially, the regulatory language tracks that of the statute.2/

Section 433.45(a) further implements Section 1902(a)(2) by expressly recognizing that "public funds" may be considered as the state's share, if those funds meet the following conditions:

> (2) The public funds are appropriated directly to the state or local Medicaid agency, or transferred from other public agencies . . . to the State . . . and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

1/ Conference Report No. 682 (to accompany H.R. 6675), July 26, 1965, at 2244-45.

2/ As part of the standard state plan documents, the Health Care Financing Administration ("HCFA") has developed a form to implement Section 433.33. On this standard form, states indicate whether local financial participation is utilized as part of the non-federal share of Medicaid expenditures.

(3) The public funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds.

(Emphasis added.)

As discussed below, the local government financial participation under SB 855 clearly falls within the authority of these Medicaid regulations.

The SB 855 Program Complies With Federal Regulations Regarding Local Financial Participation

Under SB 855, those public entities which are licensees of disproportionate share hospitals are mandated to transfer certain amounts to the State to support the SB 855 program. For this purpose, a public entity is defined as a county, a city, a city and county, the University of California, a local hospital district, a local health authority, or any other political subdivision of the State. No private entity is involved in these intergovernmental transfers to the State.

The intergovernmental transfers under the SB 855 program meet each of the federal requirements for local financial participation. First, the amount of the transfers contemplated from public entities under SB 855 will constitute less than 20% of the non-federal share of the Medi-Cal program. Therefore, in accordance with 42 C.F.R. § 433.33, State funds will be used to pay at least 40% of the non-federal share.

Moreover, more than 90% of the local funds will be used to pay additional payment adjustment amounts to disproportionate share hospitals, including all public, private and district hospitals which qualify for this status. As a result, the local government funding will not effect the amount, duration or scope of services provided in the Medi-Cal program as a whole, but will serve to provide financial stability for those facilities that serve a disproportionate share of California's most needy population. This results in the statewide uniformity required by subsection (c) of Section 433.33, while furthering the purpose of the disproportionate share payment provisions of Section 1923 of the Medicaid Act (42 U.S.C. § 1396r-4).

In addition, the proposed transfers are consistent with Section 433.45(a). SB 855 provides for transfers from public entities to the state Medicaid agency, with the latter assuming exclusive administrative control over the funds. In addition, each local government entity must assure that the public funds transferred are not federal funds, or that they are federal funds authorized by federal law to be used to match other federal funds. Thus, in every respect, the funding mechanism of the

SB 855 program satisfies the criteria of the controlling federal Medicaid statute and regulations.

History Of Local Government Funding Of Medi-Cal

Under California law, counties are political subdivisions of the State, and hold all property as agents of the State. Board of Supervisors, County of Butte v. McMahon, (1990) 219 Cal.App.3d 286; County of Marin v. Superior Court, (1960) 53 Cal.2d 633, 638-639. As early as 1893, the California courts held that local funds are, in fact, funds acquired under the authority of the State for public purposes and that the State Legislature can direct a local government to make payments of its funds. Conlin v. Board of Supervisors, (1893) 99 Cal. 17, 21. Thus, the mandatory intergovernmental transfers required under SB 855 are consistent with California law.

Moreover, there is historical precedent in California for local financial participation in the Medi-Cal program. For nearly a decade during the 1970's counties were statutorily required to provide substantial cash transfers to the State in support of Medi-Cal. During the 1977-78 fiscal year, the final year in which this statutory requirement was in place, counties were required to transfer more than $400,000,000 to the State in support of Medi-Cal. While this requirement was in effect, the State received federal matching funds for expenditures made with the transferred funds.

In addition, California currently receives federal matching funds for various local expenditures under the Medi-Cal program. Included among these expenditures are certain costs incurred by county welfare departments in processing applications for Medi-Cal benefits. Thus, the local funding concepts in SB 855 are supported by both current and historical Medi-Cal precedents.

Local Government Financial Participation In Other States

In light of the authorization of local financial participation since the inception of Medicaid, various states have implemented a variety of local financing approaches, and have modified their approaches periodically as economic circumstances have changed. This parallels the experience in California, as discussed above.

A review of HCFA's implementation of the Medicaid statute and regulations relating to local funding indicates that states have had considerable flexibility in developing approaches to local financial participation. Official data available from the Health Care Financing Administration regarding periods from 1966-1986 demonstrate that numerous states have utilized local

funding and that a broad range of approaches has been recognized as appropriate by the federal government.3/

Some states impose a flat percentage local match requirement. For example, in North Carolina, counties pay 15% of the non-federal share for all Medicaid services. Another approach which has been adopted by some states is to impose local financial participation requirements only with respect to certain services. For example, local governments may be required to contribute only to the cost of nursing home services, such as in Florida and New Hampshire. In other states, such as New York, the local financial participation may apply to all services, but the amount of participation may vary among types of services.

Other programs are similar to SB 855 in that they do not require contributions from all counties. For example, Colorado requires a 2% participation for certain ICF nursing home admissions only from the 20 largest counties. Other states extend their local financial participation requirements beyond counties, to other public entities.

Given this history, the approach adopted under SB 855 clearly falls within the range of acceptable approaches to local funding under the Medicaid program.

The SB 855 Program Is Different Than Taxation And Donation Programs

As the foregoing discussion demonstrates, the SB 855 program is neither a provider-based donation nor a taxation program. The funding source, local government transfers, involves only public entities. As a result, the SB 855 program does not fall within the limitations imposed under Section 433.45(b) regarding private donated funds. Moreover, the term "donation" connotes a voluntary aspect to the transfer. Here, the transfers are mandatory on those public entities that fall within the statutory definitions and cannot be considered in any sense voluntary contributions to the State.

In addition, the SB 855 program is not an exercise of the State's taxing powers. As discussed above, wholly aside from any taxing powers, the State has ultimate control over the funds and property held by its agents, local governmental entities. Board of Supervisors, County of Butte v. McMahon, supra. Through the SB 855 program, the State is exercising its authority to utilize local public funds in the furtherance of its obligation to fund the Medi-Cal program. The authority to do so is recognized, not only under California law, but under the federal Medicaid statutes.

The funding mechanism adopted in SB 855 is consistent with the Medicaid statute, regulations, and twenty-five years of Medicaid history. Provider-based donation and taxation programs do not share these historic attributes and therefore are different than programs which involve local government financial participation, such as the SB 855 program.

3/ See Attachment A regarding 1966-78; Attachment B regarding 1980; Attachment C regarding 1984; and Attachment D regarding 1986. These data reflect that at least 18 states have utilized local financial participation in support of their programs.

DATA ON THE MEDICAID PROGRAM: ELIGIBILITY, SERVICES, EXPENDITURES FISCAL YEARS 1966-78

Published by
The Institute for Medicaid Management

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
Medicaid Bureau
Washington, D. C. 20201
1978

C. FORMULAS FOR LOCAL FUNDING OF MEDICAID

The non-Federal share of Medicaid expenditures can be financed entirely out of State funds, or can be jointly financed by the State and localities. However, Title XIX provides that State funds must account for not less than 40 percent of the non-Federal share. In addition, it specifies that since FY 1970, the State must either fund 100 percent of the non-Federal share, or provide for a distribution of funds "which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan."

A number of States still require some local contribution in financing the non-Federal share of Medicaid expenditures. Table 22 indicates the formulas by which various States which require some local contribution to the cost of Medicaid determine what the local share is.

TABLE 22.—Formulas for local funding of Title XIX; Medical Vendor Payments

California.—Local government funding is derived from the property tax. Rates are set by the comptroller each year, with affluent counties being assessed more than poorer ones. County shares range from $.05 to $.60 per $100.00 valuation.

Florida.—Counties contribute funding in two areas:

(1) When inpatient hospital care days exceed 12 per admission, counties pay 35 percent of non-Federal share for cost of care beyond 12 days.

(2) When nursing home vendor payments exceed $170 per month, counties pay 35 percent of the non-Federal share of that amount above $170, but not more than $55 per patient per month.

Maryland.—The county of residence of the recipient pays 10 percent of the non-Federal share for inpatient hospital care.

Minnesota.—As of January, 1976, all non-Federal share split 90% State, 10% local, excluding costs for State facilities for the mentally retarded. Counties pay 4.32 percent of total Medicaid costs.

Nebraska.—Counties pay 20 percent of total Medicaid costs.

Nevada.—Local funding is derived from the property tax. According to State law $.11 per $100.00 valuation goes into the Medicaid fund.

New Hampshire.—There is local funding for services for the aged and disabled:

(1) For nursing home costs for the aged and disabled, legally liable units (i.e., cities, towns, or counties) pay 50 percent of the non-Federal share.

(2) For all other services for the aged and disabled, legally liable units pay $6 per month per old age recipient and $23 per month per APTD recipient.

New Jersey.—Counties pay 25 percent of total cost for EPSDT outreach programs and 10 percent of total cost for family planning. For these services, local funds constitute all non-Federal funds.

New York.—Counties pay 50 percent of non-Federal share.

North Carolina.—Counties pay 4.8 percent of total Medicaid costs, or approximately one-seventh of the State share.

North Dakota.—Counties pay 15 percent of State share.

Pennsylvania.—Counties paid total non-Federal share for Title XIX

recipients in county nursing homes through FY 1976. The State is planning to take over these costs gradually, and will pay 90 percent of the non-Federal share in FY 1980.

South Dakota.—State law requires counties to pay $60.00 per month per public assistance and Medicaid recipient who has been admitted to State mental hospitals. Reimbursement for such hospital claims is reduced by $60.00 to reflect the State agency's share of the claims.

D. STATE MEDICAID EXPENDITURES, BY TYPE OF SERVICE

The distribution of expenditures for services varies substantially from State to State. Table 23 breaks out total Medicaid benefits for the major types of service in each State. Table 24 presents the same data in terms of the percentages of total expenditures in each State for the major types of service. Table 25 shows, on the other hand, the proportion of dollars spent for each service represented by the expenditures of each State.

E. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES PROVIDED TO MEDICAID CHILDREN

Each State's Medicaid program must provide that early and periodic screening, diagnosis, and treatment (EPSDT) services are available to all eligibles under 21 years of age. The treatment services available under EPSDT can be within the limits of the State's plan of covered services, with the exception that eyeglasses, hearing aids, other kinds of dental care necessary for the relief of pain and infection and for restoration of teeth must be provided, whether or not such services are included under the State plan.

A penalty can be imposed on any State not providing the required EPSDT services, amounting to a one-percent reduction in Federal share of matching funds under the State AFDC program.

Table 26 displays comparative data for EPSDT children under age 21 and under age six years for each State for FY 1977. Detailed are expected screenings, based upon each State's periodicity schedule and relevant national averages from AFDC demographic data[1] versus annualized reported screenings given during FY 1977. Health assessment percentage rates are then expressed as the ratio of screenings given to screenings expected and percentages of individuals screened with at least one suspected condition are indicated. The remainder of the table indicates the percentages of individuals screened with the specified conditions of vision, hearing, dental, lead poisoning, and other. These percentages are expected to exceed 100 percent since they are an expression of the number of conditions found in those "individuals screened with at least one condition."

The terms screening, diagnosis, and treatment are defined as follows.

Screening is the use of procedures to sort out apparently well persons from those who may have a disease or abnormality and to identify those in need of more definitive study of their physical or mental problems.

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[1] Findings of the 1975 AFDC Study, (SRS) 74-03767, AFDC-1 (75), January 1975.

The Medicare and Medicaid Data Book, 1983

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HCFA Pub. No. 03156

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations

Baltimore, Md.
December 1983

TABLE 4.22

Medicaid State-Only Expenditures, Fiscal Year 1980

Jurisdiction[1]	Total Expenditures (millions)
All Reporting Jurisdictions	$1,119.8
Alaska	1.9
California	549.1
Colorado	2.1
Georgia	.2
Hawaii	15.6
Illinois	124.2
Louisiana	1.1
Maine	2.3
Maryland	72.5
Massachusetts	4.3
Michigan	7.3
Montana	4.0
New York	299.8
North Carolina	1.4
North Dakota	.3
Oregon	15.9
South Dakota	.6
Utah	2.1
West Virginia	.6
Wisconsin	14.5

[1] Some Medicaid jurisdictions that are known to have State-only expenditures, such as Pennsylvania, have chosen not to report these expenditures for 1980. Alaska, Georgia, and New York were included in the Medicare and Medicaid Data Book, 1981, but did not report for FY 1980.

SOURCE: Office of Research and Demonstrations, HCFA. The data in this table were taken from the Monthly 120 reports filed by the States.

F. Financing

Under Medicaid, service providers (physicians, pharmacists, hospitals, etc.) may be reimbursed from several different sources, including:

- the Federal government, through Federal matching assistance payments;
- the Federal government, through Medicare Part B "buy-in" agreements;
- State governments;
- local governments (in some cases);
- third parties who are otherwise liable for care provided to Medicaid eligibles; and
- Medicaid recipients themselves.

This section presents data on each source of funds, except for private third parties and expenditures contributed by Medicaid recipients themselves.

1. Federal/State Financing

The Federal share of State medical vendor payments is determined by a statutory formula based on State *per capita* income, where

$$\text{State share} = \frac{(\text{State } \textit{per capita} \text{ income})^2}{(\text{National } \textit{per capita} \text{ income})^2} \times .45$$

and where Federal share = 1.00 minus the State share. By design, the formula sets higher rates of Federal matching for States with relatively low *per capita* incomes (up to a statutory maximum of 83 percent) and lower rates for States with relatively high *per capita* incomes (down to a minimum of 50 percent).

Table 4.23 shows the Federal Medicaid Assistance Percentages in effect for fiscal years 1980 through 1983. No State receives the maximum Federal match of 83 percent (Mississippi receives the highest at 77.36 percent), and 13 States receive the minimum. These percentages apply to medical vendor payments only. For fiscal year 1980, Federal matching rates for other expenditures were as follows:

- Family Planning Services were matched at 90 percent;
- administrative costs were matched at 50 percent;
- development of automated claims processing and management information systems was matched at 90 percent and the operation of such systems was matched at 75 percent;
- costs of skilled nursing facility inspectors were matched at 75 percent;
- costs of professional medical personnel used to administer the program were matched at 75 percent; and
- State Medicaid fraud and abuse units located organizationally outside of the single State agency were matched at 90 percent.

The share of total expenditures for medical assistance borne by the States will vary with the extent to which States provide medical assistance to State-only eligibles and offer services which do not qualify for Federal financial participation (FFP).

Table 4.23 also shows the total medical vendor payments subject to Federal financial participation, along with the Federal, State and local share of such payments. The expenditure data in Table 4.23 may differ from expenditure figures in other tables, because total payments computable for Federal funding represent only those payments for which FFP is allowed (while excluding other payments, such as Medicare SMI premiums paid on behalf of the medically needy for which FFP is not allowed). The *adjusted Federal share* is the official accounting of payments to providers and reflects such accounting adjustments as changes in payments to cost-reimbursed providers following year-end audits.

2. Local Funding Formulas

The non-Federal share of medical vendor payments may be provided out of State or local revenues. A State plan, however, must ensure that at least 40 percent of the non-Federal share is borne directly by the State. It must also guarantee that lack of local funds will not result in smaller amounts, duration, scope, or quality of care provided to Medicaid eligibles. As of February 1982, 13 States provided for local funding of the non-Federal share of Medicaid vendor payments. Table 4.23 presents the total expenditures financed by these local funding sources, for those States that reported these expenditures during FY 1980. Table 4.24 presents the local funding formulas used by all 13 States in February 1982.

TABLE 4.23

Medicaid Vendor Payments, by Jurisdiction, Fiscal Year 1980[1]

Medicaid Jurisdiction	Total Payment Computable for Federal Funding[2] (millions)	Percent Federal Share FY 1980-1981	Percent Federal Share FY 1982-1983	Adjusted Federal Share (millions)	State Share (millions)	Local Share[3] (millions)
All Reporting Jurisdictions	$23,930.3			$13,316.1	$10,614.4	$1,130.1
Alabama	309.9	71.32	71.13	215.5	94.4	0
Alaska	37.2	50.00	50.00	19.1	18.1	0
Arkansas	242.7	72.87	72.16	177.8	64.9	0
California	2,887.7	50.00	50.00	1,458.7	1,429.0	0
Colorado	187.4	53.18	52.28	97.6	90.0	0
Connecticut	337.2	50.00	50.00	172.1	165.1	0
Delaware	44.4	50.00	50.00	23.1	21.3	0
District of Columbia	168.7	50.00	50.00	83.7	85.1	0
Florida	408.6	58.94	57.92	236.1	172.5	33.0
Georgia	477.6	66.78	66.28	318.6	159.0	0
Hawaii	94.4	50.00	50.00	48.2	46.2	0
Idaho	50.7	65.70	65.63	33.7	17.0	0
Illinois	1,242.1	50.00	50.00	678.1	564.0	0
Indiana	379.0	57.28	56.73	215.5	163.4	0
Iowa	236.2	56.57	55.35	133.5	102.7	47.0
Kansas	192.8	53.52	52.50	104.8	88.0	0
Kentucky	314.0	68.07	67.95	220.9	93.1	0
Louisiana	416.7	68.82	68.85	282.3	134.3	0
Maine	146.2	69.53	70.83	103.7	42.5	0
Maryland	422.7	50.00	50.00	213.3	209.4	0
Massachusetts	1,051.3	51.75	53.56	544.0	507.2	0
Michigan	1,164.5	50.00	50.00	570.7	593.7	0
Minnesota	592.7	55.64	54.39	325.5	267.2	23.2
Mississippi	224.7	77.55	77.36	176.5	48.2	0
Missouri	301.6	60.36	60.38	207.3	94.3	0
Montana	62.8	64.28	65.34	41.3	21.6	0
Nebraska	109.6	57.62	58.12	67.6	41.9	19.8
Nevada	45.4	50.00	50.00	23.7	21.7	0
New Hampshire	72.8	61.11	59.41	44.1	28.8	0
New Jersey	736.6	50.00	50.00	369.3	367.3	0
New Mexico	72.7	69.03	67.19	52.1	20.1	0
New York	4,362.1	50.00	50.88	2,176.3	2,185.9	968.0
North Carolina	422.3	67.84	67.81	277.5	144.8	28.5
North Dakota	48.8	61.44	62.11	29.4	19.3	2.7
Ohio	823.9	55.10	55.10	459.8	364.7	0
Oklahoma	273.1	63.64	59.91	172.5	100.6	0
Oregon	183.5	55.66	52.81	100.6	82.9	2.3
Pennsylvania	1,248.9	55.14	56.78	685.2	550.7	11.2
Rhode Island	154.5	57.81	57.77	93.3	61.2	0
South Carolina	284.7	70.97	70.77	181.9	82.8	0
South Dakota	57.4	68.78	68.19	39.2	18.3	0
Tennessee	380.5	69.43	68.53	265.9	114.6	0
Texas	979.8	58.35	55.76	571.9	407.9	0
Utah	74.1	68.07	68.64	56.5	17.6	.2
Vermont	60.8	68.40	68.59	43.0	17.8	0
Virginia	363.3	58.54	58.74	217.6	145.7	0
Washington	367.5	50.00	50.00	188.7	178.8	0
West Virginia	107.7	67.35	67.95	72.3	35.4	0
Wisconsin	725.6	57.95	58.02	419.1	306.5	0
Wyoming	14.5	50.00	50.00	7.1	7.4	0

[1] These data include prior period claims, collections, deferrals, disallowances, and suspensions taken by the regional office or paid in that fiscal year. As a result, these numbers differ from those in other tables which do not include the same adjustments.

[2] Includes only those payments for which FFP is allowed.

[3] Data shown are only those reported to HCFA on a voluntary basis.

SOURCE: Health Care Financing Administration, Quarterly Report (HCFA-64), Bureau of Program Operations.

TABLE 4.24

Local Funding Formulas for Medicaid Vendor Payments, by State, February 1982[1]

State	Formula
Colorado	Twenty largest counties pay 2 percent of State's share for all new ICF nursing admissions.
Florida	County pays $55/mo. for each nursing home resident; 35 percent of State share for I/P hospital days over 12 and less than 46; 100 percent of State share for certain outpatient services.
Iowa	Counties must match Federal funds for ICF-MR's.
Minnesota	Counties pay 10 percent of State's share.
Montana	Counties pay 18 percent of eligibility personnel costs.
Nebraska	Counties pay 14 percent of State's share.
New Hampshire	Counties pay approximately 25 percent of State's share.
New York	Counties pay 50 percent of non-Federal share.
North Carolina	Counties pay 15 percent of non-Federal share for all services except SNF's and ICF's for which they pay 35 percent of non-Federal share.
North Dakota	Counties pay 15 percent of State's share except for ICF-MR and two other services.
Pennsylvania	Counties pay 10 percent of State's share for county nursing homes plus $3 per invoice administration fee.
South Dakota	$60 per month for each ICF/MR resident and local school district for Crippled Children's Hospital.
Wisconsin	Local contribution of 10-20 percent for specific services, that is, mental health.

[1] Table includes only those States that reported local funding formulas.

SOURCE: Summary Tables, Medicaid Program Characteristics, Office of Research and Demonstrations, HCFA, April 1982.

3. State Buy-in with Medicare

If an individual eligible for Medicaid under a State plan also qualifies for Medicare Part B coverage, a State can enroll that individual in Part B by paying his or her Part B premiums. Under this buy-in arrangement, some of the costs of providing care that would otherwise be borne by the State are instead borne by the Federal Government. (For a more detailed discussion, see Chapter I, Section C.1.)

Table 4.25 shows the number of individuals enrolled in Medicare Part B under a buy-in arrangement as of FY 1980. Also included are the numbers of such individuals receiving services and the total payments made under Medicare's SMI program on behalf of Medicaid beneficiaries. All but five jurisdictions buy into the Medicare SMI program.

G. Administrative Practices

1. Methods of Reimbursement

Medicaid regulations specify several criteria and methods for reimbursing providers. Table 4.26 shows the method of reimbursement by State for inpatient hospital services, long-term care services, outpatient hospital services, and physicians' services. The data are taken from a survey of State Medicaid agencies conducted in the spring of 1982. Forty-eight States responded to the survey.[11]

Before FY 1982, States were required by law to reimburse for inpatient hospital services on the same basis as Medicare—reasonable costs—unless they received approval from the Secretary of the Department of Health and Human Services (DHHS) to use an alternative method of reimbursement.[12] This requirement was dropped by

[11] The survey instrument was designed by the LaJolla Corporation in association with the National Governor's Association and the Urban Institute.

[12] An alternative method was to be approved only if it: (1) provided incentives for efficiency and economy; (2) provided for payment rates that are no higher than the amounts that would be determined using Medicare principles of cost reimbursement; (3) assured adequate participation of hospitals in the State's Medicaid program and the availability of hospital services of high quality to recipients; (4) afforded individual providers an opportunity to submit evidence and obtain prompt administrative review of payment rates set for them in certain instances; and (5) provided for documentation that is adequate for evaluation experience under the approved methods and standards. As of February 1982, 18 States had received approval from DHHS to use an alternative method for reimbursement of inpatient hospital services.

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Baltimore, Maryland
September 1987

HCFA Pub. No. 03247

and the Federal share equals 1.00 minus the State share. By design, the formula sets higher rates of Federal matching (up to a statutory maximum of 83 percent) for States with relatively low per capita incomes and lower rates (down to a minimum of 50 percent) for States with relatively high per capita incomes.

The Federal Medicaid assistance percentages (FMAP's) in effect since the enactment of Medicaid are shown in Table 4.19. From fiscal year 1984 to fiscal year 1985, no State received the maximum Federal match of 83 percent; 17 States received the minimum; and Mississippi received the highest, 77.6 percent. These percentages apply to medical vendor payments only.

Although FMAP's are calculated for the territories, the total amount of Federal Medicaid matching funds payable to the territories is limited by law. Under the Deficit Reduction Act of 1984 (Public Law 98-369), the following higher limits applied for fiscal year 1984:

American Samoa	$1,150,000
Guam	2,000,000
Northern Marianas	550,000
Puerto Rico	63,400,000
Virgin Islands	2,100,000

For fiscal year 1984, Federal matching rates for other expenditures were as follows:

- Family planning services were matched at 90 percent.
- Administrative costs were matched at 75 percent. (For States that had a certified Medicaid Management Information System, administrative costs were matched at 50 percent).
- Development of automated claims processing and management information systems was matched at 90 percent, and the operation of such systems was matched at 75 percent.
- Costs of skilled nursing facility inspectors were matched at 75 percent.
- Costs of professional medical personnel used to administer the program were matched at 75 percent.
- State Medicaid fraud and abuse units located organizationally outside of the single State agency were matched at 90 percent.

The share of total expenditures for medical assistance borne by the States varies with the extent to which States provide medical assistance to State-only eligibles and offer services that do not qualify for Federal financial participation.

Section 2161 of OBRA-81 reduced the total Federal reimbursement for each State by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. The specified reduction was computed on the total Federal Medicaid reimbursement claimed by each State in that year. However, a State can lower its annual reduction rate by 1 percentage point for each of three conditions: operation of a qualified hospital cost review program, an unemployment rate exceeding 150 percent of the national average, and fraud and abuse recoveries (including third-party liability recoveries in fiscal year 1982) equal to 1 percent of Federal payments to the State (42 CFR 433, subpart E).

In addition to the conditions cited previously, section 2161 of OBRA-81 allows for a decrease in the designated reduction in Federal matching dollars for each State that keeps its spending levels within a target rate of growth. For fiscal year 1982, the target level was set at 109 percent (that is, a 9-percent rate of growth) of each State's estimate of the Federal share of its fiscal year 1981 spending level. For fiscal years 1983 and 1984, target levels were based on changes in the medical care component of the Consumer Price Index. In each year, $1 was deducted from a State's scheduled reduction in Federal matching funds for every dollar in State spending below the target level. (For purposes of calculating the target rates only, section 137 of TEFRA removed the effect of changes in FMAP's for the States after fiscal year 1981.)

Beginning in fiscal year 1983, section 133 of TEFRA requires that Federal matching funds to States with eligibility error rates greater than 3 percent be reduced by the amount of the excess erroneous expenditures. The Secretary of DHHS is permitted to waive the penalty retroactively in certain limited cases based on a determination that the State made a good-faith effort to reduce its error rate to 3 percent. Several factors are considered in calculating the error rate:

- Inclusion of payments to ineligible medical vendors and overpayments to eligible medical vendors.
- Exclusion of technical errors.
- Inclusion of the smaller amount of medical assistance provided, or spend-down and resource errors, or the amount attributed to both.

Total administration and training payments and medical vendor payments subject to FFP, along with the Federal and State share of such payments in fiscal year 1983, are shown in Table 4.20. These expenditure data may differ from expenditure figures in other tables because total payments computable for Federal funding are limited to payments for which FFP is allowed. Payments for which FFP is not allowed, such as Medicare supplementary medical insurance (SMI) premiums paid on behalf of the medically needy, are excluded. The adjusted Federal share reflects accounting adjustments, such as changes in payments to cost-reimbursed providers following yearend audits.

Local funding formulas

The non-Federal share of medical vendor payments may be provided out of State or local revenues. However, a State plan must ensure that at least 40 percent of the non-Federal share is borne directly by the State. It must also guarantee that lack of local funds will not result in smaller amounts, duration, scope, or quality of care provided to Medicaid eligibles. As of March 31, 1984, 14 States provided for local funding of the non-Federal share of Medicaid vendor payments. The local funding formulas used by these States in March 1984 are presented in Table 4.21. Formulas range from

Table 4.13

Amount and percent distribution of Medicaid payments, by maintenance assistance status and basis of eligibility: Fiscal year 1983

Basis of eligibility	Total payments in millions	Maintenance assistance status: Cash assistance	Maintenance assistance status: Medical assistance only
		Percent distribution	
Total	$32,350 5	52 8	47 2
Age 65 or over	11 953 9	25 1	74 9
Blind	183 1	72 4	27 6
Disabled	11,183 1	61 4	38 6
Dependent children under age 21	3,822 1	84 9	15 1
Adults in families with dependent children	4,483 1	85 8	14 2
Other Title XIX	725 3	NA	100 0

SOURCE Health Care Financing Administration Office of the Actuary Data from the Division of Medicaid Cost Estimates

that used in Colorado, which requires that the 20 largest counties pay 2 percent of the State share for all new ICF nursing home admissions, to that used in New York, which requires that counties pay 28-50 percent of the State share.

State buy-in with Medicare

If individuals eligible for Medicaid under a State plan also qualify for Medicare SMI coverage, the State can enroll them by paying their SMI premiums. Under this buy-in arrangement, some of the cost of providing care that would otherwise be borne by the State is instead borne by the Federal Government. (A more detailed discussion can be found in Chapter 1.)

The number of individuals enrolled in Medicare SMI under a buy-in arrangement as of calendar year 1983 is shown in Table 4.22. Also included are the number of such individuals receiving reimbursed services and the total payments made under the SMI program on behalf of Medicaid beneficiaries. All but five jurisdictions (Alaska, Louisiana, Oregon, Wyoming, and Puerto Rico) buy into the Medicare SMI program.

Administration

Methods of reimbursement and cost containment

Medicaid regulations specify several criteria and methods for reimbursing providers. The method of reimbursement for inpatient hospital services, long-term care services, outpatient hospital services, and physicians' services in 1984 is presented by State in Table 4.23.

Before fiscal year 1982, States were required by law to reimburse inpatient hospital services on the same basis as Medicare, reasonable costs, unless the Secretary of DHHS approved an alternative method of reimbursement. This requirement was dropped by section 2173 of OBRA-81. States are now required only to provide assurances satisfactory to the Secretary that the rates paid to hospitals:

- Are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to provide care in accordance with applicable laws and quality and safety standards.
- Take into account the unusual costs incurred by hospitals, especially public and teaching hospitals, that serve large numbers of low-income patients.
- Provide reasonable access to inpatient hospital services of adequate quality.
- Are routinely documented through uniform cost reports filed by each hospital and through periodic State audits of such reports (42 CFR 447.252).

States must ensure that their payment systems for SNF and ICF services are reasonably related to cost. Use of a cost-related payment system for long-term care institutional services has been required by law since July 1, 1976, but became fully operational in different States at different times after that date. For all other services, States are free to choose their own method of payment as long as the aggregate Medicaid payment levels do not exceed the amounts that would be paid under Medicare.

As of March 1984, 16 States reported using Medicare principles for inpatient hospital services, 26 for outpatient hospital services, and 17 States for physicians' services.

Before October 1, 1981, Medicaid eligibles were free to choose any provider, practitioner, or supplier of health services covered by a State's Medicaid program. However, the Secretary of DHHS was authorized to waive any Federal Medicaid requirements to enable States to conduct experimental, pilot, or demonstration projects that limit freedom of choice, including prospective reimbursement demonstrations. To provide States more flexibility in implementing various cost-saving measures, section 2175 of OBRA-81 provides that a State will not be held out of compliance for failure to meet certain State plan requirements if it limits free choice in any of the following ways:

- Purchases laboratory services and medical devices through a competitive or other arrangement, if the Secretary finds that adequate services or devices were available to beneficiaries.
- Contracts with organizations that agree to provide services in addition to those offered under the State plan to eligible individuals who reside in the area served by the organization and elect to receive care from the organization.
- Pays for certified rural health clinic services.
- "Locks in" beneficiaries who overutilize services to a particular provider for a reasonable time period.
- "Locks out" providers who abuse the program, subject to prior notice and opportunity for a hearing and provided that eligible individuals have reasonable access to services of adequate quality.

Table 4.21

Local funding formulas for Medicaid vendor payments, by State: March 1984

State	Formula
Colorado	20 largest counties pay 2 percent of State share for all new ICF[1] nursing admissions
Florida	Counties pay 35 percent of cost or $55/mo., whichever is less, for each nursing home resident; 35 percent of cost for 13th-45th inpatient hospital days; 100 percent of State share for first $101-$499 of outpatient service expense for each recipient
Iowa	Counties match Federal funds for ICF's/MR[2]
Minnesota	Counties pay 10 percent of State share
Montana	Counties pay 18 percent of eligibility personnel costs
Nebraska	Counties pay 14 percent of State share
New Hampshire	Local contributions of approximately 25 percent of nursing home costs, excluding residents in State institutions
New York	Counties pay 50 percent of State share except for certain long-term care services, for which they pay 28 percent of State share
North Carolina	Counties pay 15 percent of State share for all services except SNF's[3] and ICF's, for which they pay 35 percent of State share
North Dakota	Counties pay 15 percent of State share except for ICF's/MR, clinic services, and waivered home and community based services for recipients of services for the mentally retarded
Pennsylvania	Counties pay 10 percent of State share for county nursing homes plus $3 per invoice administration fee
South Dakota	$80 per month for each ICF/MR resident and local school district for Crippled Children's Hospital
Utah	Local contribution of less than 1 percent for specific services such as mental health
Wisconsin	Local contribution of 10-20 percent for specific services such as mental health

[1] Intermediate care facility
[2] Intermediate care facilities for the mentally retarded
[3] Skilled nursing facilities

NOTE: Table includes all States with local funding formulas

SOURCE: Health Care Financing Administration. *Analysis of State Medicaid Program Characteristics, 1984*. HCFA Pub. No. 03204. Office of the Actuary. Washington: U.S. Government Printing Office, 1985.

mental health care services. It does provide the following:

- Inpatient hospital services.
- Physicians' services.
- Outpatient hospital services.
- Laboratory and X-ray services.
- Medical supplies, medical equipment, and prosthetic devices.
- Pharmacy services.
- Emergency services.
- Emergency ambulance and medically necessary transportation.
- Emergency dental care and extraction.
- Early and periodic screening, diagnosis, and treatment services for individuals under 18 years of age.
- Medically necessary dentures.
- Orthognathic surgery for children under 18 years of age.
- Podiatry services.

The data presented in Table 4.26 are from the evaluation report of the cost of AHCCCS during its first 2 years (Trapnell et al., 1986). In the report, the cost of the AHCCCS program is compared with that of the traditional fee-for-service Medicaid program. The cost of a fee-for-service program in Arizona was estimated by using actual data on the cost of the same services provided to comparable beneficiaries by Medicaid programs during fiscal years 1983 and 1984. For example, in fiscal year 1983, the estimated Medicaid average recipient cost per month was $78.96, and the estimate of person-months of Federal eligibility was 979,561. The product, $77.3 million, is the estimated cost for Medicaid. This retrospective approach is the most appropriate approach for measuring possible savings achieved by the program. Detailed methodologies used to project costs for Arizona are described in the evaluation report. In estimating the cost of the AHCCCS program, the conceptual basis, methodology, and underlying assumptions used to estimate both traditional Medicaid program costs and actual program costs were taken into account.

The authors of the evaluation report were cautiously optimistic about AHCCCS program savings. AHCCCS program costs and the estimated costs of a traditional Medicaid program in Arizona for fiscal years 1983 and 1984 are presented by eligibility category in Table 4.26. The total program costs incurred for fiscal years 1983 and 1984 were $79.1 million for AHCCCS, and an estimated $87.8 million for a traditional Medicaid program.

In fiscal year 1983, the first year of AHCCCS, the cost of the program was $1.8 million more than the cost of a traditional Medicaid program, representing a 2.3-percent loss. Losses during the first year of the program were largely attributed to administrative difficulties that resulted in delays in enrolling eligibles into prepaid health plans. A large proportion of enrollees were therefore covered under the fee-for-service system. Fee-for-service costs for noncapitated recipients were much higher than originally anticipated. In fiscal year 1984, the AHCCCS program saving was $3.2 million; it cost 3.5 percent less than a traditional Medicaid program.

The AHCCCS program had net savings of $1.4 million during its first 2 years. Program savings were not consistent across eligibility categories. For fiscal year 1984, there were program savings for the aged, disabled, and AFDC categories. There were program

ATTACHMENT D

Health Care Financing Program Statistics

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- Costs of skilled nursing facility inspectors were matched at 75 percent.
- Costs of professional medical personnel used to administer the program were matched at 75 percent.
- State Medicaid fraud and abuse units located organizationally outside of the single State agency were matched at 90 percent for the first 3 years of their operation and 75 percent thereafter.

The share of total expenditures for medical assistance borne by the States varies with the extent to which States provide medical assistance to State-only eligibles and offer services that do not qualify for Federal financial participation.

Section 2161 of OBRA-81 reduced the total Federal reimbursement for each State by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. The specified reduction was computed on the total Federal Medicaid reimbursement claimed by each State in that year. However, a State could lower its annual reduction rate by 1 percentage point for each of three conditions: operation of a qualified hospital cost review program, an unemployment rate exceeding 150 percent of the national average, and fraud and abuse recoveries (including third-party liability recoveries in fiscal year 1982) equal to 1 percent of Federal payments to the State (42 CFR 433, subpart E).

In addition to the conditions cited previously, section 2161 of OBRA-81 allowed for a decrease in the designated reduction in Federal matching dollars for each State that kept its spending levels within a target rate of growth. For fiscal year 1982, the target level was set at 109 percent (that is, a 9-percent rate of growth) of each State's estimate of the Federal share of its fiscal year 1981 spending level. For fiscal years 1983 and 1984, target levels were based on changes in the medical care component of the Consumer Price Index. In each year, $1 was deducted from a State's scheduled reduction in Federal matching funds for every dollar in State spending below the target level. (For purposes of calculating the target rates only, section 137 of TEFRA removed the effect of changes in FMAP's for the States after fiscal year 1981.)

Beginning in fiscal year 1983, section 133 of TEFRA requires that Federal matching funds to States with eligibility error rates greater than 3 percent be reduced by the amount of the excess erroneous expenditures. The Secretary of DHHS is permitted to waive the penalty retroactively in certain limited cases based on a determination that the State made a good-faith effort to reduce its error rate to 3 percent. Several factors are considered in calculating the error rate:

- Inclusion of payments for services for ineligible recipients and overpayments for services for eligible recipients.
- Payments for services that a third party was liable to pay.
- Exclusion of technical errors.

Total administration and training payments and medical vendor payments eligible for Federal financial participation (FFP), along with the Federal and State share of such payments in fiscal year 1985, are shown in Table 4.20. These expenditure data may differ from expenditure figures in other tables because total payments computable for Federal funding are limited to payments for which FFP is allowed. Payments for which FFP is not allowed, such as Medicare supplementary medical insurance (SMI) premiums paid on behalf of the medically needy, are excluded. The Federal share reflects accounting adjustments, such as changes in payments to cost-reimbursed providers following year-end audits.

Local funding formulas

The non-Federal share of medical vendor payments may be provided out of State or local revenues. However, a State plan must ensure that at least 40 percent of the non-Federal share is borne directly by the State. It must also guarantee that lack of local funds will not result in smaller amounts, duration, scope, or quality of care provided to Medicaid eligibles. As of March 1985, 14 States provided for local funding of the non-Federal share of Medicaid vendor payments. The local funding formulas used by these States are presented in Table 4.21.

State buy-in with Medicare

If individuals eligible for Medicaid under a State plan also qualify for Medicare SMI coverage, the State can enroll them by paying their SMI premiums. Under this buy-in arrangement, some of the cost of providing care that would otherwise be borne by the State is instead borne by the Federal Government. (A more detailed discussion can be found in Chapter 1.)

The number of individuals enrolled in Medicare SMI under a buy-in arrangement as of calendar year 1985 is shown in Table 4.22. Also included are the number of such individuals receiving reimbursed services and the total payments made under the SMI program on behalf of Medicaid beneficiaries. All but five jurisdictions (Alaska, Louisiana, Oregon, Puerto Rico, and Wyoming) buy into the SMI program.

Administration

Methods of reimbursement and cost containment

Medicaid regulations specify several criteria and methods for reimbursing providers. The method of reimbursement for inpatient hospital services, outpatient hospital services, long-term care, and physicians' services as of March 1986 is presented by State in Table 4.23.

Before fiscal year 1982, States were required by law to reimburse inpatient hospital services on the same basis as Medicare, reasonable costs, unless the Secretary of DHHS approved an alternative method of reimbursement. This requirement was dropped by section 2173 of OBRA-81.

Table 4.21

Local funding formulas for Medicaid vendor payments, by State: March 1986

State	Formula
Colorado	20 largest counties pay 2 percent of State share for all new ICF admissions
Florida	Counties pay 35 percent of cost or $55.00 per month, whichever is less, for each nursing home resident, 35 percent of cost for 13th-45th inpatient hospital days.
Iowa	Counties match Federal funds for ICF's/MR
Minnesota	Counties pay 10 percent of State share.
Montana	Counties pay 16 percent of eligibility personnel costs
Nebraska	Counties pay 4.6 percent of total expenditures.
New Hampshire	Local contribution of approximately 28 percent of nursing home costs, excluding residents in State institutions
New York	Counties pay 50 percent of non-Federal share except for long-term care, for which they pay 20 percent of non-Federal share.
North Carolina	Counties pay 15 percent of non-Federal share for all services.
North Dakota	Counties pay 15 percent of State share except for ICF's/MR, clinic services, and waivered home and community-based services for mentally retarded, aged, and disabled recipients.
Pennsylvania	Counties pay 10 percent of State share for county nursing homes plus $3 per invoice administration fee.
South Dakota	Local contribution of $60.00 per month for each ICF/MR resident and local school district for Crippled Children's Hospital.
Utah	Local contribution of less than 1 percent for specific services (e.g., mental health).
Wisconsin	Local contribution of 10-20 percent for mental health services.

NOTE: ICF is intermediate care facility. ICF/MR is intermediate care facility for the mentally retarded.

SOURCE: Health Care Financing Administration, Office of the Actuary. Data from the Office of Medicaid Estimates and Statistics

States are now required only to provide assurances satisfactory to the Secretary that the rates paid to hospitals:

- Are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to provide care in accordance with applicable laws and quality and safety standards.
- Take into account the unusual costs incurred by hospitals, especially public and teaching hospitals, that serve large numbers of low-income patients.
- Provide reasonable access to inpatient hospital services of adequate quality.
- Are routinely documented through uniform cost reports filed by each hospital and through periodic State audits of such reports (42 CFR 447.252).

States must ensure that their payment systems for SNF and ICF services are reasonably related to cost. Use of a cost-related payment system for long-term care institutional services has been required by law since July 1, 1976, but became fully operational in different States at different times after that date. For all other services, States are free to choose their own method of payment as long as the aggregate Medicaid payment levels do not exceed the amounts that would be paid under Medicare.

As of March 1986, 16 States reported using Medicare principles for inpatient hospital services, 24 for outpatient hospital services, and 14 States for physicians' services.

Before October 1, 1981, Medicaid eligibles were free to choose any provider, practitioner, or supplier of health services covered by a State's Medicaid program. However, the Secretary of DHHS was authorized to waive any Federal Medicaid requirements to enable States to conduct experimental, pilot, or demonstration projects that limit freedom of choice, including prospective reimbursement demonstrations. To provide States more flexibility in implementing various cost-saving measures, section 2175 of OBRA-81 provides that a State will not be held out of compliance for failure to meet certain State plan requirements if it limits free choice in any of the following ways.

- Purchases laboratory services and medical devices through a competitive or other arrangement, if the Secretary finds that adequate services or devices were available to beneficiaries.
- Contracts with organizations that agree to provide services in addition to those offered under the State plan to eligible individuals who reside in the area served by the organization and elect to receive care from the organization.
- Pays for certified rural health clinic services.
- "Locks in" beneficiaries who overutilize services to a particular provider for a reasonable time period.
- "Locks out" providers who abuse the program subject to prior notice and opportunity for a hearing.

ISBN 0-16-037246-1