

GOVERNORS' PERSPECTIVE ON MEDICAID

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED FIFTH CONGRESS
FIRST SESSION

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CONTENTS

OPENING STATEMENTS

	Page
Roth, Hon. William V., Jr., a U.S. Senator from Delaware, chairman, Committee on Finance	1
Moynihan, Hon. Daniel Patrick, a U.S. Senator from New York	3
Bryan, Hon. Richard H., a U.S. Senator from Nevada	3

PUBLIC WITNESSES

Miller, Hon. Bob, Governor of the State of Nevada	4
Leavitt, Hon. Michael O., Governor of the State of Utah	8

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Bryan, Hon. Richard H.:	
Opening statement	3
Jeffords, Hon. James M.:	
Prepared statement	31
Leavitt, Hon. Michael O.:	
Testimony	8
Prepared statement with attachments	32
Miller, Hon. Bob:	
Testimony	4
Prepared statement with attachments	32
Moynihan, Hon. Daniel Patrick:	
Opening statement	3
Roth, Hon. William V., Jr.:	
Opening statement	1

GOVERNORS' PERSPECTIVE ON MEDICAID

TUESDAY, MARCH 11, 1997

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:30 a.m., in room SD-215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, D'Amato, Gramm, Jeffords, Moynihan, Rockefeller, Breaux, Conrad, Graham, Moseley-Braun, Bryan, and Kerrey.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order. It is indeed a pleasure to welcome two very distinguished Governors, Governor Miller and Governor Leavitt. I am going to call, in a few minutes, on Senator Bryan to introduce Governor Miller.

I want to point out how the work of the Governors has been key to the welfare reform we enacted last year, and frankly, it is my hope that we can achieve the same success in Medicaid.

Governor Miller, and Governor Leavitt in particular, both of you, have devoted a tremendous amount of time and resources to finding solutions to the problems we face in Medicaid and that is greatly appreciated by this committee.

I think they deserve the credit and have our gratitude for forwarding the goals of Medicaid reform.

Over the past 10 years, there has been a tug of war between the Federal Government and the States over Medicaid, as each side has sought to assert its will over the other.

From the mid 1980's through the early 1990's, the Federal Government imposed mandates on the States, and, in turn, the States shifted costs to the Federal Government.

So the result was devastating to all our budgets, as Medicaid routinely grew at a double digit pace, reaching as high as a 29-percent increase in 1992 of Federal dollars, following State dollars in the Medicaid program. About half of Medicaid expenditures are spent at the option of the State.

But even spending on optional services is often inflated by Federal policies and actions. Medicaid and Medicare, including State funds, now spend more than Social Security.

Since September 1995, I have tried to make two major points about our policies on Medicaid. First, that we were not cutting Medicaid. We were trying to control the unacceptable and unsustainable rate of growth in the program. And second, it has been my contention that the national debate over Medicaid is not about spending, but rather, who controls the spending.

The real issue which has separated us from the administration is who makes the decisions, Governors and State legislatures, or the Federal bureaucracy. And despite misleading representation to the contrary, there is very little difference between the Republicans and the administration on the overall level of Medicare spending. The recent data on Medicaid spending in the President's Fiscal Year 1998 Budget makes both of these points very clear.

In 1996, the growth in Medicaid expenditures were at a historical low. Expenditures increased by just 3.3 percent, and the Governor's deserve a large share of the credit for this slowdown.

Now, they have initiated a number of reforms to help constrain costs, even while expanding coverage to more needy families. The new CBO baseline shows that the annual rate of growth in Medicaid spending will be 7.8 percent, rather than nearly 10 percent, which was being projected 2 years ago.

Second, from the perspective of Medicaid spending, there is little difference between previous Republican proposals and the President Clinton administration recommendations. In September 1995, Medicaid spending was projected to total \$955 billion between 1996 and 2002. Under the President's 1998 budget, coupled with the spending levels for 1996 and 1997, Medicaid spending will total \$822 billion, a reduction in spending from the September baseline of \$153 billion.

This is a level similar to that of previous Republican proposals and, of course, this reflects the change in the baseline as a result of slower growth in the program.

The administration recognizes that the rate of growth in Medicaid spending can be reduced further, if only the President's savings proposals are adopted, but the new spending initiatives are not. Medicaid spending would be \$738 billion, or a difference of \$172 billion from the September 1995 baseline.

And by comparison, the President's budget assumes \$138 billion in Medicaid spending in the year 2002, and this is nearly identical to the 2002 spending level in S. 1795. Although Medicaid spending has been slowed, it is also important to note that 45 States now exceed the Federal requirements for providing coverage to pregnant women and children—in at least one area—and have developed new State initiatives to expand coverage to children through State programs and private partnerships.

Today's hearing is not about the politics of the past year, but rather, the policies which will carry us into the next century. In formulating these policies, we need and welcome the input of our State partners.

Last month, the nation's Governors adopted an important policy position on Medicaid, and they formulated some specific reforms for the program as well. So we welcome the Governors.

It is my pleasure now to call on Senator Moynihan.

**OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN,
A U.S. SENATOR FROM NEW YORK**

Senator MOYNIHAN. Thank you, Mr. Chairman. And we certainly do welcome the Governors and their collective inquiry into this issue.

I make the point, sir, that even a growth rate of 7.8 percent is considerable. As Senator Gramm over there would tell you—as an economist—that rate doubles every 9 years. It compounds pretty quickly.

I want to just make one comment, and I hope that our witnesses can speak to it, which is that while clearly this is a national program—and we are thinking about the next century, as the Chairman says—it remains, in a curious way, a regional program, with its origins in another age almost.

The formula by which the Federal Government shares and matches the State monies come from the Hill-Burton Hospital Construction Act of 1946, if I am right. And the former chairman of this committee, Senator Long, used to say that Hill-Burton was the south's revenge for the Civil War.

It used a formula, which is the square of the difference between State median income and national median income. And for 20 hapless years, gentlemen, I have been proposing square root. If you are going to put algebra in the constitution, why not?

But your respective States represent this. The State of Nevada has a matching rate of 50 percent, as you know, sir. The Federal Government matches almost dollar for dollar. But Utah has 72 percent. You get 3 Federal dollars for every State dollar. And that is a disparity that is surprising at this stage in our National history, and perhaps you will speak to that.

At any rate, I look forward to hearing what you have to say, and we are honored that you could come.

The CHAIRMAN. Well, it is indeed a pleasure to welcome both Governors. I now call upon Senator Bryan to introduce his Governor, please.

**OPENING STATEMENT OF HON. RICHARD H. BRYAN, A U.S.
SENATOR FROM NEVADA**

Senator BRYAN. Mr. Chairman, thank you very much for the courtesy. It is a real pleasure for me, as a Nevadan, to introduce Governor Bob Miller and formally present him to the committee.

The Governor has had a distinguished background in public service in our own State of Nevada as District Attorney, and as Lieutenant Governor. This year marks his ninth year of service as Nevada's Governor—a longer period of service than any Governor in our State's history.

He currently serves as chairman of the National Governor's Association, and last year, in his capacity as vice chairman of that association, played a pivotal role in working with Congress in shaping the welfare reform legislation that was enacted in the 104th Congress.

Let me say I am pleased to have him here as a representative of our State, of the Nation's Governors, and as a long-time personal friend, along with his wife, Sandy. Governor, it is a pleasure to have you here.

Governor MILLER. Thank you, Senator Bryan.

Senator MOYNIHAN. The State has had a series of distinguished Governors, as I understand it.

Senator BRYAN. There is no question about that. The present Governor, however, is the most distinguished of them all, having come in at a time when we were in real trouble in Nevada, I would say.

The CHAIRMAN. I regret that Senator Hatch could not be here this morning because of his being chairman of the Judiciary Committee, and that responsibility requires that he be elsewhere.

Just let me mention that Governor Leavitt has served as Governor of Utah since 1992. He has served as chairman of both the Republican Governor's Association, as well as the Western Governor's Association. He is now co-chairing the Governor's Medicaid Task Force. Gentlemen, it is indeed a pleasure to have both of you here.

Governor Miller, would you like to begin the testimony?

STATEMENT OF HON. BOB MILLER, GOVERNOR OF THE STATE OF NEVADA

Governor MILLER. Thank you very much, Mr. Chairman. I thank my predecessor, Senator Bryan, not only for that introduction, but for creating the circumstance by which I could be the longest serving Governor of Nevada.

His election to the U.S. Senate was the reason that I had those 2 extra years, and certainly his footsteps are difficult ones to follow. I am still trying to learning how to do that.

Senator ROCKEFELLER. He was the one that created the mess that he was talking about that you cured?

The CHAIRMAN. With all due deference.

Senator ROCKEFELLER. With all due deference.

Governor MILLER. It has been tremendous growth ever since Dick moved back here.

The CHAIRMAN. Could I just interrupt for a moment?

It is my understanding that this hearing is being shown on Internet. It is either the first or one of the very first times that this has been done live. So we welcome the Internet audience to the show and hope they are entertained.

Governor Miller? Sorry.

Governor MILLER. And hopefully all of those watching on the Internet will write to the Nevada State Legislature and emphasize the importance of computers in the classroom in my present budget. The preceding was a paid political announcement.

As chairman of the National Governor's Association, and as one of the members of our Medicaid Task Force, it is truly a pleasure for me to be here today to discuss one of the most important issues facing the States, and that is the future of Medicaid reform.

Joining me today, as you have indicated, is Governor Leavitt, who, for the last 2 years, as well as myself, has been a member of that task force. And this year's task force also includes Governor Lawton Chiles of Florida, Governor Howard Dean of Vermont, Governor Tommy Thompson of Wisconsin, and Governor George Voinovich of Ohio.

We welcome the opportunity to share with you our ideas and concerns regarding Medicaid reform and truly believe that the reform can only be effective when the Federal and State Governments cooperate fully as partners, with joint responsibility for insuring that recipients receive a high-quality of care and cost effective health care.

Governor Leavitt and I will review several issues of concern to Governors that the Congress and administration will be working on for the next several months. First, I will set forth the Governors general views on Medicaid savings, and then Governor Leavitt will walk through our specific recommendations about how these savings can be achieved.

I would also add that Governor Leavitt will handle all the difficult questions. We will also comment briefly on issues relating to managed care quality and children's health.

No one recognizes more clearly than Governors the need to control Medicaid spending because we continually wrestle with the pressure that Medicaid exerts on our own budget. In fact, 49 of the 50 States cope with Medicaid costs in the context of State balanced budget requirements.

And the challenges that Medicaid poses to State budgets became particularly acute, as you mentioned, Mr. Chairman, in the late 1980's and early 1990's. During that time, Medicaid spending increased at an average rate in excess of 20 percent. These growth rates were unsustainable.

To address the financial pressures and to develop a more quality oriented system, Governors began a fundamental transformation of their individual Medicaid programs.

Historically, Medicaid programs have been claim processors and bill payers, but today the States are becoming more sophisticated, valued purchasers of quality health care services, developing integrated systems of care for a vulnerable population. And this transformation is producing results.

Medicaid spending grew only 3.3 percent last year, and that is a dramatic reduction in growth, which stems, in large part, from an aggressive State pursuit of administrative simplification, innovation and good management.

Our successes in controlling growth have been recognized. In February of 1997, the CBO lowered its baseline projections of future growth in Medicaid spending by almost \$86 billion, a reduction that could not have been achieved without State efforts.

Now, given the progress that States have already made in controlling costs, there is less room in the program from which to squeeze additional savings, without having a potentially detrimental effect on the number of people served by Medicaid or the range of benefits that they receive.

For that reason, the Governors believe that additional Medicaid savings included in any deficit package should be kept to a minimum. We do believe that additional savings are possible.

With the additional flexibility that Governor Leavitt will spell out in a minute, Governors believe that States will be able to produce an additional \$8 billion in scoreable Medicaid savings between now and the year 2002, which is very close to the net Medicaid savings included in the President's budget.

Combined with the \$86 billion in savings acknowledged by the CBO, that would put Medicaid's contribution to deficit reduction at \$94 billion during this budget cycle, and that is well within the savings parameter discussed during last year's Medicaid reform debate.

Just as important as the level of savings we support is the question of how those savings would be achieved. Governors adamantly oppose a cap on Federal Medicaid spending in any form. The proposed per capita caps will help the Federal Government balance the budget, potentially on the backs of State Government. We oppose these caps for a number of reasons.

First, they are unworkable administratively. In 4 categories, 50 States, there could be as many as 200 separate caps. Second, they could result in States becoming solely responsible for unexpected program costs, such as a loss in a lawsuit or the development of expensive new therapies that drive up treatment costs beyond the Federal allowable rate.

And third, the cost shift resulting from caps presents States with a number of bad alternatives. States would essentially have to cut back on payment rates to providers, eliminate optional benefits provided to recipients, end coverage for optional beneficiaries, or come up with additional State funds or taxes to absorb 100 percent of the cost of services.

Now, it seems to us unnecessary to undertake such a disruptive and fundamental transformation of a program on which the Federal Government will spend half a trillion dollars over the next 5 years in order to achieve the \$8 billion in additional savings that we consider reasonable.

If we consider the President's budget package, his expectations for savings through a per capita cap are even smaller. Although his package includes \$22 billion in gross Medicaid savings, only \$7 billion of that total comes from the program cap.

The other \$15 billion in savings comes from the disproportionate share program, the hospital program. And because Governors consider \$8 billion to be a reasonable savings target, we oppose the magnitude of the DSH cuts that are included in the President's budget.

We also strongly believe that DSH funds must continue to be distributed through the States, not directly to the providers, to ensure that the program is coordinated with the States' overall health systems infrastructure.

Governors believe there are better ways to achieve an additional \$8 billion in Medicaid savings by 2002, and our task force has developed these alternatives. Our strategy sets forth a number of policy options that, when combined, will produce significant savings. We grouped these options into 3 broad categories: Reforms related to managed care, reforms tied to reimbursement policy, and other program reforms.

The categories, which Governor Leavitt will discuss are managed care, managed care for the dually eligible, provider selectivity, reimbursement rates for QMDs and the dually eligible, the Boren repeal, cost based reimbursement, cost sharing, EPSDT and fraud and abuse. Governor Leavitt will walk through all of those.

A number of our recommendations relate to managed care. And before I turn to him, I want to briefly set forth some of our ideas that relate to the quality in the managed care area.

Like you, we are committed to insuring that all Medicaid recipients receive high-quality health care. This focus on quality fits in well with the States' emphasis on value purchasing, and the Governors believe that our goal of promoting quality can be accomplished more effectively through a broad base agenda focused on monitoring results and evaluating improvement, rather than through a series of procedure specific requirements.

This approach builds in the flexibility to address medical innovations and to take advantage of the continuous evolution of more sensitive and sophisticated quality measures.

NGA's Medicaid Task Force has begun preliminary discussions about what will be included in a quality package, and the Health Care Financing Administration has expressed strong interest in the approach that we are developing.

As envisioned by the Medicaid Task Force, States would develop quality assurance plans, which could include a number of elements, such as a grievance process, a comparative report card of health performance plans, a deeming of NSQA accreditation standards and HEDIS reporting requirements.

States could establish benchmarks to measure future quality performance and a range of indicators could be monitored and assessed annually by the States, including consumer satisfaction, the number of low birth rate babies and immunization rates, to name just a few of the dozen of possibilities.

These plans would be submitted to HCFA and updates would be provided annually. The States would monitor the results achieved by health plans in meeting the goals established for them, and this performance would be considered by the States when deciding whether to continue the contractual relationship between the health plan and the Medicaid program.

A critical component on efforts to promote quality would involve the development of a more informed consumer base, and States will provide Medicaid recipients with the information they need to make good choices for themselves, while creating mechanisms to insure that problems get resolved quickly and successfully.

We would welcome the opportunity to work with Congress as managed care quality issues are debated and believe the quality assurance partnership we envision between the States, managed care organizations and consumers, could become a model worthy of replication.

Let me also comment briefly on one other issue I know has been of a particular interest to members of this committee, and that is children's health. The Governors agree that health care is essential to the well-being of children. In fact, the States have been leaders in making insurance coverage available to millions of children.

There are 18.7 million children below the age of 18 who are covered by Medicaid today. Thirty-nine States already have extended Medicaid eligibility beyond Federal mandated levels. A number of States are in the process of implementing major expansions to Medicaid eligibility for children.

For example, Governor David Beasley, of South Carolina, has announced a Medicaid expansion that would extend coverage to 50,000 children. Governor Voinovich, of Ohio, has included in his budget funds to extend Medicaid to an additional 96,000. And that level of savings set forth in the President's budget, or the Blue Dog Coalition Plan, and even higher levels of savings discussed by others in the Congress, could potentially jeopardize these and other State expansions of Medicaid eligibility.

States are also experimenting with approaches outside the traditional Medicaid framework to extend health care coverage to more children. These experiments typically rely on State funds and family contributions.

For example, Florida's Healthy Kids Program seeks to give children access to health care through a school enrollment based program, and Governor Chiles plans to extend the Healthy kids Program to an additional 60,000 children this year.

Over the next few months, the Congress and administration will consider a number of different approaches to extend health insurance to children who are currently uninsured. The Governors are in the process of reviewing the various children's health proposals that have been set forth thus far, and we can share with you some of those preliminary thoughts.

First, it is critical that any new Federal initiative should be designed to compliment, not jeopardize, the array of children's health activities already underway in the States.

Second, new programs should not create an opportunity for shifting private sector insurance costs to the public sector. And third, the Governors would oppose any mandated Medicaid eligibility expansion.

We hope to work closely with the Congress and the administration as these children's health issues and Medicaid, as a whole, are debated.

We would be happy to answer any questions. But first, let me defer to Governor Leavitt for his presentation on the details of the NGA Medicaid Task Force cost saving strategy. Thank you.

[The prepared statement of Governor Miller appears in the appendix.]

The CHAIRMAN. Governor Leavitt.

STATEMENT OF HON. MICHAEL O. LEAVITT, GOVERNOR OF THE STATE OF UTAH

Governor LEAVITT. Thank you, Senator. And, Senator Moynihan, may I respond, first of all, to your suggestion?

The mysteries of Medicaid funding have long fascinated me as well. In a previous context—a year or so ago—as we were debating this issue, I had the responsibility of sorting through with States, looking for some way to develop a funding formula that might accommodate some form of—if you will remember the discussion—block grant. It was a fascinating experience.

The question that you raised in terms of cost sharing percentage was one of the interesting issues. I might add that, of course, as you know, that is tied directly to State income. And since our State income is growing, our percentage has been dropping. You indicated it is 74. It is actually now 63 percent. So we are slightly bet-

ter than one to one. But as our income has improved as a State, that percentage has gone down. [Note: the 1997 Federal Medical Assistance Percentage (FMAP) for Utah is 72.33.]

But there are other mysteries that, for example, were uncovered as we went through this experience. The State of New York receives a reimbursement, on an average, per capita, of about \$7,800. The State of California, a state of similar size and similar demographic make up, is only \$1,500.

The CHAIRMAN. You are quite right. Although, in each case, it is a 50-percent match. New York gets many more dollars.

Governor LEAVITT. Both have a 50/50 cost shift. I mean there are lots of mysteries here that I think cannot be—at least on the surface—looked at as a rational approach, but they have added up to be what they are.

I might use that as a place to step off in terms of this discussion. There are also lots of different ways to look at this. I have just developed a little graphic here that is not very good, but I just did it sitting at the table listening to the conversation.

Just to give this some context, last year, as we came to this panel, we were talking about achieving cost savings between 54, which was ultimately the President's proposal, and 86, which is where the Congress ended up. The debate died there.

Since that time, CBO has concluded that there will be \$86 billion worth of savings, and so they have readjusted the base. So what we were calling zero before, actually was \$86 billion last year.

So as we come today saying we recognize that there is a need for savings to be achieved, and as we put an additional \$8 billion of ideas on the table, we would like to have it recognized that much of that \$86 billion came as a result of the kinds of things that we are talking about being able to be applied in a limited fashion.

I will break the ideas of the NGA into 3 different categories. The first one would be areas of managed care, the second would be reimbursement reforms, and the third would be other reforms, and I will just touch on these briefly.

The first one I will mention is the repeal of the requirement to achieve a waiver to use managed care. The States have been, on a limited basis, pursuing managed care very aggressively. For example, the State of Michigan has achieved a 2.5-percent savings in the overall budget. Missouri has achieved a \$50 million savings; Wisconsin \$90 million.

In Utah, I can tell you, for example, 2.5 percent of our entire program has been a reduction because of our use of managed care. It makes very little sense to us why we should need to go to HCFA for waivers. This is a proven approach. It is one that is just unnecessary.

The second area I will mention will be managed care dual eligibles. As all of you well know, there are people, many of them—roughly 6 million in America; many of them the elderly and disabled—who are eligible for both Medicaid and Medicare. Utah, for example, has developed a voluntary program within the scope of the guidelines that would allow to use managed care in these dual eligible categories.

We have achieved a significant savings in doing so. Minnesota has a similar program, and they have achieved a 5-percent savings.

As it currently stands, we are not able to use managed care on these dual eligible populations.

The next suggestion would be in our provider selection. In plain language, all we are asking here is that the States be allowed the same tools that are available in the private sector for managing large health care systems. By using competitive bidding, being able to recognize that we are the largest health care purchasers in our States and in our regions, we are clearly able to achieve that, which both the National Government and the States gain the benefit of.

Texas, for example, has achieved 2 percent savings in their hospital by using selective contracting, where they have contracted with a limited number of hospitals in the community, as opposed to making them all eligible.

Another area is in the reimbursement of the dual eligibles and what are referred to as QMBs, which are dually qualified beneficiaries. Currently, we have to reimburse the providers on the basis of Medicare's reimbursement rates. If they are dually eligible, if we are responsible for managing their care, it seems logical to us that we should be able to use the contracts that we are able to negotiate under Medicaid as opposed to Medicare rates.

Michigan, for example, estimates that they would save \$85 million per year if we had that capacity. Much has been spoken of in the area of cost based reimbursements. The Boren Amendment is a prime example. It is often spoken of and one on which there is basically universal agreement.

But we would like to point out that there are a number of other cost based reimbursement regulations that make it impossible for us to allow the market to set these rates. Our basic request here is we believe that there are savings for both of us, if we could just allow the market to set the costs, as opposed to an artificial system that is now in place.

Mr. Chairman, that would conclude my presentation.

[The prepared statement of Governor Leavitt appears in the appendix.]

The CHAIRMAN. Thank you very much, Governor Leavitt.

The 3.3 percent national growth rate in 1996 was, of course, the result of a number of factors, and there was, understandably, wide variations in growth rates among individual States. For example, I understand both Utah and Nevada experienced double digit growth between 1995 and 1996, while a few States actually reduced their Medicaid expenditures.

Now, CBO is predicting that Medicaid will increase an average of 7.8 percent between 1997 and 2002. Have the States made their own projection about Medicaid costs in this period? And if so, would you share them with us?

Governor MILLER. Thank you, Mr. Chairman. We have not done a nationwide survey of the States. There has been a brief study of 10 of the largest States, which would indicate a slightly lower projection, when you compile their estimates, than that that was indicated by CBO. But we do not have one that is national in its scope or content.

The CHAIRMAN. Let me ask you this. It dropped to 3.3 percent, which is a very significantly lower figure. Now we are saying it will

go back up to 7.8 percent. What is the reason for this rather significant climb?

Governor MILLER. Well, I would assume you would have to ask the CBO for their particular reasons. But I would suspect that it would relate to fluctuations in the overall economy. And the economy has been vibrant for so many years that there is probably some level of expectation there would be some slight dips, which would occasion more people becoming eligible and participating in the program.

Also, if the States are restricted—as we have been in the past with the types of programs we put forward—then the costs could continue to escalate from extraneous sources, such as court interpretations.

Governor LEAVITT. Mr. Chairman, I might add to that some. On 2 points. The first with respect to is the number reasonable.

Again, going back to the mysteries of Medicaid funding, this is a very complex issue. And we got into this last year. It became very clear that there were some States that were going to see substantially greater growth than 3.3 percent. Bob Miller has nearly that much in population growth every year.

When you add that to inflation, there are States that were referred to in this discussion as the growth States and those that were not, and it dramatically impacts the way these formulas affect their State.

With respect to the 7.8, may I also point out that we have been going through, in the health care industry, a rather aggressive, competitive transition. It is much more competitive than it was before, and that has had the effect of driving the rates down. But that 7.8 actually reflects closer to medical inflation rates than the 3.3 percent.

This is a very significant point. Because the rates are 3.3 percent today, does not mean that they will not continue to go up to higher levels, and that is one of the grave concerns that we have about caps.

Governor MILLER. May I add just one more thing, Mr. Chairman? The CHAIRMAN. Sure.

Governor MILLER. In looking at our notes here, the other factor that probably was considered is the aging of the baby boomers, which alone will drive a number of more people into the Medicaid roles, in both case size load and per capita costs.

The CHAIRMAN. You mentioned, Governor Leavitt, the opposition of the Governors' to per capita caps. Are there ways to limit the growth in Federal and State expenditures which would be acceptable to the Governors?

Governor LEAVITT. Well, we recognize that there is a need to achieve greater efficiencies, and we have put ideas forward with respect to how we think that can occur. I would like to restate our opposition, however, to any form of per capita cap. We think there are only three ways that the States can respond to that. All three are bad.

The first is to cut providers, which ultimately means that you do not have access. The second would be to cut benefits, which is a very difficult thing to do, even among optional populations. We refer to them as optional populations, but they actually are preg-

nant mothers, children and the disabled. Those, as the States have proven, are not optional with us.

And the third would be to have the States pay, if there was, in fact, an overage. But let me just give you an example of how that works in my State.

Currently, the average person cost is about \$2,000, based on the 60/40 split roughly. That means the National Government currently pays about \$1,200 and the State pays \$800. If because of a lawsuit or because of inflation, or any other number of changes that could be affected by Congress that went up to \$2,500, the \$500 excess of the \$2,000 would not be shared by the National Government.

It would go directly to the State, which would mean that this would all be done on the back of the State. We do not think that sounds like a partnership.

The CHAIRMAN. I understand your point; that a one-sided cap on spending is unfair as the risk is shifted to the State. But if you were given greater flexibility to limit the entitlement, do caps on spending become more acceptable?

Governor MILLER. I think, Mr. Chairman, that is what we outlined today in trying to reach an additional \$8 billion, coupled with the \$86 billion already realized, is that the flexibility outlined and detailed by Governor Leavitt, and overviewed by myself, is designed to reach that other \$8 billion.

The CHAIRMAN. My time is up, but let me ask, are Governors proposing changes in their State budgets which will result in Medicaid savings? Has any study been made of that?

Governor LEAVITT. Mr. Chairman, I can respond to that. Every Governor is struggling with this problem. We have the burden of a balanced budget every year, and Medicaid has become a greater and greater weight for us to carry.

It is now the second largest category of spending in State budgets. It is pressing hard up against education as the highest user of public funds. So we are desperately looking for ways to save money, not just for you, but for us. So there is considerable pressure on us already to be saving these dollars.

The CHAIRMAN. But I was wondering whether the current proposals would reflect significant change in spending at the State level?

Governor LEAVITT. Well, maybe I am not understanding the question. But every time we save a dollar, you save a dollar.

The CHAIRMAN. Right.

Governor LEAVITT. And we find that to be considerable incentive for us, and it has been present for some time. And we look with some pleasure on the \$86 billion that has been saved, and the \$31 billion on top of that that CBO has acknowledged. And while we are not so bold as to say we are responsible for all of that, we think that the kinds of management changes that the States are making are basically the only changes that have occurred in the program.

The CHAIRMAN. As I said in my opening remarks, I think you are entitled to great credit for those accomplishments.

Senator MOYNIHAN. Something happened.

The CHAIRMAN. That is right. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman. Could I just note, on this general point, that Mr. Robert Pear, in the New York Times, wrote recently that Mr. Clinton's proposal, which is the per capita cap, would limit the financial obligation of the Federal Government, but not the States.

And I do not know why we want to be doing that right now when we are seeing results of effort and thought.

Could I say to Governor Leavitt that the complexities of this formula are formidable. I am glad you want to get one of those computers up from Nevada. But just as an example, and being open in this I hope, in terms of the Federal benefit per capita in the State of Nevada, it is \$138. In the State of New York it is \$582.

Even though we have a higher matching rate, we get more Federal monies. And all this you know. But it should be. I think candor requires me to agree with you.

I would like to put a general question to the 2 of you, which is that you argue that sound policy should drive Medicaid reform decisions, not budgetary politics. And that is surely an unexceptional statement, and this committee would agree with you.

Last year the National Governor's Association urged the President and the Congress, "to adopt a consumer price index that accurately reflects the real rate of inflation."

And, as you know, the committee has been much concerned with this matter; the chairman has been. We have a new universal judgment of witnesses. We have had before us the chairman of the Federal Reserve Board and such.

Our present use of the consumer price index, which is not a cost of living index, greatly adds to our costs. And that if we were to get the correction that was proposed by a commission that we established in this committee, you would get a trillion dollars in 12 years in just getting your numbers right.

Might we assume that the Governors are still of this view; that we ought to get as near as you can—you can never get exactly—a good cost of living index by which we can index our Federal programs and the tax program as well?

Governor MILLER. We, in fact, enacted a similar resolution in early February of this year. So, for 2 years in a row, that has been our position. It is our position, and we feel that is something that should be strongly considered in balancing the budget, which we believe is a desirable goal.

But we are concerned that some efforts to balance the budget might be at the expense of the States and their ability to provide services.

Senator MOYNIHAN. I think we would take the view that we should seek to get a correct number, regardless of its budgetary impact.

Governor LEAVITT. Mr. Moynihan, it is very seldom that I have an opportunity to get in the same line as the distinguished chairman of the Federal Reserve Board, in a forum this profound, but I would like to add my solid amen to his words. We just ought to get it right.

Senator MOYNIHAN. Yes. They are. Thank you very much, Governors. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bryan.

Senator BRYAN. Thank you very much, Mr. Chairman. With all of these numbers that are dancing around, let me share at least some information that we have; that in fiscal year 1995, Nevada received less, in terms of Medicaid funds per capita, than any other State. Roughly, \$155 versus a national monthly average of approximately \$342.

We have the lowest Medicaid reimbursement formula, and the highest growth rate in the country. My question Governor Miller, is how would this proposed per capita cap affect States like Nevada that have high growth and low reimbursement rates, in terms of the formula?

Governor MILLER. Well, I think it would be particularly disadvantageous to States like Nevada. And, in somewhat of an answer to both Senator Roth and Moynihan's questions earlier, Nevada has less room within our programs for flexibility.

So, some of the options that are offered by other States are not offered in Nevada. We are what you might characterize as a Volkswagen State and have less room to maneuver. I mean, we are literally frozen when it comes to that, in terms of what is particularly mandated, and we receive less money per capita than any other State. And we have the fastest growth, on top of all those factors.

It is difficult to ascertain exactly what numbers would result from the per capita cap, but it is reasonable to believe it would be a more significant percentage in our State than many others.

And the DSH formula proposal is also particularly disadvantageous to Nevada because we are one of the 15 States that is characterized as high DSH, but we are a low high DSH State in the way that the formula is to be revised.

It works better if you are a high DSH State or you are a non-DSH state than if you are in that middle category. So again, we might lose as much as \$8 million in a round basis in DSH, which is a significant amount of money in our budget.

Senator BRYAN. In an earlier hearing before the committee, Secretary Shalala testified, in response to a similar question, Governor, that I just asked of you, there is really nothing to worry about; that high growth States are protected because this is a per capita cap would be indexed based on the GDP.

Now, I am not sure that the GDP is necessarily the kind of index that would be helpful to a high growth State whose growth rate may be substantially higher than the overall GDP, which is a meld obviously, of the 50 States. Would you care to comment on the Secretary's response?

Governor MILLER. Well, I think your characterization is accurate. It would not be advantageous to us. And then it is multiplied by the fact, as I pointed out, that we are very restricted in the benefits that we provide, giving us less latitude and less flexibility.

So, if there was such a limitation, we are in both categories that get disadvantaged, high growth and low benefits.

Governor LEAVITT. Senator Bryan, can I comment on that?

Senator BRYAN. By all means, Governor Leavitt.

Governor LEAVITT. There is no question that those States that are experiencing high growth would be disproportionately ill served by this proposal. It should also be pointed out that one of the other downsides of this kind of a cap is that there are many States—

some of them low growth, some of them high growth—who have aggressively gone out and used managed care and other manager methods in order to get their per person cost down.

This would basically freeze that, and it would reward States who have done nothing; who have high per capita costs or high per person costs. It basically freezes their inefficiencies. It would allow them then to start to moving to inefficiencies and reap great wind-falls. That would be unfair to those States who have aggressively sought that kind of efficiency before.

Senator BRYAN. I appreciate that both of you have made the point that the National Governor's Association does oppose the per capita cap. But I think what you were saying is that even if one accepts, but does not concede, for purpose of the debate, that this kind of per capita cap would be particularly difficult for a high growth State that has worked into its own program some of the efficiencies that both of you have outlined.

Governor LEAVITT. Nothing in our comments should reflect any support whatsoever for caps.

Senator BRYAN. I do understand that. Sometimes the legislative process at the Federal level does produce, as I know both of you understand, some unintended consequences. Just in case this might occur, I wanted to make the point that this proposed index would be particularly difficult for a high growth State.

Governor Miller, my last question is to you. You talked about the 6 million beneficiaries that are dually eligible for both Medicare and Medicaid. Is there anything that we can do to provide greater help to the States in terms of some of the implications for these dual eligibles that we have?

Senator LEAVITT. I think, Senator, the primary thing would be to recognize any discussions of Medicare would include Medicaid, because as you modify Medicare, not only do you affect those 6 million dual applicants, but you potentially affect even more because of the Medicaid formula.

If you restrict some of the Medicare services, you could shift those costs, perhaps even inadvertently, to Medicaid. And so it has been our position at the National Governor's Association that we would like to see both studied together and the interrelationship being a constant subject of discussion. We are very concerned that some of those unintended cost reductions in Medicare would just shift to Medicaid and extrapolate our problems.

Senator BRYAN. Governor Miller, anything you would care to add to that comment?

Governor MILLER. No, thank you.

Senator BRYAN. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. I would like to join in in welcoming the Governors here. We have had an excellent relationship with both of these Governors over many years, and I am glad to see you again.

I would like to ask a couple of questions. I will start off with that you repeal the cost reimbursement provided to federally qualified health clinics. In other words, to community health centers. There is a cost base reimbursement that is there now, and I was active

in getting that in place several years ago. But you would repeal it. And maybe that is all right.

I have talked to our folks at home, and they are not opposed to that. But they are worried about whether they are going to be adequately reimbursed. As you know, these community health centers, at least in my part of the country, carry a very, very heavy burden with the poor, as far as health care goes, and they do not have another source of income.

In other words, they cannot make up with charging higher to those that come in, because everybody that comes in there, nearly all of them are on Medicaid. How would you handle that? In other words, how are we going to make sure that these institutions are adequately reimbursed?

Governor LEAVITT. Senator, the community health care centers in our State are a wonderful addition, and they do pick up a service source that no one else would at times, and it is in the interest of the States to maintain them as healthy entities. But they should not be insulated completely from the competitive nature of a marketplace.

So we are just looking for ways to find that balance. Currently, it is tipped entirely one way; it is entirely cost based. And what that means is they are not subject to any market pressures whatsoever.

Senator CHAFEE. Yes. They are reimbursed as Medicare recipients. Medicare providers are. Well, we all want them to survive. And I guess your point is, as a Governor, you are not going to let them fail because of the crucial services they provide.

What do you say to that, Governor Miller?

Governor MILLER. My response is very similar to what Governor Leavitt just said. But I think the NGA position collectively is that these are valuable resources in the individual States that need to be retained.

But their cost basis needs to be similar to what the State is experiencing for the rest of the Medicaid program, and it should not stick out on the one end. It should be a part of an overall package to provide health care in the State.

Governor LEAVITT. Senator, could I add one more piece?

This is a wonderful illustration of what we believe is an untapped resource, and that is the ability for the States to learn from each other as we undertake some of the difficult questions.

What you have asked is a very difficult problem. On the one hand, they serve a population that may not be served in any other way. On the other hand, they are not subject to the marketplace. We cannot allow them to not be adequately funded.

We think, as we move into this, that the States have every incentive and have every desire to see them continue, and we will find ways to find that balance. If we have to find them all in a hearing room like this or in Washington, we likely will not find them. But we think, with the incentives being what they are for the States, we will find the solutions.

Senator CHAFEE. Yes. The only point I want to stress is that they do not have an alternate source to go to to make it up; from private payers or whoever it is.

Now, we all support repealing the waiver requirement to enter managed care for Medicaid recipients. I do not think there is any argument with that. At least I have believed there should be some minimal standards in there. Both of you have testified that you do not want that.

But I am not sure just what you would have in lieu of that. I think it was you, Governor Leavitt, that suggested that there be an accounting procedure or a tabulation of how they have done on an annual basis. What do we do to track these providers under this managed care waiver; a waiver to managed care?

Governor LEAVITT. If I could just make a general statement on that. I cannot respond specifically to what you are referring to because I am not connecting on it.

But, generally speaking, we recognize that there is a need for standards, but standards often become prescriptions. And standards often become so detailed that that is the form and the basis under which all of our flexibility disappears.

So I am sure that there will need to be some form of standard because of the National Government's involvement. We just argue that the less prescriptive they are, the more efficient we think the marketplace can become.

Governor MILLER. Senator, actually I believe it was myself that outlined that.

Senator CHAFEE. I guess it was you, Governor Miller.

Governor MILLER. What we have suggested is quality assurance plans that would include a number of elements, grievance process, comparative report cards of health care performance, deeming of NCQA accreditation standards and HEDIS reporting requirements and benchmarks, future quality performance, etcetera, and basically, an annual assessment.

But we have also suggested that there might be external indicators, such as consumer satisfaction, the number of low birth weight babies, immunization rates, many that should also be considered, and we do not believe that that list is exclusive either. We want to work with the Congress to establish parameters by which those measures could be reached.

Senator CHAFEE. So presumably, these reports would come in at the end of the year or whatever the period is. So, in effect, they become a standard to some degree. In other words, if they are not providing the adequate number of immunization shots or not caring for low birth weight babies in some fashion, then that managed care unit, I presume, would be dropped?

Governor MILLER. That is correct. It would be a performance measure, much like most managed care organizations are critiqued now in the private sector.

Governor LEAVITT. Senator, I think our general statement would be Governors would like to be measured on the basis of our results, not have every process monitored.

Senator CHAFEE. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Gramm.

Senator GRAMM. Mr. Chairman, I want to join everybody else in welcoming our Governors today. I do want to bring up a very unpleasant fact that seems to be lost in all of this discussion. And

that very unpleasant fact is that both the President and the Congress have committed to balancing the budget in the year 2002.

The President submitted a budget last year that called for \$35 worth of Medicaid savings. We have adopted budgets calling for substantially more. The President, this year, has proposed a savings figure of \$26 billion. But his budget, without this sort of cataclysmic automatic cut in the last 2 years, is \$70 billion short of being in balance by the scoring that we are required by law to follow.

And so there is no possibility that we are going to write a budget that does not have at least \$26 billion worth of Medicaid savings. There is no possibility that is going to happen.

I do not know how you could possibly write a budget that would have any hope of being in balance without doing that.

Second, I am kind of a little bit amazed in that the President has made a proposal, which you can like it or dislike. And there are parts of it I like. There are parts of it I do not like. But it is a real proposal to drive change in Medicaid, and the proposal is have a per capita cap.

Now, we may decide to do it; we may not decide to it obviously, as I look at the President's budget. And I have been very critical of it, and for good reason. In Medicare, for example, the President phases out a co-payment that adds \$11 billion a year to the cost of Medicare. And so I have been very critical of that.

But, on the other hand, this is real, genuine, honest to God reform that will save money, that will drive change, and that will force States, not only to look at the things you have talked about, but dramatically changing the system as well.

And it seems to me that one of the things that we are going to have to answer on this committee, at some point when a budget is written, is where are we going to get the \$26 to \$35 billion worth of savings we are going to have to have to make the budget work? And if we do not use the President's per capita cap, what are we going to do?

Now, I certainly understand that you cannot have a per capita cap without giving dramatic flexibility to States. But at some point, somewhere, we are going to have to find a way to fill this hole. There is no way there is going to be a budget that saves only \$8 billion in Medicaid.

Medicaid has grown, in the 1980's and 1990's, at 20 percent a year. Every time we reformed it, we have added benefits that cost more than we saved. Every single time. And we phased them in over time so it looks like we are cutting when we are actually increasing.

But I did not want to let the opportunity pass, and I am certainly not trying to get into an argument with you. And I understand where you are coming from in terms of what you are trying to do in your State.

But I did not want to pass the opportunity to sort of throw the question out at least that if in the end we are required by budgetary considerations to save more money in Medicaid, even if we rejected the President's proposal, which is a genuine proposal—and I see it as a very powerful, but obviously unpopular proposal—what ideas would you have, from the States' point of view, of things we

could do that would give us any hope to fill this gap between the \$8 billion you are talking about and the \$26 to \$35 billion we are going to have to come up with, ultimately, on this committee to make our budget work?

Have you got any thought of things that we ought to be looking at as an alternative to this?

Governor MILLER. Well, Senator, it certainly is a difficult problem, and it is the belief of all the Governors that the Federal budget should be balanced like we do in the States. However, respectfully, I would point out that there are tradeoffs in the budget and such considerations as tax cuts or whether or not to modify the CPI could very well be considered in balance as compared to Medicaid adjustments, which would result in the States having to raise taxes.

I do not think anybody desires to have Federal tax cuts at the expense of States having to raise taxes on the very same individuals. And we believe that the \$8 billion, coupled with the \$86 billion that has already been achieved, is a significant savings in Medicaid.

If you become more restrictive than that in terms of the money, then it is going to result in a reduction in services or an increase in taxes at the State level.

Governor LEAVITT. My response would be similar. I agree with you, Senator, that the proposal does drive change. The unfortunate part is that all of the changes that it drives are bad, particularly for States like yours that are high growth and use DSH extensively.

We have proposed a series of flexibilities that we think would allow us to put the \$8 billion on the table. We do not have a policy with respect to DSH, for example, in NGA, and so I speak of it only as a matter of reference.

When we were talking about this a year ago, we discovered that you can freeze DSH and save \$12 billion on a going forward basis. That discussion ultimately will come up. We do not have a policy on it in NGA.

But I think Governor Miller accurately portrayed it. CPI is a very good solution that would, we think, add to your ability to do it. But ultimately, this panel will have to face whether or not if they are going to enact tax cuts that will cause us to raise the taxes in the States.

Senator GRAMM. Well, Mr. Chairman, if I could just make one final comment. I think that we ought to look at CPI. I think we ought to put together a distinguished panel of economists and statisticians to look at it.

But I think if it is clear that we are just trying to jimmy around with the basic measure of inflation so that we do not have to make any hard choices, I think that we are not going to find any kind of great public support for it.

Finally, the one area where changing CPI is not going to do us any good of any substantial degree is in the area of medical care. It is not going to have a substantial impact or significant on Medicare; it is not going to have a substantial impact on Medicaid. Changing the CPI reduces Social Security benefits and it raises taxes.

That is where the benefits, if you call those benefits, comes from. But it still does not deal with our problem of Medicaid. And if, in fact, as many feel in the administration, and in the Congress, and in the various think tanks that this lull in Medicaid costs were due to a surge in States moving benefits—recognizing that reform was on the way and that we are going to be back in these double digit increases, which I think is probably the more probable scenario—we have a major problem here that is not going to be solved by CPI, whatever the benefits may be of it.

The CHAIRMAN. I would just like to ask one follow-up question. If we were to give you the flexibility you desire, which would include limiting the States' liability as well, could some type of limiting growth be supported by the Governors, Governor Leavitt?

Governor LEAVITT. We have a very difficult time. In fact, have not arrived at a conclusion that would allow us to say that a per capita cap either serves the program or serves the States or the National Government's long-term interest, unless the National Government were to decide that they wanted to limit their liability and not the States. There is just a basic inequity in the National Government stepping away from this partnership in that way.

The CHAIRMAN. You were suggesting that you could limit the States' liability as well.

Governor LEAVITT. Well, that was not the inference I was making. We were saying that we believe it would be an unfair thing for them to limit theirs and not ours.

The CHAIRMAN. But if the flexibility was given the States, including limiting their liability, could that be supported by the Governors?

Governor LEAVITT. It would, I suspect, depend on how that was done.

Governor MILLER. We have never analyzed the limitation on the States' liability, Mr. Chairman. What we discussed extensively in our 100 hours of comradeship last year discussing this issue was limiting the Federal. So I am not prepared to answer that question, unless we have a great deal of specificity as to what it might mean, and then we could analyze what it might mean budgetarily.

Governor LEAVITT. Mr. Chairman, I think that the important thing here is to recognize that we do not have NGA policy on this subject. As you know from previous testimony before this panel, there have been many Governors who have come and indicated that we believe, given full responsibility to manage this program with the flexibilities that we need, that we can achieve significant savings.

We do not have policy in the NGA related to limiting the States' liability.

The CHAIRMAN. I would just conclude by saying this committee is going to have make some hard decisions down the road—I am confident—once the budget begins to move. The more information as to what you can support in this kind of a situation, the better.

Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. First, just a comment, which I feel duty bound to make about States balancing their budgets and we do not.

I have not actually added up the number of revenue bond sources and capital budget techniques and the things that I had when I was Governor of West Virginia, but it has always caused me, when anybody ever said we balance our budgets and you folks do not—and they are quite right about the fact that we folks do not—that the States have a good deal more flexibility.

And it could be argued the fact that if you applied the same procedures as to the States as you do to the Federal Government, your budgets would not be balanced either. But that is just small-minded on my part.

What is more on my mind, in fact, is the attitude in the States about giving health care coverage to kids that do not now have it, many of whom are poor.

And my sort of philosophical context comes from the highly unsuccessful health care program put forward by the President several years ago, because what was interesting about that was that people were saying—and we knew at that time there were about 37 million uninsured people in this country, and obviously, some of those were children—by very large margins—70 percent, 72 percent, 73 percent—two things.

One, that they wanted to have universal health coverage. And second, that they were willing to be taxed to make sure that it came about. And this was not just, you know, the Kaiser Foundation. This was a number of polls that were taken.

Now, what actually the case is is that the people were not answering truthfully. What they really cared about was their own personal health insurance, about which they were extremely nervous, and there was this kind of denial statement about the public good. But when it came down to decisions that need to be made, what is going to happen to my health insurance, I am nervous about it, I want to keep my doctor, etcetera.

We have a number of proposals in Congress. Senator Dashiell has one; the President. In fact, in his \$25 billion of cuts in Medicaid, there are some things that he does that affect children, outreach efforts and other things for health care.

Senator Kennedy and Senator Kerrey from Massachusetts have one, I have one that is coming up, and they have different approaches. They are tax credits. One is just an outright grant based upon a tobacco tax. They cover different numbers of children.

My question to you is, what is the attitude in your States about poor childrens' health care coverage as a priority or item for you as Governors to be doing something about? In truth.

Governor MILLER. Certainly it is an area of concern, and I think the recent findings of GOAS submitted there were about 2.9 million children falling into the general category I believe you are discussing. We do not have specificity as to who those children are. We are trying to work with GAO to ascertain how we can best determine that.

But I think that as we embark on further outreach and some of the programs I outlined earlier in my first statement—do that—first, I think we need to consider that some of these children might not need Medicaid. They might already have health insurance.

And second, States like Vermont, with extensive experience in children's health issues, have found that some families avoid association with Medicaid because of a perceived stigma. That needs to be addressed. Finally, as Medicaid would become instantly as available to these children, should a need arise, I think that that is the primary consideration, because certainly, if any child in this category needs the medical service, it is there.

So the question then is in preventative care and then diagnosis, in large part. But I think many of the States are very concerned about, and I outlined several of the expansion plans in my initial testimony.

Governor LEAVITT. Senator, may I say that in 1994, in our State, as just an example, we extended our Medicaid program to include all of the children in our State under 18 who were below, I believe, 185 percent of the poverty level. And extensions and optional coverage. There are many other States who have actually proposed waivers to do more.

Governor Beasley, from South Carolina, recently announced a Medicaid expansion targeted at children. I know that Arizona, Arkansas, Florida, Massachusetts, New Jersey, North Carolina, Wisconsin, and New York recently expanded one. There is a great appetite on the part of Governors to find ways to cover these children.

Not all of them are public sector. Many of them are private sector. I think, in terms of priorities, there is no higher one.

Senator ROCKEFELLER. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. And to the Governors, I would like to add my thanks for your appearance this morning. I would actually kind of like to follow-up on Senator Rockefeller's question regarding children.

I hope it is not, but there seems to be something of a contradiction in your statements regarding the desire to achieve coverage for—particularly for children and your recommendation EPSDT. Your recommendation 8.3 speaks to the early periodic screening diagnostic and treatment component of the Medicaid program, which, as you know, provides for immunization and early intervention and prevention services for children.

And given the fact that—at least in my State—almost half of the people receiving Medicaid coverage are children, on average, I think the Medicaid expenditures for children is about \$1,400. For everybody else it is about \$4,100. So you have got a low cost, very vulnerable part of the population here that we are all talking about expanding coverage for, and yet, at the same time, this set of recommendations says that we want to be able to reduce it.

While I certainly recognize and support your interest in flexibility in partnership with the Federal Government in determining what is covered under this program and how it works, at the same time, it seems to me that the flexibility should not be achieved at the expense of the most vulnerable population being put more at risk, and frankly, in a situation which would be of least to your State budgets.

And so, if you could speak to that contradiction, I would appreciate it.

Governor LEAVITT. I am happy to, Senator. The disparage of that provision is not challenged by Governors. It is the redundancy it creates, and frankly, there is a lot of redundancy in the process.

And what we find is we believe we can do it a lot more efficiently than under the current program, particularly under the T, under treatment. There is a lot of areas that could just be done far more efficiently, and there is a basic redundancy that comes up in the process when you actually start managing the program.

So we are not asking that it be eliminated. What we are suggesting is we think there is a better way to do it.

Senator MOSELEY-BRAUN. But you are not suggesting any less treatment for children?

Governor LEAVITT. No. We are just asking to be able to manage it in a different way. Right now, the Federal regulations are so prescriptive on how it happens that there is basically one way to do it, and that is it.

Senator MOSELEY-BRAUN. But again, then so long as you are not suggesting that the kids get less treatment and less intervention and less prevention, because again, this is a very vulnerable population and early intervention saves so much money. It just seems to me that tinkering—if it ain't broke—with this might not produce the savings that you believe.

Governor LEAVITT. I wish I could call to my mind some of the anecdotes that I have experienced in the last 4 years as Governor. But there have been times when we get into some of the children's populations where we will have to take them for examinations 4 or 5 times over the course of a very short period of time, simply because the law requires it under certain program.

We are just looking for a way to be able to coordinate it better.

Senator MOSELEY-BRAUN. So you could just work through this? This is something that could be worked without repealing the initiative?

Governor LEAVITT. Again, the policy statement basically says we think there is a lot better way to do it. Now, I will tell you, from my own standpoint as a Governor, that the problem here is that it is so prescriptive in the way we go about it. No one wants to deny people immunizations; children. No one wants to not have them examined.

What we are looking for, however, is a way to be able to both achieve that and then treat them in a way that is more efficient. And frankly, this is where a lot of the inefficiencies crop up.

Senator MOSELEY-BRAUN. Thank you, Governor. I am very happy to hear you say that. I was concerned because it just seemed to be at odds with the general thrust of your other remarks.

Governor MILLER. I think, Senator, I would just add that the consideration that we have is not limiting the applicants, but the cost factor again. In this instance, the practice has been that physicians prescribe, and it is automatic, whatever they prescribe. And sometimes that is somewhat arbitrary, and we feel that it can be better handled in an overall health-care package in which there are some limitations therein.

Governor LEAVITT. Senator, I have a paper that I will submit to you that talks about some of the problems, particularly with the

"T" portion, the treatment portion. It is just some of the inflexibilities that we are finding, and I think you would find it instructive.

Senator MOSELEY-BRAUN. Thank you. I appreciate that. Thank you very much. Thank you, Governor.

Senator CHAFEE. Mr. Chairman, I wonder if we could also get a copy of that? That would be of interest to me.

Senator MOSELEY-BRAUN. We can share.

The CHAIRMAN. No. No. Absolutely not.

Senator CHAFEE. All right. I will get it from Senator Moseley-Braun. Thank you.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. I thank our Governors. Mike, I cannot see you. Where are you? Welcome to the committee.

Governor LEAVITT. Thank you.

Senator BREAUX. Thank you for your testimony.

One of the problems with the way we have to handle any savings in any of these programs is we have to come up with scoreable savings. And one of the things that they tell us that is not scoreable is to say give the States all the flexibility they want, and I am sure they are going to come up with the savings of \$8 billion or whatever; \$9 billion that we need.

It is sort of like trust. They do not trust us, and they do not trust you. They do not trust anything unless it is spelled out in black and white. So we have a difficulty getting the savings we need by just saying we are going to give the States a great deal more flexibility, without being specific. And that is why the cap is in there, because it can be very specific, and you get your savings on it.

So my question is this, suppose that we give you the flexibility that you are requesting—and I happen to think it is a pretty good idea—by repealing the Boren Amendment, by repealing the cost based reimbursement for the Federal qualified health centers, but did not impose a capital per capita cap, but tried to achieve our savings through reforming the DSH Program, but have a type of trigger mechanism for the Medicaid program that would trigger in a per capita cap if the savings were not achieved by these new flexibilities that you have.

In other words, that would give us, I think, a way of getting some scoreable savings because it would be an automatic trigger if, in fact, what you are saying will get the job done does, in fact, not get the job done. If it gets the job done, there is no per capita cap.

But if everything we give you, flexibility-wise, gets it done, there is no cap per capita that would kick in. Any comments on that?

Governor MILLER. Well, half a pie is better than none.

Senator BREAUX. All right. Thank you.

[Laughter.]

Governor MILLER. The fact is that our estimates are that those would result in \$8 billion in savings. The other component that is on the side of that is the DSH payments, which, if they are reduced by some \$15 billion, for example, as in the President's budget, that is going to have another severe impact on States and their ability to provide those services that somehow has to be in the cost equation adjustment.

Senator BREAUX. I understand that. But I think, for scoring purposes, Mr. Chairman, we are going to have to have something that is realistic and that is scoreable. And I guess if we give the States the flexibility they ask for, I would think that some type of a stand-by or a trigger in mechanism of a per capita cap, if, in fact, the savings are not achieved, is something that is worth exploring.

Governor LEAVITT. Senator, could I comment on it?

Senator BREAUX. Sure, Mike.

Governor LEAVITT. Something that we have not, I think, driven home enough is the logistical nightmare that would be created by a per capita cap.

Senator BREAUX. I agree with that.

Governor LEAVITT. We have got 50 States. On average, you have 4 eligibilities in each State. That is 200 separate caps. This is an expansion of an administrative cost on the national level and the State level that is very profound, making greater than even the savings could be achieved in some sort of cap.

Senator BREAUX. But you have convinced me that if we give you the flexibility, you will come up with a savings so that this trigger mechanism of a per capita cap is just theoretical, and we do not have to worry about it. Right?

Governor LEAVITT. But even with your theory, you have to manage it.

Senator BREAUX. Yes. Well, I think that we are going to have to have something that is scoreable, and I think that maybe this is a possibility. Let me ask you about DSH.

While we are talking about reforming DSH, would distributing the money to the States based on the number of uninsured, as opposed to the number of people on Medicaid, be helpful? Or does it make a difference?

There is a very large number of uninsured in all of our States who are not eligible for Medicaid, which contribute to the cost of health costs in your State because these people are not left on the Street. In America, they are treated.

Governor MILLER. Well, in Nevada it would probably be very helpful because we have the highest rate of uninsured. But we have not analyzed, I do not think, at a national level as to how it would work out. Frankly, DSH is not a subject that there is uniform agreement amongst the nation's Governors upon, as you might suspect, because some are in DSH States, some are in non-DSH States, some are in high DSH States, some in low, and even last year it was a troublesome area for us when we were trying to reach an overall package.

Senator BREAUX. If you could have some of your folks back at NGA take a look at that concept, I would appreciate hearing your thoughts, Bob, on it.

Also, the matching rate, I know, is based on per capita among. And GAO, among others, has suggested that perhaps it would be good to have it based on the poverty rate, as opposed to just a per capita income level, and that is another thing that needs to be explored. Thank you.

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. And I thank the witnesses as well. I think I just witnessed Senator BreauX herding

you into a boxed canyon in this question of a standby trigger, but it may be an idea whose time has come.

The hard reality is we do have to have scoreable savings. And when you sit down and seriously address trying to get a budget plan that adds up to actually balance, my own judgment is the real test ought not to be unified balance because that is not balance at all. When we are talking about raiding every trust fund in sight to claim balance, that is just a fraud.

The real test ought to be true balance. True balance is not using any of the trust funds. I just came from a budget committee hearing at which the Blue Dog coalition on the House side testified, and they have come up with a budget proposal that balances without counting Social Security trust funds by the year 2005. In fact, they do not use any trust funds. That is true balance.

That is when we start to get serious about balancing budgets around here. We adopt a budget like that one. Now, they do not have any tax cuts. They have a correction in the CPI. Those fellows, and the women that are involved with that effort, have stepped up to the plate, and I would hope that we would step up to the plate.

It does not mean that you have got to have every detail the same as theirs, but if we are going to be really square with the American people about a balanced budget, we cannot be talking about raiding every trust fund in sight of every nickel and claim we balance something.

That takes me to the question of DSH because last year we had a difference with respect to this. Senator Graham and I felt very strongly that we cannot have these scams going on at the State level, and I outlined, in some detail, some of the scams that were going. I might say not in either of your States, to your credit. Not in my State either, to my State's credit. But we have got other States that have engaged in it heavily.

And we have got a study from the Urban Institute that says 1/3 of DSH money goes to uses completely outside of health care. I do not know how anybody can justify that. You play these games and pretty soon you find out that money that is Federal money that is supposed to be for Medicaid is over in the transportation budget.

I would just ask how could anybody justify DSH money going for uses outside of health care? Is there any justification, in your minds, for that?

Governor MILLER. I do not think there is, Senator. But I also believe that those abuses were prior to 1993 reforms. At least it is our opinion that those abuses are not presently occurring, and much has been frozen in the DSH formula since then.

The question is, what do you do if there is a complete freeze or elimination of DSH in those States where there has been a reliance thereupon. Those persons that have been served by it are still going to have to be served by it in some capacity and that cost adjustment could be particularly disadvantageous.

Senator CONRAD. To who?

Governor MILLER. To the State or the individuals that would be deprived of the medical services.

Senator CONRAD. All I can tell you is that I have absolutely zero sympathy for States that engage in this charade of playing this game of getting money out of the Medicaid program and sticking it in other programs. I have zero sympathy for those folks.

If they are going to have to take a jolt because they engaged in a phony presentation to the Federal Government of what they were doing, why should they not have to pay a cost.

Governor MILLER. I do not believe that they are in that category now. If that is applicable to all DSH States, then my State would be included therein, but that is not something we have done, and do not think any of the States do it after the 1993 reforms.

Senator CONRAD. Well, this Urban Institute study suggests otherwise. It suggest that we still have a problem, and I am just asking, on a principled basis, there is no justification for that, is there?

I know I am kind of putting you guys on the spot, and you guys are not the guilty parties.

Governor LEAVITT. This is a conversation I am happily left out of as a State that has not engaged in it. And I have also been through all of the formula debates, and I know how sensitive it is. And it gets played off against the reimbursement rates the minute you bring that up.

Ultimately, what you say has some appeal to me, but, on the other hand, I recognize that that is where we are.

Could I just reflect on your earlier comment for a moment? You used the term boxed canyon. I would like to point out that that is what the States view this per capita to be. We have a lot more confidence in your willingness to cap your liability and ongoing commitment to this program than we have optimism that you are ultimately going to give us the flexibility we need and keep it there.

We feel like we are going to get herded into this boxed canyon, and we will have a cap. And as soon as things get tough, all that flexibility will be gone. That is why we have great reluctance to go down this road.

Senator CONRAD. I can understand that. I say it is somewhat interesting. Last year you guys were in here wanting a block grant, at least some of you.

Governor MILLER. No.

Senator CONRAD. Not you, Governor Miller. I remember well. Others did. And now, this year, you are adamantly opposed to any kind of a cap. It is a little hard for me to see the consistency of those positions.

Governor LEAVITT. Well, I think the issue there is, if you are going to ask to manage this program, let us manage it. If you want to be partners, then let us be partners.

Senator CONRAD. All right. Thank you both. I would just leave you with a thought. At the end of the day, we do have to have scoreable savings. And if we are going to be serious about balancing budgets around here, and I mean really balancing—I do not mean this kind of Washington talk about balanced budgets. I mean real balance—we are going to have to have scoreable savings here, as well as elsewhere.

The CHAIRMAN. Senator D'Amato.

Senator D'AMATO. Thank you, Mr. Chairman. Mr. Chairman, let me first say that I think that you and the Senior Senator from New

York, the ranking member, Senator Moynihan, have been engaged in taking on some very significant important issues, as it relates to the health care, the cost, the attempt to bring cost containment to the table, but it is a lot more difficult than some would spell out.

You have an aging population. It is going to continue to age. There are going to be more people in it. This business of thinking that you can wring out the kinds of savings necessary to balance the budget is preposterous, and we are going to find ourselves in one heck of a position.

We will destroy a great health care system. With all its inadequacies, there is no health care system in the world that is better. Now, you can take some tiny little country and say it has more.

You take a country with a diversity; with the numbers of people; with the kinds of problems that we have throughout this Nation with millions of people pouring into this country. And they do not come with insurance, and sometimes they do not even come with legal documentation. And we are not known as a country that says we are going to let you die out on the streets. So we better be careful.

And I think that the Governors have been working under tremendous liabilities and problems that we impose upon them, and that is why they come to the table. And some of our members think that we know and that we can do better and that they are cruel, heartless and are going to allow people to starve and die on the streets and die without care. Now, that is preposterous.

We have got an attitude up here that I think really says that folks back home just do not know what to do, and I defy it. They are there, and they are attempting to do, and they are struggling under some of the most restrictive legislative barriers that have been created, either by the Congress and/or administrations in the past by way of rules and regulations. Now, let us understand that.

So what Governor Miller and Governor Leavitt are, I think, saying, quite correctly, is listen. While you are engaged in cutting back, give us the flexibility necessary.

Now, I noticed that in the President's budget of this year he acknowledged the importance of encouraging flexibilities, and he proposed eliminating the need for State waivers in order to let the States move into managed care. I imagine both of the Governors in the association, democrats and republicans, strongly endorse that. Is that correct?

Governor LEAVITT. That is correct.

Senator D'AMATO. There are horror stories. Senator Moynihan can tell you, notwithstanding our States' application—and I think we are beginning to move towards a point when we will get that waiver—it is now 2 years in the making. Two years.

Now, that is just not right. We are not suggesting that New York came with the perfect plan and it did not need some kind of review and overhaul. But 2 years is just absolutely not right. How many young people would have been provided care under that managed care plan. So that is one.

Number 2, I am pleased to see that the President has also recommended to repeal the Boren Amendment, and both of you have testified to this. This would reduce a nightmare of litigation and the law of unintended consequences, I guess, came about when the

Boren Amendment was enacted. So both of you, the Governors, are for repeal of that.

Governor MILLER. For many years.

Senator D'AMATO. Last, but not least, the business of caps. Again, it is almost laughable to have the Congress of the United States insist upon sound fiscal management. This is just really preposterous.

So now, I want you to tell me why no caps, if you can. I do not think there should be caps, but you tell me why.

Governor LEAVITT. Senator, let me respond to that by referring to discussions we had last year. Many proposed that we have a partnership where the States become the managing partner, and essentially, the National Government take a limited partner role and that was rejected.

Now the proposal, when it comes to per capita caps, is basically this:

We would like to be partners with the National Government. We would like to be partners with the State, the National Government says. But we would like you to take all the risks. We would like you to take all the upside risk, and we would like to limit our liability. But we want you still to manage it. So you manage it, you take all the risks, and we will call ourselves a full partner.

We just do not think it is reasonable for the National Government to pull away from this partnership if that is what it is going to be, and maintain all of the control; maintain all of the control on who the eligible populations are, what the benefits will be, how it will be managed, and then say to the States, but, if there is a problem, you pay for it. That does not pass the fairness test.

Senator D'AMATO. Governor Miller?

Governor MILLER. I would only expand to that by saying that, in effect, it also says, in this proposal, that we will tell you how much you are going to save. You are not qualified to know how much you are going to save yourself.

Senator D'AMATO. That is because we have done such a great job. Right?

Governor MILLER. Well, the \$86 billion has been kind of lost in the shuffle. That is why we suggested another \$8 billion is a significant amount when you look at what the targets were just a year ago. We have all kind of slipped kind of that point and decided we need even more.

Senator D'AMATO. Mr. Chairman, Senator Moynihan, I want to commend you for these hearings, and the Governors. I hope they have brought some clarity to the table. Really, I think you have, and I applaud you on it. Thank you for your testimony.

The CHAIRMAN. I have just two brief questions I would like to ask. How does Medicaid coverage compare with coverage in the private sector or in the public sector?

Governor LEAVITT. Senator, I can tell you, in my State, that a Medicaid recipient has a benefit package that is 30 percent richer than the average of a person who works in a mill or a car dealership in my State.

Governor LEAVITT. I think that is probably true in most States. Not maybe the exact percentage, but it is generally better.

The CHAIRMAN. But generally better.

Governor LEAVITT. Better.

The CHAIRMAN. A second question I would like to ask is how do we provide coverage to enroll more children in Medicaid without creating disincentives to families to provide for their own insurance?

Governor MILLER. I outlined in my initial testimony some plans that several of the States have. But the concern that we have is that if a per capita cap is imposed, it would be very difficult for any State to expand in any service, so that there would be a disincentive to expand the inclusion of children because of the limitations and the fear that there might be insufficient funds to meet the basic needs that are already in the program.

The CHAIRMAN. Governor Leavitt?

Governor LEAVITT. Again, referring to my own State, I will tell you we have expanded health care to children simply by using the limited flexibilities we have to achieve savings, and then we have used those savings to expand coverage for children.

There are some 40,000 children in my State who have health care today who did not have it 3 years because we have been able to implement managed care under a waiver.

It has taken us a long time to get. It is still imperfect. We could make a lot more savings, if we had the flexibility, and we could expand it to more people.

We are now looking for waivers to be able to expand, not just to children, but also to the working poor. In many cases, that is where some of the children are who are not being covered, are those whose parents are working, but do not have enough income to be able to afford it, but they do not qualify. So we would like to get to those populations.

I might add, I think, in terms of barriers to children, that the uncertainty of this situation is adding to it as much as anything. There are many States who would like to proceed to cover more children. But not knowing what we are going to face in the future is causing us to have a great concern about expanding populations.

The CHAIRMAN. That makes a certain amount of sense. Let us hope we are able to move.

I would ask you, gentlemen, to be available as we proceed with this legislation because we are going to have to make some very difficult decisions that will score, and we will need your help and advice.

I want to thank both of you for being here today. I think it has been most informative. We look forward to working in the future with both of you. Thank you very much.

Governor LEAVITT. Thank you.

Governor MILLER. Thank you.

The CHAIRMAN. Thank you very much indeed. The hearing is adjourned.

[Whereupon, at 12:13 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. JAMES M. JEFFORDS

I would like to thank the Chairman, Senator Roth, for holding this hearing. We have work to do this year that is critical to maintaining one of the best programs we have ever developed to improve the well-being of children, and we can look for no better guidance than the wisdom and experience of the governors who administer the Medicaid program.

We have the potential to add great value to the Medicaid program by making incremental, well-tailored and much-needed improvements. We need to give states the flexibility they need to keep pace with changes in both the financing and delivery of health care. At the same time, we must recognize the potential for great harm through uninformed and poorly calculated amendments to the program.

I would like to outline briefly several Medicaid policies I consider ripe for revision. First, we should repeal the provision we passed as part of the Health Insurance Portability and Accountability Act (HIPAA), P.L. 104-191, that for the first time makes it a federal crime to dispose of assets to qualify for Medicaid coverage of nursing home expenses. I believe the goal to stop fraud and abuse in the Medicaid program is laudable and should be pursued. However, there is a growing consensus that Section 217 of HIPAA is vague, unenforceable, and unduly threatening to the elderly. I have introduced S. 369 which would repeal this unnecessarily harsh provision.

Next, we should recognize that six million people are eligible for both Medicare and Medicaid. This group makes up 17% of the Medicaid numbers, but accounts for 35% of Medicaid expenditures, and 30% of Medicare expenditures. This group tends to have unique medical needs, and is by definition very poor. Common sense tells us we should provide some mechanism for coordinating the delivery of care for these individuals, but we have provided no incentives to do so, and the barriers to coordinated care for dually eligible persons are many. Several states have undertaken demonstration projects in this area. I will be following with interest their results, and looking for ways to encourage better coordinated and more cost-effective care for this dually eligible population.

I am also interested in working with my colleagues to consider the Medicaid model as an effective way to help address the needs of uninsured children. I do not support further mandates on the states, but I do believe that the Medicaid program has proven to be a great example of federal/state partnership. I am developing a proposal that will enhance this partnership by providing incentives for the states to expand their Medicaid programs to more uninsured children.

Finally, I am pleased to know of the Governors' interest in addressing issues of quality. I held a hearing on March 6 on this issue, and I know that health plans, health purchasers, and state regulators are all doing what they can to address these and other problems. It is time for the federal government to help and support these efforts and to restore confidence in our health care system.

We need a health system that encourages competition based on quality, not just on price. We need to insure system wide quality and accountability. We should not legislate standards disease by disease. However, we do need to insure that patients are given the right care at the right time. We need to invest in better health outcomes measures and learn how to incorporate those outcomes efficiently into practice. We need to set minimum standards for grievance procedures. We need an accreditation process for health plans. We need uniform performance indicators that let consumers choose health plans based on price, satisfaction, benefits, and quality. I look forward to working with my colleagues to ensure quality health care for mem-

bers of all health plans, including those who participate federally financed programs.



Statement of
Governor Bob Miller, Nevada
Governor Michael O. Leavitt, Utah

before the

Finance Committee
United States Senate

on

Medicaid Reform

on behalf of

The National Governors' Association

March 11, 1997

NATIONAL GOVERNORS' ASSOCIATION

Hall of the States • 444 North Capitol Street • Washington, DC 20001-1512 • (202) 624-5300

Page 2

It is an honor to testify before the committee today on one of the most important issues facing states - the future of the Medicaid program. Today we appear before you as members of the National Governors' Association Medicaid Task Force. Also on the task force are Governor George V. Voinovich of Ohio, Governor Lawton Chiles of Florida, Governor Howard Dean, M.D., of Vermont, and Governor Tommy G. Thompson of Wisconsin.

The Governors' Medicaid Task Force serves as a bipartisan forum for discussion related to the impact of proposed Medicaid policy changes on states. The task force also proactively makes recommendations on program improvements to help states in their efforts to make high-quality, cost-effective health care available to Medicaid recipients.

We welcome the opportunity to share with you our ideas and concerns regarding Medicaid reform. Reform can be effective only when federal and state governments cooperate fully as partners, with joint responsibility for the program.

Briefly, today we will review several issues of primary concern to Governors, including Medicaid cost saving strategies, children's health, and managed care quality.

Much of the discussion about Medicaid reform that has taken place in recent months has focused on producing savings to contribute to efforts to balance the federal budget. No one recognizes more clearly than Governors the need to control Medicaid spending, because we continuously wrestle with the pressure Medicaid exerts on our own budgets. In fact, almost all states must cope with Medicaid costs in the context of state balanced budget requirements.

The challenges Medicaid poses to state budgets became particularly acute in the late 1980s and early 1990s. During that time, Medicaid spending increased at average annual rates in excess of 20 percent. The program grew in both absolute and relative terms, and as a result of this growth, Medicaid now is the second largest expenditure in state budgets, behind primary and secondary education.

These growth rates were unsustainable. Medicaid costs were making it difficult to fund investments in other important state priorities. To address financial pressures and to develop a more quality-oriented system, Governors have begun a massive transformation of state Medicaid systems. Historically, Medicaid programs have been claims processors and bill payers. The transformation currently underway is helping states to become more sophisticated value purchasers of quality health care services and to develop integrated systems of care for vulnerable populations.

Already this transformation is producing results. Medicaid spending grew only 4.5 percent between federal fiscal years 1995 and 1996, and only 3.3 percent between 1996 and 1997. The dramatic reduction in Medicaid growth rates we have enjoyed in recent years stems in large part from aggressive state pursuit of administrative simplification, innovation, and good management.

Our successes in controlling growth rates have been recognized. In February 1997, the Congressional Budget Office (CBO) lowered its baseline projections of future growth in Medicaid spending by almost \$86 billion. This recalculation follows a similar baseline revision released in December 1995 that produced \$31 billion in Medicaid savings. These reductions could not have been achieved without state cost-containment strategies.

Page 3

The Governors are committed to building on their record of success in controlling Medicaid costs. But this must be done very carefully. And it must be done in a way that preserves the partnership of shared financial responsibility between the federal government and the states.

Recommended Savings Level

As a starting point for Medicaid reform, we believe it is critically important that the level of Medicaid savings not be set arbitrarily to fill a hole in a deficit reduction package. Instead, Governors, Congress, and the administration should agree on a package of needed Medicaid reforms. The reforms set forth will lead to a level of savings that states and the federal government will be able to achieve by taking advantage of newly expanded programmatic flexibilities. Sound policy should drive Medicaid reform decisions, not budgetary politics.

Any consideration of Medicaid's role in balancing the budget must acknowledge that even before the first decision is made regarding a reconciliation package during this Congress, Medicaid already has contributed \$86 billion toward deficit reduction in this budget cycle. CBO's revised baseline projections make efforts to reach a balanced budget agreement easier by \$86 billion.

The revised CBO projections reflect the transformations underway in Medicaid programs to become streamlined value-purchasers of quality health care services. Given the progress already made, there is less room in the program from which to squeeze additional savings without having a detrimental effect on the number of people served by Medicaid or the range of benefits they receive.

For that reason, the Governors believe that additional Medicaid savings included in any deficit reduction package developed by Congress and the administration should be kept to a minimum. However, we agree that additional savings are possible, and we are committed to working with you to continue to eliminate all unnecessary spending from the Medicaid program.

We are confident that with the additional flexibility we will ask you for today, states will be able to produce an additional \$8 billion in scorable Medicaid savings between now and 2002, very close to the net Medicaid savings included in the President's budget. As has been the case in the past, although the scorable savings may be in the range of \$8 billion, our ability to actually achieve savings could exceed CBO's expectations given this enhanced flexibility. Combined with the \$86 billion in savings already acknowledged by CBO, Medicaid's contribution to deficit reduction will be at least \$94 billion through 2002.

This level of savings should be considered in the context of the Medicaid savings targeted in last year's Medicaid reform efforts. The original Republican reform package would have produced \$185 billion in savings by 2002. By the end of the debate, Congress supported a package including Medicaid savings of \$85 billion. Throughout last year's reform discussions, the President supported a reform package that would have generated \$54 billion in savings.

A \$94 billion contribution to deficit reduction by 2002 fits well within these parameters. In fact, when you combine Governors' recommended savings with the two baseline recalculations made by CBO within the last 18 months, Medicaid savings have already contributed \$125 billion in deficit reduction, exceeding the targets set forth by Congress and the administration at the end of last year's Medicaid debate.

Page 4

The Governors therefore would not support the President's proposal to produce \$22 billion in gross Medicaid savings by 2002, nor would we support packages calling for even higher levels of Medicaid savings we have heard discussed by many in Congress. As we have said before, savings of that magnitude cannot be achieved without adversely affecting those who rely on Medicaid for their health care needs.

Recommended Savings Strategy

With an expectation of additional achievable savings in the range of \$8 billion to add to the \$86 billion in savings already realized, the question of primary importance becomes what policy choices will be needed to achieve these savings.

The Governors adamantly oppose a cap on federal Medicaid spending in any form. Any unilateral cap on the Medicaid program will shift costs to state and local governments that they simply cannot afford. Once the federal spending obligation is fulfilled, all additional costs will be passed on to the states. The proposed per capita caps will help the federal government balance the budget on the backs of the states.

The Governors' opposition to Medicaid caps extends to the per capita cap proposals set forth both in the President's budget package and in the budget developed by the Blue Dog Coalition. We oppose these per capita caps for a number of reasons.

First, the caps are unworkable. There would need to be four separate caps on different eligibility categories for each of the fifty states. This means 200 separate caps, which would have to be monitored by state agencies and audited and enforced by a new bureaucracy in the Health Care Financing Administration (HCFA).

Second, caps could result in states becoming solely responsible for unexpected program costs, such as a loss in a lawsuit on reimbursement rates or the development of expensive new therapies that drive up treatment costs beyond the federally allowable rate.

Third, the cost shift resulting from a unilateral federal cap would present states with a number of bad alternatives. States essentially would have to choose between cutting back on payment rates to providers, eliminating optional benefits provided to recipients, ending coverage for optional beneficiaries, or coming up with additional state funds to absorb 100 percent of the cost of services.

It seems unnecessary to us to undertake such a disruptive and fundamental transformation of a program on which the federal government will spend half a trillion dollars over the next five years in order to achieve the \$8 billion in additional savings we consider reasonable. If we consider the President's budget package, his expectations for savings attributable to a per capita cap are even smaller. Although his package includes \$22 billion in gross Medicaid savings, only \$7 billion of that total comes from the program cap.

The President's package also includes \$15 billion in savings from the disproportionate share hospital (DSH) program. Because Governors consider \$8 billion to be a reasonable savings target, we oppose the magnitude of the DSH cuts included in the President's budget. We also strongly believe that DSH funds must continue to be distributed through states, not directly to providers, to ensure that the program effectively complements other federal and state sources of health care funding. Maintaining the state role in distribution will ensure that DSH is coordinated with the state's overall health systems' infrastructure.

Page 5

The Governors are convinced that there are better ways to achieve an additional \$8 billion in Medicaid savings by 2002, and NGA's Medicaid Task Force has developed an alternative. Our strategy sets forth a number of policy options that, when combined, will produce significant savings. We believe those savings will be scorable at \$8 billion through 2002, and upon implementation will likely yield additional savings. The savings in our alternative strategy stem from a series of policy changes that would assist states in their continued transformation toward value purchasing.

In some combination, the reform suggestions we believe Congress and the administration should consider would eliminate the need to institute any unilateral cap on beneficiary spending. We can group these suggested reforms into three broad categories -- reforms related to managed care, reforms tied to reimbursement policy, and other program reforms.

Managed care reforms

1. *Managed care.* Repeal of the waiver requirement for mandatory managed care will facilitate further development of the Medicaid managed care market. As Medicaid markets mature, competition between managed care entities will enable states to negotiate even more favorable rates. With the development of models to accommodate special population needs, Medicaid managed care will increasingly penetrate the more complicated and costly segments of the caseload -- the elderly and disabled.

States have already achieved significant savings through Medicaid managed care. For example, Michigan will save \$120 million in Medicaid costs through managed care in 1998, about 2.5 percent of the state's total program budget. Missouri's managed care program will have saved \$50 million through 1997 compared to fee for service costs.

Managed care does not simply produce a one-time savings bonus for states. Between 1990 and 1996, Wisconsin has saved more than \$100 million as a result of managed care. Through competitive bidding, Florida's newest round of managed care contracts include capitation rates between 87 percent and 92 percent of fee for service rates. Previous contracts included rates at 95 percent of fee for service rates.

2. *Managed care for the dually eligible.* The dually eligible population, which currently is 6 million people, would be enrolled in managed care, creating a more streamlined, cost-effective system of health care delivery for those elderly and disabled individuals who receive a complete, but uncoordinated, package of benefits from both Medicaid and Medicare. Managed care would produce savings for both programs while creating a more user-friendly health care experience for recipients.

Utah has conducted a voluntary managed care program for the dually eligible, operating within existing federal limitations, and has seen a reduction in costs for services of approximately 10 percent for the population enrolled in managed care. Minnesota's managed care program for the dually eligible has produced a 5 percent reduction compared with fee for service costs.

We would like to submit for the record an NGA staff working paper that begins to explore issues related to the connections between the Medicaid and Medicare programs, including dual eligibility, and the implications of those connections for the states.

Page 6

3. *Provider selectivity.* To clarify that there is no *de facto* entitlement for providers to participate in the Medicaid program in the fee for service environment, HCFA should support states in their efforts to contract with a limited number of facilities so they can negotiate better rates. For example, Medicaid recipients could be directed to two out of four hospitals in a city for services, or to a particular source to have prescriptions filled. Texas and Washington each have achieved 2 percent savings in their hospital reimbursement rates through selective contracting.

Reimbursement policy reforms

4. *Reimbursement rates for Qualified Medicare Beneficiaries (QMBs) and the dually eligible.* Recent judicial interpretations have begun to force states to reimburse providers at Medicare rates for services provided to these populations. Medicaid rates, which are on average significantly lower than Medicare rates, should be sufficient to discharge state obligations until the federal government assumes full responsibility for the cost-sharing obligations associated with QMBs and until a more integrated system is developed to serve the dually eligible.

Michigan estimates that permitting the state to limit reimbursement rates to Medicaid levels for these populations would save \$85 million per year in Michigan alone. Florida had to include \$87 million in its 1997-1998 budget following a suit requiring the state to use Medicare rather than Medicaid reimbursement rates. Alabama has seen its costs increase approximately \$50 million per year following its loss in the defining case on this issue, *Haynes Ambulance Service, Inc., et al. v. State of Alabama, et al.*

5. *Boren repeal.* The states and HCFA agree that reimbursement rates for institutional care will be significantly moderated when the Boren amendment is repealed. The American Public Welfare Association has developed a model projecting federal savings through Boren repeal ranging from a conservative estimate of \$6 billion to as much as \$8 billion over four years in nursing facility costs and additional savings ranging from a low of \$4 billion to \$10 billion in hospital costs. The Governors would welcome the opportunity to work with Congress and the Administration to fully explore the cost saving potential of repealing the Boren Amendment.

6. *Cost based reimbursement.* Policies that require states to reimburse providers such as federally qualified health clinics (FQHCs) at rates that do not reflect states' positions as dominant purchasers in the health care marketplace should be repealed. Wisconsin will save \$5 million annually through the repeal of FQHC provider protections.

Similarly, Boren-like language that has exposed states to lawsuits driving up rates for services including outpatient and home health care should be repealed. California's recent loss of a case on outpatient care rates will cost the state hundreds of millions per year. Ohio currently faces a cost-based reimbursement lawsuit for home health services that could cost the state between \$100 million and \$130 million, essentially doubling home health reimbursement rates.

Other reforms

7. *Cost sharing.* Significant Medicaid savings could be realized through a number of cost sharing models. For example, if every Medicaid recipient were responsible for a sliding scale premium that averages \$5 monthly, more than \$2 billion in Medicaid savings would be generated annually, contributing

Page 7

significantly to efforts to avoid a per capita cap in spending. An even more fundamental reexamination of family cost-sharing obligations for children with disabilities living at home or institutions would yield additional savings.

Oregon has implemented a sliding scale premium for new enrollees in the Oregon Health Plan, with premiums ranging from \$6 to \$28 per month. Between December 1995 and January 1997, Oregon has collected more than \$7 million in premiums from its expanded eligibility group of approximately 75,000 households.

8. *EPSDT.* Governors, Congress and the Administration should work together to assess the difference in cost between EPSDT and an actuarially based package of benefits comparable to those offered by Medicaid's package of mandatory and optional benefits.

9. *Fraud and abuse.* Aggressive new state-based strategies to prevent Medicaid fraud should be expanded nationwide as needed. For example, a Florida fraud reduction initiative that includes a provision requiring durable medical equipment suppliers to purchase surety bonds has produced savings between 1 percent and 2 percent of the state's total Medicaid budget. Florida's nonpartisan budget scoring entity predicts additional savings from fraud reduction of \$81 million in 1998 and \$111 million in 1999.

We would like to submit for the record a more detailed listing of these proposals, including the specific legislative barriers that currently prevent implementation.

Some of these options were included in President Clinton's budget package, and the Governors gratefully acknowledge the President's support of important state flexibility priorities, including elimination of the need for 1915(B) waivers to enroll recipients in managed care; elimination of the need for waivers to provide recipients with home- and community-based supports as alternatives to institutional care; repeal of the Boren Amendment; repeal of the 75-25 rule; and repeal of the cost-based reimbursement requirement for FQHCs. When considered separately from the per capita cap, we are confident that CBO will recognize the savings potential of these recommended reforms.

The Governors would welcome the opportunity to work with Congress and the administration to further explore any of the recommendations we have set forth regarding cost savings. We also would be happy to provide you with any additional information you may require.

Although program financing and cost savings have dominated the Medicaid reform discussion so far this year, the Governors are also very interested in other reform initiatives that could impact the Medicaid program. We expect that issues related to children's health and managed care quality will also be at the top of congressional priority lists during the next few months, and we would like to briefly share with you some of our ideas concerning these important topics.

Children's Health

Like Congress and the administration, the Governors agree that health care is essential to the well-being of children. In fact, states have been leaders in making insurance coverage available to millions of children. There are 18.7 million children below age eighteen who are covered today by Medicaid. Thirty-nine states already have extended Medicaid eligibility beyond federally mandated levels.

Page 8

Other states are in the process of implementing major expansions for children's coverage. In recent weeks, Governor David M. Beasley of South Carolina has announced a Medicaid expansion that will extend coverage to 50,000 children. Governor George V. Voinovich of Ohio has included in his budget a plan to cover 96,000 additional kids. Arizona, Arkansas, Florida, Massachusetts, New Jersey, North Carolina, Utah, and Wisconsin also plan eligibility expansions for children. Medicaid savings levels in the range of those included in the President's budget, the Blue Dog Coalition plan, and the even higher levels discussed by others in Congress will jeopardize these and other state expansions of Medicaid eligibility.

States are also experimenting with approaches outside of the traditional Medicaid framework to extend health care coverage to more children. For example, Florida's Healthy Kids program seeks to give children access to health care through a school enrollment-based program. Governor Lawton Chiles plans to extend the Healthy Kids program to an additional 60,000 children this year. New York's Child Health Insurance Program makes health coverage available to children below age nineteen who would not otherwise have access to health insurance. These experiments, and others underway in Minnesota and Pennsylvania, typically rely on state funds and family contributions.

We understand that during the next few months, Congress and the administration will likely consider a number of different approaches to extending health insurance coverage to children who are currently uninsured. The Governors are in the process of reviewing the various children's health proposals that have been set forth thus far. We can share with you some preliminary thoughts.

First, we believe it is critical that any new federal initiative be designed to complement, not jeopardize, the array of children's health activities underway in the states.

Second, new programs should not create an opportunity for shifting private sector insurance costs to the public sector.

Third, the Governors would oppose any mandated Medicaid eligibility expansion.

The Governors are particularly interested in issues surrounding the population of children currently eligible for Medicaid but not enrolled in the program. We understand that the General Accounting Office (GAO) estimates that 2.9 million children fall into this category.

We would appreciate any assistance GAO could provide in helping states learn more about this population. The Governors strongly agree that children entitled to Medicaid benefits should receive those benefits. In order to make that happen, we need to know more specifically who is not receiving coverage, where they live, and how old they are.

The Governors are ready to do more where more is needed, but we must keep in mind that the process of successfully enrolling this group of children in Medicaid is more difficult than it may appear initially for a number of reasons. First, some of these children may not need Medicaid. They may already have health insurance coverage through a noncustodial parent. Second, states like Vermont with extensive experience in children's health issues have found that some families avoid association with Medicaid because of a perceived stigma. Finally, as Medicaid will be instantly available to these children should a need arise, their families may not feel compelled to enroll before they encounter a particular need for services.

Page 9

States already have in place a broad array of outreach strategies designed to promote Medicaid enrollment. Those strategies include simplifying eligibility processes, promoting aggressive public awareness campaigns, locating enrollment centers out in communities, and using a single application form for a number of assistance programs, just to name a few examples of effective outreach programs. We would like to submit for the record an initial compilation of state outreach activities prepared by the National Governors' Association.

If we had a more concrete sense of who is *not* being captured by existing outreach efforts, more targeted strategies could be put in place. For example, an outreach campaign targeted at school-age children would be designed differently than one aimed at infants and toddlers.

Managed Care and Quality

Given their history of leadership on this issue, the Governors also have been following with interest the emerging debate surrounding quality in the Medicaid managed care environment. Through their contracting practices, Medicaid programs already prioritize quality protections, and managed care has been an effective means of delivering quality health care services in the states. In some states, Medicaid managed care has been the most effective means of delivering quality health care to recipients. Like you, we are committed to ensuring that all Medicaid recipients receive high-quality health care.

The Governors believe that this goal can be accomplished most effectively through a broad-based agenda focused on monitoring quality and evaluating improvement, rather than through a series of procedure-specific requirements. This approach builds in the flexibility to address medical innovations and to take advantage of the continuous evolution of more sensitive and sophisticated quality measures.

NGA's Medicaid Task Force has begun preliminary discussions about what would be included in a quality package, and the Health Care Financing Administration has expressed strong interest in the approach we are developing.

As envisioned by the NGA Medicaid Task Force, states would develop quality assurance plans, which could include a number of elements, such as a grievance process, a comparative report card of health plan performance, deeming of NCQA accreditation standards, and HEDIS reporting requirements. States could establish benchmarks tied to measuring future quality performance. A number of indicators could be monitored and assessed annually by states, including consumer satisfaction, immunization rates, and numbers of low-birthweight babies, to name just a few from dozens of possibilities.

These plans would be submitted to HCFA, and updates would be provided annually. The states would monitor the results achieved by health plans in meeting the goals established for them, and this performance would be considered by the state when deciding whether to continue the contractual relationship between the health plan and the Medicaid program.

Quality monitoring would continue to be an important part of a state's role as a value purchaser of health care services. A critical component of efforts to promote quality would involve the development of a more informed consumer base. Our goal would be to help Medicaid recipients make good choices for themselves while creating mechanisms to ensure that problems get resolved quickly and successfully.

We would welcome the opportunity to work with Congress as managed care quality issues are debated. We are hopeful that the quality assurance partnership we envision between the states, managed care organizations, and consumers could become a model worthy of replication.

We thank you for your interest in the Governors' perspective on Medicaid reform. As the reform process moves forward, this committee will consider a range of issues of the utmost importance to states. Please view us as a resource. We will be happy to provide you with additional information on any of the issues outlined in our testimony. We appreciate your consideration of our ideas and concerns, and we would be happy to answer any questions you may have.

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**Cost Saving Strategies as Alternatives
to Any Medicaid Cap
March 1997**

Background. In the late 1980s and early 1990s, Medicaid spending was increasing at average annual rates of more than 20 percent. These growth rates were unsustainable. Medicaid costs were making it difficult to fund investments in other important state priorities. To address financial pressures and to develop a more quality-oriented system, Governors began to transform state Medicaid systems — moving states from their historical role as claims processors and bill payers to the more sophisticated role of value purchasers of quality health care services.

This transformation is producing results. Governors have been able to significantly restrain spending despite limited flexibility in the program. Medicaid spending has grown at an average rate of less than 4 percent over the last two years. In February 1997, the Congressional Budget Office (CBO) lowered its baseline projections of future growth in Medicaid spending by almost \$86 billion, reflecting the successes states have achieved in controlling costs. This \$86 billion makes a significant contribution toward efforts to balance the federal budget, and follows a similar CBO revision in December 1995 that produced \$31 billion in Medicaid savings.

Last year, Congress initially considered Medicaid reform proposals producing \$185 billion in Medicaid savings over seven years. By the end of the debate, Congress supported a package including Medicaid savings of \$85 billion. Throughout last year's reform discussions, the President supported a reform package that would have achieved \$54 billion in Medicaid savings.

With the savings already produced and recognized by CBO, Medicaid's contribution of \$86 billion toward deficit reduction this year is well within the parameters of last year's debate. In fact, when the two baseline recalculations made by CBO within the last eighteen months are combined, Medicaid savings have already contributed \$117 billion in deficit reduction, exceeding the targets set forth by both Congress and the administration at the end of last year's Medicaid debate.

Recommended Savings Level. Given this contribution, Governors believe that additional Medicaid savings included in any deficit reduction package developed by Congress and the administration should be kept to a minimum. With state program transformations reflected in the new CBO baseline, there is less room in the program from which to squeeze additional savings without having a detrimental effect on the number of people served by Medicaid or the range of benefits they receive.

However, the Governors do believe that limited new Medicaid savings are possible, in addition to the \$86 billion already achieved. The same pursuit of administrative simplification, innovation, and good management that produced the extraordinary low Medicaid growth rates of recent years will continue to restrain unnecessary program spending.

We believe that with the additional flexibility outlined below, states can produce \$8 billion in scorable Medicaid savings between now and 2002. As has been the case in the past, although the scorable savings may be in the range of \$8 billion, states' ability to actually achieve savings could exceed CBO's expectations given this enhanced flexibility. Governors would not support a savings target and policy changes based purely on the budgetary process. Instead, the flexibility provided through programmatic reforms should determine the level of savings targeted.

Recommended Savings Strategy. The Governors adamantly oppose a cap on federal Medicaid spending in any form. It seems to us particularly unnecessary to experiment with a fundamental transformation of a program on which the federal government will spend half a trillion dollars over the next five years in order to achieve the \$8 billion in additional savings that the Governors consider reasonable.

Unilateral caps in federal Medicaid spending will result in cost shifts to states. The federal budget must not be balanced at the expense of the states. Under a cap, once the federal spending obligation is fulfilled, states would have to choose between cutting back on payment rates to providers, eliminating optional benefits provided to recipients, ending coverage for optional beneficiaries, or coming up with additional state funds to absorb 100 percent of the cost of services.

The Governors believe that there are better ways to achieve an additional \$8 billion in Medicaid savings by 2002. The Medicaid Task Force of the National Governors' Association has developed an alternative strategy to realize these savings. The Governors would welcome the opportunity to work with Congress and the administration to explore a number of options that, when combined, would produce significant budgetary savings.

The following reform possibilities provide Congress and the administration with concrete alternatives to program caps. Federal legislative or administrative action would be necessary for the changes set forth below to be implemented. The specific barriers that currently prohibit state implementation are identified in bold following each description.

Managed care reforms

1. *Managed care.* Repeal of the waiver requirement for mandatory managed care will facilitate further development of the Medicaid managed care market. As the Medicaid markets mature, competition between managed care entities will enable states to negotiate more favorable rates. -- **1902(a)(23)**

Savings attributable to managed care should be calculated using three separate assumptions. First, that managed care enrollment is mandatory. Second, that mandatory enrollment would be triggered if voluntary enrollment does not reach a targeted level. Third, that managed care enrollment is voluntary.

States have already achieved significant savings through Medicaid managed care. For example, Michigan will save \$120 million in Medicaid costs through managed care in 1998, about 2.5 percent of the state's total program budget. Missouri's managed care program will have saved \$50 million through 1997, compared with fee-for-service costs.

Managed care does not simply produce a one-time savings bonus for states. Between 1990 and 1996, Wisconsin has saved more than \$100 million as a result of managed care. Through competitive bidding, Florida's newest round of managed care contracts include capitation rates between 87 percent and 92 percent of fee-for-service rates. Previous contracts included rates at 95 percent of fee for service rates.

With the development of models to accommodate special population needs, Medicaid managed care will increasingly penetrate the more complicated and costly segments of the caseload—the elderly and disabled.

2. *Managed care for the dually eligible.* The dually eligible population, which is currently 6 million people, would be enrolled in managed care, creating a more streamlined, cost-effective system of health care delivery for those elderly and disabled individuals who receive a complete, but uncoordinated, package of benefits from both Medicaid and Medicare. Managed care will produce savings for both programs, while creating a more user-friendly health care experience for recipients. -- 1902 (a)(23) and 1802

As above, savings attributable to enrolling the dually eligible in managed care should be calculated using three separate assumptions. First, that managed care enrollment is mandatory. Second, that mandatory enrollment would be triggered if voluntary enrollment does not reach a targeted level. Third, that managed care enrollment is voluntary.

Utah has conducted a voluntary managed care program for the dually eligible, operating within existing federal limitations, and has seen a reduction in costs for services of approximately 10 percent for the population enrolled in managed care. Minnesota's managed care program for the dually eligible has produced a 5 percent reduction, compared with fee-for-service costs.

3. *Provider selectivity.* To clarify that there is no *de facto* entitlement for providers to participate in the Medicaid program in the fee-for-service environment, the Health Care Financing Administration should support states in their efforts to contract with a limited number of facilities so they can negotiate better rates. For example, Medicaid recipients in a city could be directed to two out of four hospitals for services, or to a particular source to have prescriptions filled. Texas and Washington each have achieved 2 percent savings in their hospital reimbursement rates through selective contracting. -- 1902(a)(23)

Reimbursement policy reforms

4. *Reimbursement rates for Qualified Medicare Beneficiaries (QMBs) and the dually eligible.* Recent judicial interpretations have begun to force states to reimburse providers at Medicare rates for services provided to these populations. Medicaid rates, which are on average significantly lower than Medicare rates, should be sufficient to discharge state obligations until the federal government assumes full responsibility for the cost-sharing obligations associated with QMBs and until a more integrated system is developed to serve the dually eligible.

Michigan estimates that permitting the state to limit reimbursement rates to Medicaid levels for these populations would save \$85 million per year in Michigan alone. Florida had to include \$87 million in its 1997-1998 budget following a suit requiring the state to use Medicare rather than Medicaid reimbursement rates. Alabama has seen its costs increase approximately \$50 million

per year following its loss in the defining case on this issue, *Haynes Ambulance Service, Inc., et al. v. State of Alabama, et al.* -- For a definition of Medicare cost-sharing, see 1905(p)(3).

5. **Boren repeal.** States and HCFA agree that reimbursement rates for institutional care will be significantly moderated when the Boren amendment is repealed. The American Public Welfare Association has developed a model projecting federal savings through Boren repeal ranging from a conservative estimate of \$6 billion to as much as \$8 billion over four years in nursing facility costs, and additional savings ranging between \$4 billion and \$10 billion in hospital costs. -- 1902(a)(13)(A)

6. **Cost based reimbursement.** Policies that require states to reimburse providers such as federally qualified health clinics (FQHCs) at rates that do not reflect states' positions as dominant purchasers in the health care marketplace should be repealed. Wisconsin will save \$5 million annually through the repeal of FQHC provider protections.

Similarly, Boren-like language that has exposed states to lawsuits driving up rates for services including outpatient and home health care should be repealed. California's recent loss of a case on outpatient care rates will cost the state hundreds of millions per year. Ohio currently faces a cost-based reimbursement lawsuit for home health services that could cost the state between \$100 million and \$130 million, essentially doubling home health reimbursement rates. -- 1902(a)(30)(A) and 1902 (a)(13)(E)

Other reforms

7. **Cost sharing.** Significant Medicaid savings could be realized through a number of cost sharing models. For example, if every Medicaid recipient were responsible for a sliding scale premium that averages \$5 monthly, more than \$2 billion in Medicaid savings would be generated annually, contributing significantly to efforts to avoid any cap in spending. An even more fundamental reexamination of family cost-sharing obligations for children with disabilities living at home or institutions would yield additional savings.

Oregon has implemented a sliding scale premium for new enrollees in the Oregon Health Plan, with premiums ranging from \$6 to \$28 per month. Between December 1995 and January 1997, Oregon has collected more than \$7 million in premiums from its expanded eligibility group of approximately 75,000 households. -- 1916

8. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The Governors, Congress, and the administration should work together to assess the difference in cost between EPSDT and an actuarially based package of benefits comparable with those offered by Medicaid's package of mandatory and optional benefits. -- 1905(r), especially 1905(r)(5)

9. **Fraud and abuse.** Aggressive new state-based strategies to prevent Medicaid fraud should be expanded nationwide as needed. For example, a Florida fraud reduction initiative that includes a provision requiring durable medical equipment suppliers to purchase surety bonds has produced savings of between 1 percent and 2 percent of the state's total Medicaid budget. Florida's nonpartisan budget scoring entity predicts additional savings from fraud reduction of \$81 million in 1998 and \$111 million in 1999. There is an administrative concern regarding whether states have adequate authority to proceed without additional clarification from HCFA.

Utah**PROBLEMS WITH THE "T" IN EPSDT**

EPSDT stands for Early Periodic Screening, Diagnosis and Treatment. The interpretation of the "treatment" component of EPSDT has caused and will continue to cause funding problems for Utah Medicaid, as well as other states. This problem is illustrated by the following examples.

OBRA 90 required the states to extend Medicaid payment for any service to a child that would treat or ameliorate a defect or condition identified by an EPSDT examination. This service coverage is available to children even if the services are not included in the State's Plan. The problems with EPSDT breakdown into two major categories. First, we have seen courts interpret EPSDT provisions in combination with other parts of Medicaid law thereby requiring coverage of new services for adults. The second area of concern is an increasing pressure to cover services which may not be medical in nature, thus expanding the scope of Medicaid beyond what many states believe to be the programs purpose.

An example of the first problems is illustrated by what happened in Utah with transplants. In 1996, our Medicaid policy of providing most transplant coverage only to children based on the EPSDT provision was legally challenged by an individual who was not EPSDT eligible. The judge disagreed with the argument that Congress, through OBRA, allowed children to have a broader scope of services not otherwise available to adults. The judge reasoned that, since transplants are totally optional services, if the services are provided by the State, they must be provided to all those who are "similarly situated", regardless of age. There have been other, inconsistent rulings by two other US district courts. Obviously, this issue needs more clarification. This ruling resulted in the need to add about 5 million in total dollars (state and federal) to Utah's Medicaid budget.

The second problem relates to medical services, equipment and assistive devices. HCFA's position is that in order to have a service or piece of equipment paid for by Medicaid, it must be medically necessary and covered under 1905(a) of the Social Security Act. Further, HCFA maintains that all services and equipment must be primarily medical in nature. Finally, HCFA also maintains that the state is responsible for determining medical necessity and whether or not a service or device is primarily medical in nature. Therefore, while one may assume that swing sets, tricycles and some other such assistive devices are not benefits of the Medicaid program, under certain interpretations of the law, they may be.

HCFA has stated that under the rehabilitation benefit, under other habilitative benefits, or under a home and community based waiver, computers, computer software, exercise equipment, including exercise bikes, therapeutic toys, swings set, tricycles and other assistance devices are coverable benefits when determined to be medically necessary. Therefore, service or equipment must be provided to EPSDT beneficiaries when medically necessary. Again, HCFA stresses that, "it is the State's responsibility to determine medical necessity."

Not only does this create enormous pressure on the states by advocacy groups to approve such services and devices, but the courts, in a continuing pattern, have told the states what is "medically necessary". With increasing regularity, the courts have also overturned the state's determinations and replaced them with their own determinations of medical necessity.

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Human Resources Group

Medicaid and Medicare: Implications for States

By Jennifer E. Baxendell

*Staff Working Paper
February 1997*

Executive Summary

Medicare reform is one of the most important issues facing the 105th Congress. To prevent cost shifting and to take advantage of an opportunity to rationalize an inefficient system of care, it is critical that Medicare reform not be undertaken in a vacuum. The long-term needs of Medicaid and Medicare must be considered jointly, because the two programs are fundamentally interrelated—demographically, categorically, programmatically, and financially.

Most basically, the programs are linked through the populations they serve. Currently, 6 million people are classified as dually eligible. They receive a full package of benefits from both Medicaid and Medicare. For low-income senior citizens and people with disabilities, Medicaid has evolved to provide a package of wrap-around benefits to complement Medicare services. Medicaid is the primary payer for long-term care.

Given the close connections between Medicaid and Medicare, decisions made in one program can have a significant cost impact on the other program. Medicaid is responsible for meeting the cost-sharing obligations of the dually eligible, Qualified Medicare Beneficiaries, and Specified Low-Income Medicare Beneficiaries. Both Medicaid and Medicare will face enormous financial pressures as the baby-boom generation begins to retire, because increased caseloads will lead to increased costs.

Managing the complicated network of program interrelationships is important because it provides an opportunity to promote quality, develop a more seamless system of care for recipients, and reduce costs. Effective management has proved difficult for a number of reasons, however, including the involvement of two levels of government that provide services and the existence of federal barriers that impede effective program coordination. State flexibility to experiment with managed care models for the dually eligible has been restricted by the lack of clear statutory authority.

Reforming Medicare without considering the impact of those changes on Medicaid places Medicaid at great risk of cost shifting. Such an approach would also miss an important opportunity to strengthen both programs, systemically and financially, in preparation for the aging of the baby boomers.

Only through the creation of a more rational, cost-effective continuum of care for the elderly and the disabled will the two programs be able to accommodate the impending caseload explosion. A number of reform strategies should be considered to begin to prepare the programs for the future, ranging from broad-based systems integration efforts to more narrowly framed management efficiency actions. The Governors invite Congress, the administration, and other interested parties to work together to address jointly the long-term needs of Medicaid and Medicare.

Introduction

One of the most important issues facing the 105th Congress is the long-term financial stability of the Medicare trust fund. Without congressional intervention, Medicare's hospital trust fund will be depleted by 2001. In addition, an even more fundamental overhaul of Medicare financing will be needed to prepare for the retirement of the baby-boom generation, which will begin to impact Medicare in 2010. Regardless of whether Congress and the White House decide to address the need for Medicare reform directly, or indirectly through a commission, decisions must be made now to effectively prepare and protect Medicare for the future.

Medicare reform cannot be undertaken in a vacuum, however. Medicare is one crucial link in the continuum of services provided to senior citizens. Social Security is another. These two programs have long been at the forefront of the public debate on, and interest in, preparing for the fundamental demographic shift accompanying the aging of the baby boomers. Yet there is a third vital component of this system of support for senior citizens. Despite its common perception as a welfare program for young, low-income families, Medicaid also provides long-term care services to millions of senior citizens.

Given this vital role, Medicaid must be included in any discussions related to the future of Medicare. The two are fundamentally interrelated demographically, categorically, programmatically and financially. The demographic pressures that will cause Medicare enrollment to explode as baby boomers retire will also result in enormous increases in Medicaid caseloads. To make changes to Medicare to protect its financial viability without considering the impact of those changes on Medicaid exposes Medicaid to the risk of cost shifting from one program to the other. Even more important, to exclude Medicaid from reform discussions would amount to a real missed opportunity to create a more rational, cost-effective, and high-quality continuum of care. From the state perspective, the long-term needs of Medicaid and Medicare must be addressed together.

Background

Demographics

Much attention has been paid in policymaking communities and in the media to the tremendous costs that will be incurred by Medicare as the baby boomers reach retirement age. Undoubtedly the costs will be enormous, and thoughtful and early planning is needed to prepare successfully for the financial pressures Medicare will begin to face in 2010. Medicare currently covers 38 million beneficiaries. By 2030, when the last of the baby boomers retire, it is estimated that 78 million Americans will be on Medicare (Figure 1). Today, there are three working taxpayers for every one Medicare recipient. By 2030 the ratio will be reduced to two to one. Clearly, fundamental financial reforms will have to be enacted to support this caseload explosion, extending far beyond the short-term cost savings measures needed immediately to shore up the hospital trust fund.

Just as Medicare will face tremendous new financial pressures, so too will Medicaid. The timing of the demographic impact on the two programs will vary. Medicare caseloads will be impacted as soon as the baby boomers begin to retire in 2010. The Medicaid impact will be felt most dramatically several years later, when

the baby boomers reach the ages at which nursing home care becomes more prevalent.

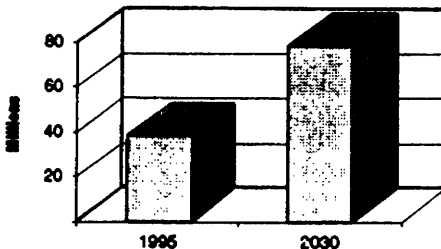
Today, 16 percent of the Medicare caseload is classified as dually eligible. If that percentage remains constant, by 2030 more than 12 million individuals will be dually eligible for Medicare and Medicaid (see Figure 2). Currently, the aged, blind, and disabled comprise roughly one quarter of the Medicaid caseload and account for roughly three quarters of program costs (see Figure 3). As baby boomers age, that portion of the Medicaid caseload that is already the most expensive will grow significantly larger, both in absolute numbers and as a percentage of the overall Medicaid caseload.

Categorical Overlap

Dually Eligible

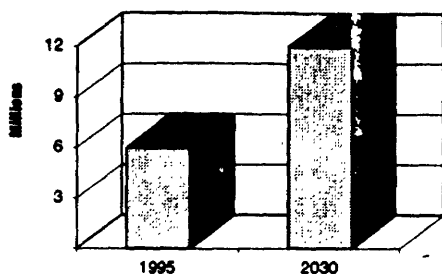
The most direct connection between the Medicare and Medicaid programs comes through the dually eligible population. This population consists of individuals who qualify for both Medicare and Medicaid. They are generally poor and either disabled or above age sixty-five. The dually eligible generally receive a full package of benefits from each program, and Medicaid covers recipients'

Figure 1: Number of Medicare Beneficiaries, 1996 and 2030



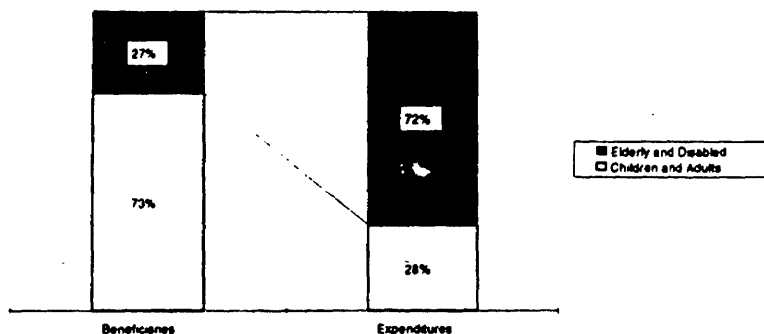
Source: Health Care Financing Administration.

Figure 2. Number of Dually Eligible, 1995 and 2030



Source: Health Care Financing Administration.

Figure 3. Medicaid Beneficiaries and Expenditures, Fiscal 1986



Source: Health Care Financing Administration

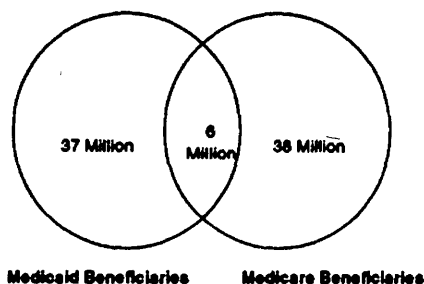
Medicare cost-sharing obligations. Currently, more than 6 million people are classified as dually eligible (see Figure 4).

Fifteen states and the District of Columbia have taken advantage of an option set forth in the Omnibus Budget Reconciliation Act of 1986 that expands the range of dually eligible individuals by permitting states to extend full Medicaid coverage to the elderly and disabled with incomes up to 100 percent of the federal poverty level. In these states, in addition to receiving Medicaid coverage for their Medicare cost-sharing obligations, these populations receive a full package of Medicaid benefits.

Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries

Medicaid and Medicare also are linked through Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs). QMBs are individuals who are not dually eligible but have incomes below the poverty level and resources below twice the resource standard set by the Supplemental Security Income program. SLMBs have incomes between 100 percent and 120 percent of poverty and meet the same resource standard applied to the QMB population. Approximately 500,000 individuals are classified as QMBs or SLMBs.

Figure 4. Categorical Overlap Between Medicaid and Medicare Beneficiaries



Source: Health Care Financing Administration.

As with the dually eligible, Medicaid is responsible for helping QMBs and SLMBs meet their cost-sharing obligations under the Medicare program. The QMB requirement was set forth in the Medicare Catastrophic Cost Act of 1988. When this legislation was passed, it was expected that QMB coverage would be financed through the savings states would realize as a result of expanding Medicare coverage for nursing home services and prescription drugs, which would free up Medicaid funds. When the Medicare expansions in the catastrophic act were repealed in 1989, the QMB mandate was maintained. In fact, the mandate was expanded through the Omnibus Budget Reconciliation Act of 1990 to include SLMBs. Although none of the promised savings were realized, Medicaid cost-sharing obligations were increased. For QMBs, Medicaid pays Medicare Part A premiums when required, as well as Part B premiums, and copayments and deductible costs incurred when services are provided. For SLMBs, Medicaid is responsible only for premium costs.

The dually eligible, QMB, and SLMB populations represent categorical connections between Medicaid and Medicare. The health care experiences of more than 6 million people

depend on the effective interaction of the two programs.

Programmatic Overlap

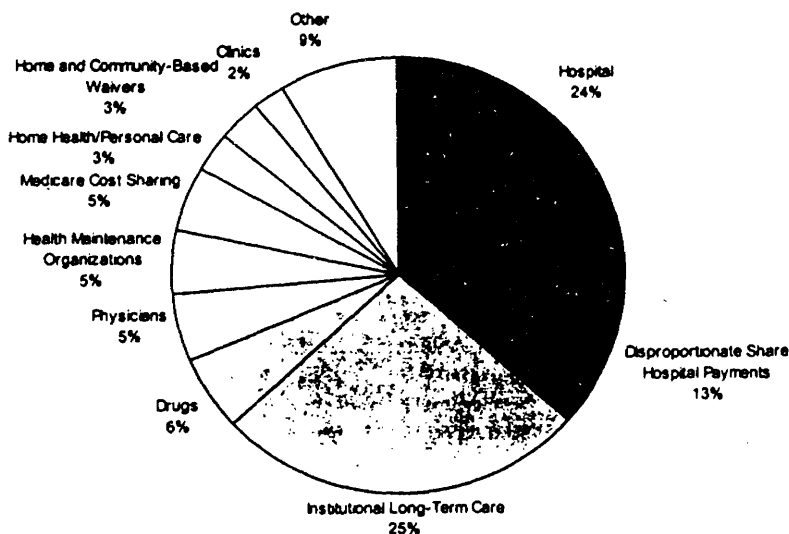
Benefit Packages

Beyond these categorical connections, Medicaid and Medicare provide packages of benefits that taken together amount to a comprehensive system of care for the dually eligible. However, the distinctions between the services covered by Medicaid and those covered by Medicare are complicated. In every case, if an individual is dually eligible for Medicare and Medicaid, Medicare is the primary payer for those services covered through both programs.

Medicare was not designed to be a long-term care program. It was established to provide senior citizens with insurance coverage for hospitalization and physician services. Medicaid has evolved so that it now fills the gaps in Medicare coverage for low-income senior citizens and certain people with disabilities. Medicaid pays for many of the services Medicare does not cover, including most nursing home care, prescription drugs, and extended home care.

For example, Medicare will cover 100 days of nursing home care per episode of illness, but

Figure 5. Medicaid Expenditures, Fiscal 1995



Source: Health Care Financing Administration.

only following hospitalization and only as long as skilled services such as therapy are being provided. Once these skilled services are not needed, Medicare coverage ends, even if the individual has been in a nursing home fewer than 100 days. For low-income senior citizens, once Medicare nursing home coverage ends, Medicaid assumes payment responsibility for all nursing home costs. Medicaid now pays for more than 70 percent of all patient days in nursing homes nationwide. Payments to nursing facilities consume 25 percent of all Medicaid spending (see Figure 5).

Medicare's basic benefit package does not include prescription drug coverage, though some Medicare health maintenance organizations (HMOs) offer prescription coverage to encourage enrollment. More commonly, many senior citizens who can afford to do so purchase Medigap insurance policies to obtain this important benefit. For low-income senior citizens and individuals with disabilities, prescription drug coverage is provided through

Medicaid. Prescription drugs are an optional Medicaid benefit, and every state takes advantage of the option. Prescription drug coverage is Medicaid's third largest spending category, following hospital and nursing facility costs.

Through nursing home care and prescription drug benefits, Medicaid fills two of the largest gaps in Medicare coverage. Yet there are other even more complicated distinctions between services covered by Medicare and those covered by Medicaid. Home and community-based care services are a good example of this complicated relationship. Medicare reimburses for some home health services for people who are confined to the home; under the care of a physician; in need of skilled nursing services on a part-time or intermittent basis; or in need of physical, speech, or occupational therapy. These Medicare reimbursable services are medical in nature and can include nursing care, therapy, home health aides, and durable medical equipment. In 1995 Medicare spent \$16 billion on home care.

Medicaid also provides home and community-based care to low-income senior citizens and disabled people. Home health, private duty nurses, and personal care are all optional Medicaid services, and a separate home and community-based care waiver program is available at state option to people who would otherwise have to be institutionalized. Unlike Medicare, Medicaid can be used to fund nonmedical services needed to help individuals remain in the community. These services can include case management, housekeeping assistance, minor home modifications, and respite care. In 1995 Medicaid spent \$9.5 billion on home health benefits. The complicated overlap of covered services and payment responsibilities between the two programs makes this benefit difficult to manage and administer.

Impact on States

These complicated distinctions between services reimbursed through Medicare and those reimbursed through Medicaid place administrative burdens on state programs because they are forced to monitor which services are covered by what program. Both Medicaid and Medicare must maintain extensive billing processing systems to carefully monitor reimbursements to ensure that the correct program is paying for the services an individual receives. More fundamentally, the inefficiencies and redundancies of the status quo make it impossible for either program to obtain the maximum possible quality and value for each health care dollar spent.

Impact on Recipients and Families

Any experience with the health care system can be frightening and frustrating for individuals and for their families. That experience is only made more difficult when, in addition to coping with illness, patients and families are faced with confusing explanations of reimbursement responsibilities or discussions about why some services will be covered but other services will not be covered. Medicare and Medicaid have their own processes for determining eligibility and collecting payments and their own forms and bills. Those

experiencing a health care crisis should not be asked to navigate a redundant and confusing trail of paperwork. As it stands, to meet health care costs, an individual or family may have to interact with numerous insurers, including Medicare, Medigap, and Medicaid.

Impact on Quality

Clearly, the status quo does not represent an ideal system of care for those who rely jointly on Medicare and Medicaid for coverage of their health care costs. In a perfect system, the dually eligible would have easy access to a seamless and coordinated package of services to meet their needs. Instead, they face fragmentation, redundancy, and inefficiency.

Efforts to promote or even assess the quality of care provided to the dually eligible population are undermined by the lack of program coordination. Even if one program were to attempt quality improvements, services provided through the other program would be impervious to change. Even if both programs made a concerted effort to carefully anticipate, identify, and address a patient's needs, efforts by medical personnel to coordinate benefits are complicated by coverage distinctions between the programs. To develop a high-quality continuum of care for a recipient, a care plan should recommend the ideal treatment course, and this decision should not be affected by whether a particular care setting is paid for by one program or the other.

Financial Overlap

Similar to the categorical and programmatic connections between the two programs, the financial relationship between Medicare and Medicaid is close but complex. Decisions made in one program can have a significant cost impact on the other program. This impact can be direct, through cost-sharing responsibilities, or indirect, through shifts in services from one program to the other.

Direct Impacts

Medicare Part A services, which include hospitalization, some nursing home services, and some home health services, are paid for by a

trust fund that is financed through a dedicated Federal Insurance Contributions Act (FICA) tax, supplemented by deductibles and copayments assessed for long institutional stays. Medicare Part B covers physician services and outpatient services. Part B is financed separately, through beneficiary cost sharing and federal general revenue. Beneficiaries are responsible for 25 percent of Part B program costs in premiums, plus deductibles and copayments.

Following the implementation of the provisions in the Medicare Catastrophic Coverage Act related to QMBs in 1989 and the subsequent designation of similar cost-sharing provisions for SLMBs in 1990, Medicaid has been responsible for meeting the Medicare cost-sharing obligations of 500,000 people classified as QMBs or SLMBs. Similarly, Medicaid assumes the cost for Medicare premiums, copayments, and deductibles for the 6 million people who are dually eligible. In 1995 Medicaid payments for the Medicare recipient costs for the dually eligible as well as for QMBs and SLMBs totaled \$3.86 billion.

In meeting the cost-sharing obligations of each of these population groups, Medicaid is a passive payer that is responsible for costs beyond its control. Decisions regarding increases in individual responsibility for meeting Medicare costs are made without consideration for the impact these increases will have on state Medicaid costs, even though the impact is clear. For QMBs, SLMBs, and the dually eligible, increases are simply passed along to Medicaid. Efforts to control costs in one program shift costs to the other program.

In recent years, Medicare has gradually increased cost-sharing obligations for individual recipients. As Medicare Part B premiums have gone up, state costs for paying the premiums have increased. Monthly Medicare premiums increased again to \$43.80 per individual in 1997 from \$42.50 in 1996. Without expressing an opinion on the wisdom of increasing client cost-sharing obligations, it is clear the choice leads to increased Medicaid expenditures.

Because of the matched funding nature of Medicaid, 57 percent of the Medicaid costs shifted from Medicare will remain the responsibility of the federal government, but 43 percent of those costs now will fall to the states. State Medicaid match rates vary significantly. Eleven states and the District of Columbia pay the maximum of fifty cents of every Medicaid dollar while the federal government pays the other fifty cents. At the other extreme, the lowest current match rate is 22 to 78. For all states, regardless of the match rate, Medicaid cost-sharing obligations have increased with the change in Medicare's premium-sharing policy.

Besides having the overall responsibility for meeting the Medicare cost-sharing obligations of QMBs, SLMBs, and the dually eligible, several states have been forced to absorb Medicare copayment costs at rates higher than they are accustomed to paying. For QMBs and the dually eligible, Medicare pays for 80 percent of the cost of the services provided. The level of the remaining copayment is the outstanding question, and the courts have been actively involved in this issue.

Judicial rulings on copayment rates have begun to mandate state payment policies. In the defining case, *Haynes Ambulance Service, Inc., et al. v. State of Alabama, et al.*, the U.S. Court of Appeals for the Eleventh Circuit ruled that states are required to pay the Medicare cost-sharing amounts without limitation based on Medicaid rates. The appeals court ruling created a provider entitlement to 100 percent of the Medicare reimbursement rate for a given service. In *Haynes*, Alabama argued that if the 80 percent paid by Medicare for the cost of a service provided to a QMB exceeded what Medicaid would reimburse for the same service, then the Medicaid program would not have to pay the 20 percent balance. The U.S. District Court ruled in favor of the state, but that ruling was overturned on appeal. The appeals court decision in *Haynes* has since been used by a number of circuit courts to require states to make copayments that reflect the higher Medicare reimbursement rate rather than the lower Medicaid rate.

State attempts to manage the Medicare costs shifted to them have been invalidated by the courts.

States increasingly are tied to Medicare reimbursement rates significantly higher than what Medicaid pays for the same service. For example, Medicaid pays 90 percent of Medicare's reimbursement rate for an office visit. For an intermediate hospital care visit, Medicaid pays 77 percent of the Medicare reimbursement rate, and for an laparoscopy, Medicaid reimburses at 76 percent of the Medicare rate. Given that Medicaid reimbursement rates tend to be lower than Medicare rates, court decisions have essentially forced states to pay higher rates for services.

Indirect Impacts

Both Medicare and Medicaid face unnecessarily high administrative costs resulting from duplicative eligibility and billing processes for services provided to the same groups of people. In addition, the disconnected status quo creates an incentive for the two programs to

shift services and the accompanying costs to each other.

Tangled and uncoordinated coverage rules make this cost shift possible. For example, Medicare reimburses for hospital stays through the diagnosis-related group (DRG) payment system. A hospital receives a set fee for treating a patient based on a specific diagnosis, and that fee generally remains the same regardless of whether the patient stays in the hospital for a day or a week. Clearly, a hospital has an incentive to release a patient as soon as possible to keep down its actual costs. When release to the home is impossible, recipients are transferred to nursing facilities. Medicare reimbursement for nursing home care is limited, so once it is no longer available Medicaid reimbursement begins for low-income senior citizens. Medicare's payment obligation is shifted to Medicaid. The same incentive exists in reverse, as Medicaid nursing home costs end when an individual is readmitted to a hospital.

Federalism

The complicated web of shared responsibility for meeting long-term care needs falls outside of the more usual pattern of assigning direct responsibility for meeting a particular category of need to a single level of government. For senior citizens, that responsibility has fallen to the federal government rather than the states. Social Security is wholly a federal program, as is Medicare. Senior citizens traditionally look to Washington, D.C., for direction on the programs most important to them, as do people with disabilities. The federal government funds and administers one of the most important programs benefiting disabled Americans—the Supplemental Security Income (SSI) program.

Programs supporting the elderly and the disabled have fallen to the federal government rather than the states for good reasons. Perhaps most important, the federal role acknowledges that neither population group follows a typical demographic distribution pattern. Instead of residing in relatively equal percentages in each of the states, both groups tend to be concentrated in particular parts of the nation. For example, across the United States, an average of 12.8 percent of the population is above age sixty-five. Statewide percentages can vary widely, however, from lows of 4.9 percent in Alaska and 8.8 percent in Utah to highs of 15.7 percent in Rhode Island and 18.6 percent in Florida. Nationwide, 4.2 percent of the people below age sixty-five have a disability severe enough to prevent them from working. Variations range from a low of 2.3 percent in Alaska to a high of 8.4 percent in West Virginia. If programs for the elderly and the disabled were state-based, states with high concentrations of these populations would find themselves disproportionately challenged by the demands of financing expensive services and supports.

Medicaid has always been an exception to the usual pattern of one level of government being

assigned responsibility for a given category of services. From its inception, Medicaid has been a partnership of shared responsibility between the states and the federal government. This partnership has been effective in providing health care to millions of low-income Americans. This relationship has become more complicated, however, as Medicaid's budget has become increasingly dominated by long-term care costs for low-income senior citizens and people with disabilities.

With the emergence of Medicaid as such a primary component of support systems for low-income senior citizens and people with disabilities, federal responsibility is beginning to shift to the states. Health care costs for the elderly and people with disabilities dominate state Medicaid budgets. Nationwide, institutional long-term care costs alone consume 25 percent of all Medicaid spending. Again, statewide percentages vary widely. For example, in Ohio 37 percent of all Medicaid expenditures are attributable to institutional long-term care, while in California long-term care accounts for 17 percent of the program's budget.

As low-income senior citizens and people with disabilities have come to rely on Medicaid payment for long-term care costs, the basic federalism distinction between federal and state responsibilities has begun to blur. Groups that have traditionally been the beneficiaries primarily of federal programs are relying more on state aid through Medicaid, while beneficiaries with higher incomes remain in the sphere of the federal government and are being served mainly by Medicare and Social Security. States experience this shift disproportionately because of variations in the demographic distribution of these populations.

This shift in responsibility from the federal government to the states has created a bifurcated system of responsibility. Those with higher incomes are the responsibility of one level of government and those with lower incomes are the responsibility of the other. The traditional federal responsibility for

elderly and disabled people no longer applies to the same extent if they happen to be poor. In that case, one of their most important supports, long-term care, falls to the responsibility of the states.

Shifting responsibility for low-income senior citizens and people with disabilities exposes their benefits to an entirely different system of government financing. Federally, the most important benefits for these groups—Social Security and Medicare—are funded through special dedicated financing streams. Medicaid does not have the protection of dedicated funding sources. Financial support from a state must compete with all other state funding needs. As state costs for the low-income elderly and disabled continue to increase, states face divisive generational funding challenges (e.g., as nursing home costs compete with education funding needs).

Management

Efforts to effectively manage the interrelationships between Medicaid and Medicare are complicated significantly by this federal-state distinction, as well as by the extensive demographic, categorical, programmatic, and financial connections between the two programs. At the same time, these very connections make prudent management essential to the successful coordination of health services to those populations eligible for both Medicaid and Medicare. Successful management would promote a more seamless system of benefits for recipients, make home and community-based care a more viable alternative to institutional placements, and reduce cost shifting.

Under the best of circumstances, program coordination would be a difficult management challenge. Unfortunately, circumstances are far from ideal. State experimentation could lead to a more rationalized continuum of care for the dually eligible, but federal barriers deny states the flexibility needed for experimentation.

Managed Care and the Dually Eligible

Many states have found that managed care is an effective strategy for enabling health programs to develop coordinated systems promoting quality care. Through managed care, Medicaid programs have begun to make a transition from their historically passive role as bill payers, to a more active role as value purchasers of health care services. Medicaid's experience with managed care has evolved significantly over the past decade, moving in many parts of the nation from experimental pilot programs to mature and stable systems of care.

A similar process of experimentation and evolution could lead to the development of effective management models for the dually eligible. States have considerable experience enrolling in Medicaid managed care recipients who are pregnant women, children, or eligible

because of their receipt of benefits under the former Aid to Families with Dependent Children (AFDC) program. These enrollees are younger and healthier than many of the dually eligible. The dually eligible are far from a homogenous group, encompassing individuals with a range of health care needs. To be effective, it is possible that existing managed care models will have to be adjusted to address the special needs of the various categories of the dually eligible. Experimentation is needed to determine what changes are needed to develop successful models.

Approaches

Analysis by the National Academy for State Health Policy indicates that efforts to enroll the dually eligible in managed care have generally followed two approaches. The first approach focuses on the coordination of the two programs, with the goal of making the Medicare and Medicaid systems appear as one to the consumer. The second approach tries to integrate Medicare and Medicaid into a single service system for dually eligible consumers.

Oregon is frequently cited as a leading example of a coordinated approach to managed care for the dually eligible. It has highly

developed managed care networks for both Medicaid and Medicare beneficiaries. When a dually eligible Medicare recipient chooses to enroll in a Medicare HMO, Oregon then enrolls the recipient in the same HMO for the delivery of Medicaid benefits. Medicare HMO enrollment is not mandatory. Funding, administration, and oversight remain separate responsibilities of each of the programs, but beneficiaries have to deal with only one managed care network.

The second model, based on integration, makes it possible for the two programs to act as one in providing services to the dually eligible. The state Medicaid program essentially serves as the Medicare's program agent for this population. Minnesota has been the leader in pursuing this approach through its Senior Health Options program. Under the Minnesota model, the state negotiated a single contract for the provision of both Medicaid and Medicare services for the dually eligible. The permission granted to Minnesota by the Health Care Financing Administration to pursue this approach was controversial, however, and HCFA Administrator Bruce Vladeck has indicated that requests by other states for approval to develop similar experiments will be denied.

Another example of an integrated model can be found in the federal Program of All-inclusive Care for the Elderly (PACE) program. The program provides access to a comprehensive array of health care services, ranging from prevention to long-term care. PACE receives capitated payments from both Medicare and Medicaid. Participation in PACE is voluntary. Currently, twelve states host operational PACE sites, so availability is limited. Individual participation is restricted to those who need a nursing-home level of care.

Obstacles

For many dually eligible individuals, especially those in nursing homes and those with high prescription drug costs, Medicaid pays for more of their health care costs than does Medicare. For this reason, Medicaid has a particular need to try to control expenditures.

However, Medicare requirements interfere with states' attempts to manage costs.

The most significant obstacle to developing either a coordinated or an integrated approach to managed care for the dually eligible is the lack of clear statutory authority. This authority could be clarified either by explicit legislative approval of mandatory managed care programs for the dually eligible, or through the creation of substantial Medicare waiver authority.

Medicare does not have an option, similar to Sections 1115 or 1915(b) in the Medicaid program, to permit provisions of program statute to be waived for the purpose of experimentation. States have used Medicaid waivers as vehicles for moving recipients into managed care. Waivers create limited flexibility to design programs that might not be possible within the strict confines of Title XIX, the Medicaid section of the Social Security Act. For example, creating an option to waive Title XIX freedom-of-choice requirements allows managed care enrollment to be made mandatory. Waivers also permit states to require enrollees to remain with the particular managed care plan they selected for six months or more before changing to another plan, unless there is good cause compelling a more immediate switch.

The Medicare statute, Title XVIII of the Social Security Act, does not have sufficient waiver authority to permit experimental flexibility. Accordingly, any attempt to synchronize the programs in order to improve the health care experiences of the dually eligible would require Medicaid to conform with Medicare requirements or to make allowances for those requirements. For example, managed care enrollment for the delivery of a dually eligible individual's Medicare benefits could not be made mandatory, because there would be no way to waive Medicare freedom-of-choice requirements.

Medicare waiver authority is restricted to Section 222, which permits provisions related to reimbursement or payment to be waived. This waiver makes it possible to make capitated

payments to health plans. If an individual is enrolled in a Medicare HMO, capitation is allowable without a waiver. Medicare HMO plans also permit a one-month lock-in requirement to provide at least some stability to HMO enrollment. Because Medicare HMOs are not widely available, and because they are subject to a composition rule requiring that at least 50 percent of their membership not be on either Medicare or Medicaid, this capitation waiver authority is critical to permitting managed care experimentation for the dually eligible. Unfortunately, the flexibility does not extend beyond permitting capitation. The payment system for Medicare HMOs is extremely cumbersome, varying county by county across a state. It is complicated by plans offering different packages of benefits, further impeding coordination efforts.

Despite the precedent of the Minnesota program, HCFA has indicated that it is unlikely to permit further experimentation with the integration model of managed care for the dually eligible. For this reason, several states have begun to pursue the coordinated program model for dually eligible managed care. However, the lack of Medicare waiver authority will complicate state efforts to make the programs run together more effectively. Medicare HMO enrollment cannot be required nor can a recipient be required to remain with a chosen health plan for a guaranteed and sustained period. In addition, the bureaucratic inefficiencies and redundancies of continuing to operate two separate

programs even while trying to make them act as one are hard to justify, especially given the goal of maximizing the value obtained from each health care dollar spent.

Opportunities

States that are trying to develop a more seamless and effective delivery system for the dually eligible are frustrated by federal barriers to more complete cooperation. Yet efforts to develop a more rational continuum of care for this vulnerable population promise to yield important results.

Families will enjoy dramatically simplified contacts with the health care delivery system if they can interact with one system of care rather than two systems of care. Viewing patient needs from a broad perspective instead of questioning which benefits are provided through which category of eligibility will lead to the development of an individualized care plan that is focused on patient needs rather than reimbursable services. This will lead to a decrease in institutionalization as home and community-based care becomes more readily available. Payment processes for providers will be simplified through either the coordination or integration of Medicare and Medicaid for the dually eligible. The public programs will benefit from a reduction in administrative burdens and an elimination of the incentive to shift costs to each other. More effective management of the interrelationships between Medicare and Medicaid will ultimately help public programs become more quality-focused, value purchasers of health care.

Medicare Reform

Given the categorical, programmatic, and financial connections between Medicare and Medicaid, as well as the existing managerial barriers, reform offers the real potential for substantial and lasting improvement to the health care delivery system that serves the nation's senior citizens and people with disabilities. Conversely, undertaking reform of the Medicare program alone places Medicaid at great risk. Not only would the current range of problems not be solved by undertaking Medicare reform in a vacuum, but those problems would be exacerbated.

Short-Term Issues

The most compelling short-term issue facing Medicare is the financial viability of the hospital trust fund. Without intervention, the Part A trust fund will run out of money in 2001. At that point, the dedicated FICA tax will no longer be sufficient to cover Part A costs. Clearly, immediate action is needed. The Clinton administration has indicated that dealing with this impending shortfall will be one of its top priorities in the 105th Congress, and Republican congressional leadership agrees that action is necessary.

In developing a plan for realizing the short-term savings needed to extend the life of the trust fund, it is likely that the administration and Congress will consider two major options. Savings could be realized through reductions in provider reimbursement rates, through increases in beneficiary cost-sharing responsibilities, or through some combination of these options. Without expressing an opinion on the desirability of either option, it is clear that undertaking either option without considering its potential impact on Medicaid places that program at risk even while Medicare is being strengthened.

Provider Reimbursement

The cost-cutting strategy most likely to be advocated by federal policymakers is a reduction in Medicare provider reimbursement rates. A Medicare rate adjustment has real appeal from Medicaid's perspective because Medicaid increasingly is being held responsible for reimbursing for services to QMBs at the higher Medicare rates. However, any reduction in Medicare reimbursement levels will only exacerbate the existing tendency to shift costs between the Medicare and Medicaid programs. For example, if DRG rates are reduced, hospitals could decide to press for the earliest possible release of Medicare patients. The shorter the hospitalization, the more likely the flat DRG rate will cover the actual cost of the hospitalization.

For many medically fragile senior citizens and people with disabilities, early release from the hospital means subsequent admission to a nursing home. For the dually eligible, that leads to a transition from Medicare coverage of hospital benefits to Medicaid coverage of nursing home care. Such cost shifting already occurs, but changes in Medicare reimbursement rates that encourage even quicker hospital discharges will accelerate this dynamic.

Cost Sharing

The other major possibility for producing savings in the Medicare program is to increase the cost-sharing obligations of Medicare recipients. Increasing beneficiary cost-sharing obligations will be seriously considered because it could yield significant savings without making necessary dramatic changes to the Medicare program.

The risk to Medicaid from increasing Medicare cost-sharing obligations is obvious. For the more than 6 million QMBs, SLMBs, and dually eligible people, those costs would be passed directly to state Medicaid programs. The Unfunded Mandates Reform Act of 1995 should afford states some protection from this direct cost shift, because the Congressional Budget Office recognizes increases in Medicare cost-sharing obligations as increased costs to states.

Medicaid's potential financial exposure is enormous. If Medicare premiums were increased \$5 per month, that would result in increased Medicaid expenditures of more than \$360 million annually. Given the tremendous strides made by Governors over the past few years to restrain Medicaid spending growth, these uncontrollable increases would be particularly frustrating to states.

Another less direct cost shift would occur if the federal government decides to move home health care services from Medicare Part A to Part B. This would strengthen the Part A trust

fund, but such a change could impose significant new cost-sharing obligations on Part B beneficiaries and on states.

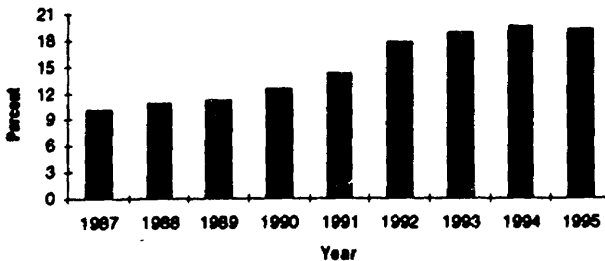
After experiencing Medicaid growth rates averaging more than 20 percent during the late 1980s and early 1990s, states recently have been able to reduce Medicaid growth rates significantly. Over the past two years, Medicaid spending has grown at an average rate of only 3.9 percent. This has been achieved due to a combination of factors, including reforms enacted by Governors to increase enrollment in managed care and reduce program fraud and abuse.

Should the federal government choose to increase Medicare cost-sharing obligations, state Medicaid programs would see their spending increase despite the reforms they have undertaken. Medicaid spending in 1995 consumed an average of 19.2 percent of state budgets, compared with only 10.2 percent in 1987. Every new dollar spent on Medicaid is a dollar not available to invest in education or other important state priorities (see Figure 6).

Long-Term Issues

The short-term risks of enacting Medicare reform without corresponding Medicaid reform are mainly financial. It is almost inevitable that any changes to realize Medicare savings will result in cost shifting. The long-term risks are more fundamental. The most important long-term consequence of failing to

Figure 6. Medicaid as a Percent of Total State Spending, Fiscal 1987 to Fiscal 1995



Source: National Association of State Budget Officers.

consider the strains placed on both Medicare and Medicaid by the aging of the baby-boom generation will be a missed opportunity to strengthen the financial viability of both programs by developing a more rational system of care to meet recipient needs.

Systemic

The existing relationship between Medicare and Medicaid is more the product of an uncoordinated evolution than a carefully developed system of care. Taken together, the two programs have been largely successful in meeting the health care needs of some of the nation's most vulnerable citizens. The status quo leaves much room for improvement, however, in terms of coordination, quality, and cost-effectiveness.

If benefits—primary and preventive care, hospitalization, home and community supports, and nursing home care—were delivered through an integrated system, care plans could be developed that focus broadly on recipients' health care needs without consideration of coverage for specific benefits. This coordination would increase the quality of an individual's experience with the health care delivery system by permitting a focus on the spectrum of need, rather than making arbitrary distinctions between primary care and long-term care. Cost-effectiveness would be increased both through the reductions of administrative costs that would accompany a simplified system, and through the savings that would be realized from use of the most appropriate care setting. For example, increased access to home and community-based care could help prevent more costly institutionalization.

If Medicare reform is undertaken independently of Medicaid reform, the chance to

make needed improvements to the interrelationships between the two programs will be lost. Existing inefficiencies will only become more problematic as caseloads increase. If reform is seen as an opportunity to design a more rational system of care, however, a new continuum of services could be developed that focuses on patient needs rather than programmatic parameters.

Financial

As the baby boomers reach retirement age, the financial pressures on Medicaid will be enormous. Looking only at Medicaid nursing home costs, it is clear that program spending will skyrocket. Currently, Medicaid pays for more than 70 percent of all days spent in nursing homes. As the population of senior citizens increases from approximately 38 million to approximately 78 million, the absolute numbers of nursing home occupants will increase roughly proportionately. Meeting this increased cost will be the responsibility of Medicaid.

Medicaid is not paid for by trust funds. The state portion of program costs is met through state general revenue funds, and the federal match is financed through the annual appropriations process. As Medicaid costs increase, those expenses can be met only by limiting eligibility, reducing spending on other programs, or raising taxes.

Just as a new financial framework will be needed to sustain Medicare through this population explosion, Medicaid too will require support. If no programmatic reforms are enacted to develop a more rational continuum of care across the two programs, the financial pressures caused by the aging of the baby boomers will be even more difficult to address.

A More Rational System

Governors believe that long-term Medicaid reform should be considered in conjunction with efforts to reform Medicare. Only through the creation of a more rational, cost-effective continuum of care for the elderly and the disabled will the two programs be able to accommodate the impending caseload explosion.

Regardless of whether reform is undertaken directly by Congress and the administration, or indirectly through an appointed commission, Governors should be included in the process to ensure that states' ideas are discussed and Medicaid's needs are addressed.

From the Medicaid perspective, a number of reform strategies should be considered to make needed improvements to the existing interrelationships between Medicare and Medicaid and to begin to prepare for the retirement of the baby boomers. These strategies include sweeping reexaminations of the status quo as well as much more limited steps to address specific problems. The Governors are not advocating any particular reform solution. Instead, they recommend that each proposal be considered carefully as the reform process moves forward and welcome all suggestions.

Systems Integration

On the surface, the simplest solution to the coordination problems associated with running two major programs to meet the health care needs of the same basic population would be to consolidate those two programs into one. Obviously, such a merger would be difficult and a number of important issues would have to be addressed. Yet, in the interests of meeting patient need and increasing cost-effectiveness, serious consideration should be given to consolidation. One option is for Medicaid's existing long-term care responsibilities to be assumed by the Medicare program. Although any model would have to be crafted

carefully, states could then assume 100 percent of Medicaid's acute care costs for the nondually eligible populations. Currently, the federal government pays, on average, 57 percent of those costs through the existing matched funding structure.

Long-Term Care

The Governors strongly support efforts to encourage the purchase of private long-term care insurance policies. The tax incentives created by the Health Insurance Portability and Accountability Act are a good first step, particularly when paired with consumer protection standards. Private sector penetration of the long-term care insurance market has historically been so low, however, that a strong cooperative effort by the federal government, state governments, employers, consumer groups, and the insurance industry will be needed to encourage Americans to plan for their futures. With a long-term care insurance policy, families facing nursing home costs would not have to spend down their life savings so they can qualify for Medicaid in order to have these bills paid.

One strategy to promote further development of the private market calls on the federal government to remove barriers to public-private partnerships that permit individuals to purchase state-certified private policies and then have a portion of their assets protected once the private benefits are paid out and public financing becomes necessary. Such experiments should be encouraged, and information

on successful strategies for promoting the purchase of private policies should be shared widely so that states can learn from the best practices in the field.

Dually Eligible

Careful consideration of proposals to consolidate Medicaid's long-term care responsibilities with Medicare will take time, as will efforts to encourage the purchase of private insurance. As these more fundamental solutions to the problems of the dually eligible are contemplated, however, real improvement is possible almost immediately.

In the short term, the Governors believe that the Health Care Financing Administration should take steps to make permit experimentation with mandatory managed care programs for the dually eligible. Given the pilot projects that have been approved in the past, it appears as though HCFA already has sufficient flexibility to allow mandatory managed care programs to be implemented, even though the agency has indicated that no further requests will be approved. If statutory change is needed to permit Medicare's freedom-of-choice requirements to be waived, Congress should make such an amendment a priority.

Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries

Medicaid's responsibility for QMBs and SLMBs is simply that of a payer. Both populations receive only Medicare benefits, not Medicaid benefits. Medicaid's only connection to either QMBs or SLMBs is a mandate for meeting their cost-sharing obligations. Because Medicare is a federal program, the federal government should bear all of its costs. These costs could then be more effectively managed within the Medicare program as a whole. States should not be given financial responsibility for part of a program over which they have no control.

The broad issue of whether Medicare or Medicaid would be responsible for the cost-sharing obligations of QMBs and SLMBs needs to be considered. Moreover, immediate action is needed to clarify that states can use Medicaid reimbursement rates rather than Medicare rates in meeting copayment costs for the QMB population.

Cash and Counseling

While moving toward a fundamental reexamination of the status quo in the long term, the federal government should now work closely with interested states to permit individuals, on a voluntary basis, to experiment with designing a health care package that meets their specific needs. Instead of the prescribed benefit packages included in both Medicare and Medicaid, a cash and counseling option would give families limited control to design their own care plans.

This option would allow Medicaid and Medicare funds to be commingled by families as care plans are designed. Ideally, in designing their own health care packages, families would be able to avoid the current confusing distinctions between Medicaid and Medicare allowable services. Such a model obviously would have to include an intensive individual technical assistance element to help families make informed choices.

Case Management

Another short-term solution to help families more successfully navigate the interrelationships between Medicaid and Medicare would be to strengthen the case management services available to dually eligible families from the beginning of their experience with the health care system. Case management would help tailor care plans to meet client needs, calling on both Medicaid and Medicare benefits to complement family resources.

Conclusion

From the Governors' perspective, the existing interrelationships between Medicaid and Medicare leave much room for improvement. Artificial program distinctions create coordination problems, family frustration, and unnecessary costs. Attempts to more effectively manage the intersections of the programs as applied to the dually eligible are stifled by administrative barriers to experimentation.

Reform is necessary, but it must be undertaken carefully. The needs of Medicare and Medicaid must be considered jointly when making decisions about how best to ensure that America's senior citizens and people with disabilities continue to receive high-quality, affordable health care. Only by looking at the system comprehensively will a more rational, cost-effective continuum of care be developed. The successful development of a more seamless relationship between Medicare and Medicaid will improve the quality of care provided to the nation's most vulnerable populations. The Governors would like to work with Congress, the administration, and other interested parties as these programs are strengthened to prepare for a future of heightened demand.

Since their initial meeting in 1908 to discuss interstate water problems, the Governors have worked through the National Governors' Association to deal collectively with issues of public policy and governance. The association's ongoing mission is to support the work of the Governors by providing a bipartisan forum to help shape and implement national policy and to solve state problems.

The members of the National Governors' Association (NGA) are the Governors of the fifty states, the territories of American Samoa, Guam, and the Virgin Islands, and the commonwealths of the Northern Mariana Islands and Puerto Rico. The association has a nine-member Executive Committee and three standing committees—on Economic Development and Commerce, Human Resources, and Natural Resources. Through NGA's committees, the Governors examine and develop policy and address key state and national issues. Special task forces often are created to focus gubernatorial attention on federal legislation or on state-level issues.

The association works closely with the administration and Congress on state-federal policy issues through its offices in the Hall of the States in Washington, D.C. The association serves as a vehicle for sharing knowledge of innovative programs among the states and provides technical assistance and consultant services to Governors on a wide range of management and policy issues.

The Center for Best Practices is a vehicle for sharing knowledge about innovative state activities, exploring the impact of federal initiatives on state government, and providing technical assistance to states. The center works in a number of policy fields, including agriculture and rural development, economic development, education, energy and environment, health, social services, technology, trade, transportation, and workforce development.

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State Strategies for Increasing Health Care Coverage for Children*

Summary

Dramatic state expansions of Medicaid eligibility, coupled with equally important reforms of outreach and service delivery systems, have enabled millions of previously uninsured women, infants, and children to access comprehensive health care services. States continue to seek effective models to link children to available health insurance options. This *Issue Brief* discusses the strategies that some states are using to identify Medicaid-eligible and noneligible children and encourage them to take advantage of state-supported health coverage programs.

State efforts to connect children to health coverage programs fall broadly into three categories: Medicaid expansions beyond the minimum federal eligibility requirements; state-only funded programs; and public-private partnerships. Regardless of how states combine these approaches, many programs incorporate a public awareness campaign. The state initiatives described in this *Issue Brief* suggest the ways that states have broadened their maternal and child health outreach efforts to identify eligible children of all ages and enroll them in appropriate state health programs. It summarizes Medicaid eligibility expansions, describes administrative streamlining efforts, and highlights outreach strategies that are used directly or indirectly to enroll eligible children in Medicaid, as well as provides examples of child health coverage programs targeted to non-Medicaid-eligible children.

Medicaid Eligibility and Outreach Strategies

Since the mid-1980s, a primary focus of the Medicaid program has been to provide health care services to low-income children of all ages.

Expanding Eligibility

The Medicaid program is the predominant way that states provide public funding for children's health insurance. Thirty-nine states have expanded Medicaid eligibility for pregnant women and all children beyond federal mandates. As of September 1996, thirty-four states had exceeded the federal mandate for eligibility for pregnant women and infants, eleven states had exceeded the minimum income eligibility thresholds for children between the ages of one and five, and twenty-four states had exceeded the minimum requirements for children ages six and older (see Table 1). These expansions have been accomplished primarily through three different mechanisms: electing an option for expanded eligibility for pregnant women and infants included in the Omnibus Budget Reconciliation

Act (OBRA) of 1989; invoking Section 1902(r)(2) of the Social Security Act, which allows states to disregard income and resources without a waiver; and obtaining a Section 1115 statewide health care reform demonstration waiver that expands eligibility in tandem with the implementation of managed care health systems.

Streamlining the Eligibility Process

States have not relied exclusively on increasing income eligibility thresholds to improve access to health care. In addition to outstationing eligibility workers in hospitals and clinics in order to maximize the opportunity for people to apply for Medicaid, states have also worked to minimize administrative barriers that make it difficult for people to access the program. Most states use multiple strategies to simplify and streamline the application process. These strategies include dropping the assets test, adopting presumptive eligibility, shortening application forms, expediting eligibility determinations, allowing application by mail, and providing continuous eligibility for newborns (see Table 2).

Dropping the Assets Test. As of February 1996, forty-five states have adopted the option to disregard assets when determining Medicaid eligibility for pregnant women, infants, and children.

Adopting Presumptive Eligibility. OBRA-86 gave states the option to allow health care providers to grant pregnant women immediate, short-term Medicaid eligibility at the provider site while a formal determination is made. Called presumptive eligibility, this option is intended to provide immediate access to prenatal care services. Currently, thirty states have adopted presumptive eligibility for pregnant women.

Shortening Application Forms. By removing assets restrictions when determining Medicaid eligibility, states have been able to reduce greatly the length and complexity of the Medicaid application form. Forty-two states have shortened their Medicaid application forms for pregnant women, infants, and children. Ten states have streamlined their application forms for the entire Medicaid population.

Expediting Eligibility Determinations. It is important that pregnant women receive early prenatal care. States have developed policies to ensure that the applications of pregnant women are given priority and that their Medicaid eligibility is determined as quickly as possible. Twenty-nine states have programs of expedited eligibility. In some states, informal guidance has been provided to local service offices to help them expedite eligibility determination for pregnant women.

Allowing Application by Mail. Allowing applications for Medicaid to be mailed is another strategy states are using to simplify the eligibility process for pregnant women and children. Thirty states have implemented programs allowing pregnant women and children to mail in their Medicaid applications, waiving the customary face-to-face interview. Mail-in applications reduce transportation and other barriers that may restrict these populations' access to care.

Providing Continuous Eligibility for Newborns. With the passage of OBRA-90, states are required to provide continuous eligibility for newborns through their first year of life as long as they remain in their mother's household. Once Medicaid eligibility is granted to either a pregnant woman or infant, this eligibility cannot be rescinded because of an increase in family income or resources. To ensure that infants are enrolled in the program and receive continuous coverage throughout the first year, many states have developed a referral form that is filled out by hospital staff when a Medicaid-eligible woman gives birth. In most cases, hospital staff send this form to the state or local eligibility office, and a Medicaid identification number is assigned to the infant. Thirty states use a referral form to facilitate Medicaid enrollment of infants.

Conducting Statewide Outreach Campaigns

Since the early 1990s, states have developed outreach campaigns as integral components of their prenatal and child health programs. These campaigns educate the public about the importance of prenatal and primary care services as well as inform pregnant women and families with children about the availability of health care benefits. Using an eye-catching logo as the foundation, these campaigns generally distribute posters and brochures, establish statewide toll-free hotlines, and produce television and radio public service announcements (PSAs). Many states have discovered the effectiveness of providing incentives to encourage people to seek preventive medical care. For example, coupon books are distributed, and the coupons must be validated by a provider before they can be redeemed. The coupons are generally redeemable at local stores for a variety of products, including diapers and baby formula.

Highlighted below are maternal and child health outreach initiatives implemented by states. Although several programs initially focused on pregnant women and infants, most of them have broadened their outreach to include activities that facilitate Medicaid enrollment of all low-income children in participating families.

The *Campaign For Healthier Babies* in Arkansas is a statewide program designed to encourage pregnant women to seek early prenatal care. Begun in 1991, the campaign refers Medicaid-eligible women and children to the program. The campaign makes use of the "Happy Birthday Baby Book," a coupon book containing free or discounted baby care and family products as well as educational information about prenatal care, pregnancy, and well-child issues. The free coupon book is available on a statewide basis to all pregnant women. Coupons are validated by the provider at monthly prenatal care visits. Also included in the book are coupons to motivate new mothers to continue postnatal and well-baby care. The *Campaign For Healthier Babies* is administered by a coalition whose members include the department of health, the March of Dimes, Advocates for Children and Families, the department of health and human services, and the children's hospital. The Arkansas Department of Health has also developed the Arkansas Health Information Line. The information line is a statewide, confidential, toll-free information system that is operated twenty-four hours a day, seven days per week. It helps Arkansans throughout the state to access information on the availability of specialized maternal and child health-related services, such as perinatal care, nutrition programs, immunizations, assistance for acquired immune deficiency syndrome and sexually transmitted diseases, child health services, and Medicaid. The health information line is staffed with trained employees who can provide callers with immediate information and referrals about health services available from its computerized resource directory.

The *Help Them Thrive, Birth to Five* initiative is a public awareness campaign launched in Florida in early 1997. Governor Lawton Chiles is the official spokesperson of this multimedia campaign that focuses on improving health outcomes of families and children up to age five. The goal of the campaign is to improve the health status of mothers and children by identifying and encouraging low-income women, infants, toddlers, and young children to access existing state health care services, including Medicaid. A statewide toll-free number provides information, support, and referrals to callers in four areas: family planning, prenatal care, immunization and preventive pediatrics, and parenting and early intervention.

The *Help Me Grow* program, implemented in Illinois in May 1993, is a comprehensive public awareness campaign that enables families to learn about all state programs through a toll-free telephone call. This toll-free number gives parents and other caretakers a single point of contact for

assistance on a variety of issues, including prenatal care, nutrition, Medicaid, and substance abuse. The program is supported through a public-private partnership between Ronald McDonald Children's Charities and twelve state agencies, including the departments of public aid and public health and the office of the Governor. Television and radio PSAs are being used to communicate the importance of prenatal care, immunizations, child safety seats, parental and family involvement, and drug and alcohol abuse prevention.

Minnesota has expanded Medicaid eligibility up to 275 percent of the poverty level for women and infants, and uses a mail-in application process that allows self-reported verification information. It also operates two statewide hotlines to facilitate enrollment in Medicaid. Although Medicaid enrollment is not the primary purpose of these hotlines, both the Minnesota Care Hotline and the Minnesota Children with Special Health Needs Hotline screen callers for potential Medicaid eligibility. Both hotlines provide callers with referrals to state service and financial support programs.

New York implemented the *Growing Up Healthy Application* in July 1994. This program combines the applications for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Medicaid. Training on the joint application process has been provided to WIC program staff, medical providers, and local departments of social services. The one-page application form is used by pregnant women and young children born on or after October 1, 1983, to apply for Medicaid and WIC. The combined application form simplifies the medical assistance application and eligibility process for pregnant women and young children. It is also a key element in determining ongoing Medicaid eligibility for pregnant women receiving benefits under the presumptive eligibility program. These programs help ensure that New York's babies and children will be "growing up healthy."

In April 1994, New Hampshire implemented the *Let's Be HealthSmart* program, a public information campaign to promote CHAP-Plus. The Child Health Assurance Plan (CHAP) is the state's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. The campaign's goals are to increase Medicaid enrollment of eligible children of all ages and pregnant women, as well as to stress the importance of health promotion through preventive measures.

In August 1994, North Carolina implemented *Health Check*. Formerly the EPSDT program, this initiative promotes the importance of children's participation in a regular preventive health care program. *Health Check* seeks to reduce child mortality and morbidity in North Carolina by ensuring the availability and accessibility of comprehensive and continuous preventive health and primary care services throughout childhood, and by providing information to parents on how to obtain these services. Outreach activities include a toll-free hotline; public service announcements; brochures, posters, envelope inserts, and billboards; parental notifications of benefits and services; and a *Health Check* traveling medical record. A statewide network of specially trained health care staff, called *Health Check* coordinators, assist families in obtaining medical benefits, such as Medicaid, as well as other community services and support needed by their children. The initiative is a collaborative effort among the division of medical assistance, the division of maternal and child health, the office of rural health, and the primary care association.

The goal of the *Help ME Grow* program, implemented in Ohio in 1995, is to improve prenatal care and preventive care of children up to age two through the use of a coupon book. Individual coupons must be validated by the medical provider after care is obtained in order to redeem the coupons. Public service announcements promote the availability of the coupon book as well as a toll-free number that people can call for referral to various state services or agencies, such as Medicaid. *Help ME Grow* is a collaborative effort of the department of health, the department of human services, and the Governor's office under the Ohio Family and Children First Initiative.

Love 'em with a Checkup is a comprehensive maternal and child health outreach and referral program in Pennsylvania that is helping thousands of low-income women and children enroll in prenatal and primary health care-related state programs. This statewide initiative was developed in 1993 to address the concern that Pennsylvania's outreach efforts were fragmented, ineffective, and often failing to reach the state's at-risk population. Many effective programs, such as the WIC program, the Children's Health Insurance Program, and Healthy Beginnings Plus, were underutilized by the people who needed them most. *Love 'em with a Checkup* bridges this gap through a unique comprehensive effort that includes a paid statewide media campaign encouraging low-income pregnant women and parents to call two toll-free hotlines (1-800-986-BABY or 1-800-986-KIDS); a team of trained telephone counselors who refer callers for checkups; a streamlined process for determining Medicaid eligibility; and an expanded network of health care providers committed to the program. *Love 'em with a Checkup* is a cooperative initiative being led by public and private sector agencies as well as health care providers.

In 1988 the department of health in Utah implemented the *Baby Your Baby* program, a prenatal outreach and media campaign to educate and encourage all pregnant women to seek early and regular prenatal care. This effort is operated in concert with an expanded system of prenatal care services through local health departments, community health centers, and other clinics. The department of health works collaboratively with a wide range of public and private agencies, including a local television station's news division. A toll-free statewide *Baby Your Baby* hotline gives callers prenatal care information and referrals and answers their questions on different aspects of the campaign. The program regularly identifies and refers eligible women and children to the Medicaid program and other financial support programs, as appropriate. The campaign consists of broadcast television and radio programs, public service announcements, news specials, four half-hour television specials, print advertising, outdoor posters, and other print support materials. In addition to prenatal care, the *Baby Your Baby* program now also focuses on infant and toddler care and nutrition during pregnancy and early childhood. It distributes a *Baby Your Baby* "Health Keepsake" book, a 130-page prenatal and child health record and memory book. The rights to use the television programs, public service announcements, and printed material have been sold to agencies and television markets in approximately thirty states.

Using Other Outreach and Service Delivery Approaches

States also have other outreach and service delivery programs that often facilitate the enrollment of low-income women and children in Medicaid, though Medicaid enrollment may not be these programs' primary objective. These programs include school-based health centers, immunization programs and campaigns, WIC programs, and infant mortality initiatives.

Some states' school-based health centers are a vehicle for identifying and triaging women and children eligible for enrollment in Medicaid. Many school-based health centers provide or make available primary medical, social, mental health, and health education services designed to meet the psychosocial and physical needs of children and youth within the context of their family, culture, and environment. For example, in New York, school-based health centers are affiliated with hospitals or community health centers that often have Medicaid eligibility workers on staff who are available to the school-based health center partners. In addition, New York school-based health centers provide initial assessments and referrals to social service agencies, as well as some on-site services. These centers provide social service assessments; referrals; and followup for needs such as food, shelter, clothing, legal services, public assistance, assistance with Medicaid and other health insurance enrollment, employment services, and day care services.

Most states also have comprehensive immunization outreach campaigns to increase public awareness about the recommended vaccine schedule for children and sites where parents can take their children to get vaccinated regardless of their health insurance coverage. In many states, public-private partnerships are critical to state and local immunization outreach campaigns. Collaborative relationships among businesses, civic organizations, community-based organizations, and public health providers help raise awareness about the need to immunize children on time, develop and coordinate immunization outreach efforts, and provide assistance such as transportation or door-to-door canvassing to increase children's access to immunization. Through these outreach efforts, parents often are guided to enroll in Medicaid or access other sources of health coverage.

The Maternal Infant Health Outreach Workers (MIHOW) program strives to reduce infant mortality in low-income rural communities. MIHOW is operated through a partnership between the Center for Health Services at Vanderbilt University and community-based programs in Arkansas, Kentucky, Tennessee, Virginia, and West Virginia. The goal of the program is to improve maternal and child health and early childhood development in rural areas through early intervention. Local mothers who are known and trusted in their communities are recruited and trained by the local MIHOW sponsoring agency to become paid paraprofessional home visitors. They learn how to refer women and children to various state programs, including Medicaid. In addition to helping and encouraging families to access available health and social services, the home visitors provide health and child development education as well as support for positive parenting practices.

Another infant mortality initiative that is helping low-income women and children enroll in Medicaid is the federal Healthy Start program. Initiated in 1991, Healthy Start was designed as a comprehensive prenatal, postpartum, and early childhood intervention program to address the twin problems of low birthweight and infant mortality in targeted inner-city communities. Fifteen cities have been awarded grants of up to \$5 million to tackle the problem of infant mortality.

State Programs to Provide Non-Medicaid Health Insurance Coverage for Children

Some states have initiated programs to provide children with health insurance funded entirely with state dollars or through public-private partnerships. Typically, these programs have age and income eligibility criteria that begin where the state's eligibility criteria for Medicaid end.

State-Only Programs

Many states have programs that provide health care coverage to children and families lacking health insurance. Descriptions of four state-initiated, publicly funded programs to provide health insurance for children follow.

The Healthy Kids program in Florida seeks to give every child access to health care through a school enrollment-based program. Eligible children are those attending school who are between the ages of five and nineteen, uninsured, and not eligible for Medicaid. (Three- and four-year-old siblings of enrollees are also eligible.) Initially funded by Medicaid and state, county, and private funds, the program's comprehensive health care package is now paid for by state general revenue funds, a county tax for children's services, other county funds, health district tax funds, county school board funds, and premium payments by families. Premiums are subsidized only for children eligible for the school lunch program. Publicity for the program includes paid and public service advertisements on radio and television, brochures and flyers, and direct mail campaigns. Migrant crew chiefs help reach migrant families, and churches help reach other targeted populations.

Using an approach that bases eligibility for health coverage on enrollment in school has several important advantages. School systems provide a way to create a sizable group of participants, so the cost benefits of a large purchasing group can be realized. By limiting coverage to school-age children, the benefits package can be tailored to meet this population's unique health needs. Coverage can be offered to all families that lack insurance. Some additional benefits may be realized by including health-related services for children with disabilities and special health care needs in the benefits package. Because these services must be provided by schools for those children who are eligible for special education, the local tax burden may be lessened. Finally, offering health coverage through the school may dissuade children from dropping out of school.

In Minnesota MinnesotaCare is a state-funded program that provides comprehensive health care coverage to children and adults statewide. The program serves children between the ages of two and eighteen living in families with incomes at or below 275 percent of the federal poverty level (FPL) who do not have access to employer-subsidized health insurance and who are not eligible for Medicaid. Children below age two are covered by Medicaid under the state's Section 1115 demonstration program. MinnesotaCare is funded through health care provider taxes and enrollment premiums. The cost for children living in families with incomes at or below 150 percent of the FPL is \$4 per month. The maximum premium is \$32 per month for a married couple without children. No copayments are required for any of the health care benefits offered to children under this program. Outreach is conducted through public service announcements on radio and television. Families applying for MinnesotaCare are referred to Medicaid, as appropriate, but they are provided sixty days of health coverage to allow time for a determination of their Medicaid eligibility. Applications for MinnesotaCare are made available in a variety of locations, including state offices, schools, and community health and social services agencies.

The Child Health Insurance Program (CHIP) was created in New York in 1991 with coverage limited to primary and preventive care for children below age thirteen. In 1994 coverage was extended to children below age fifteen. As a result of major reforms passed in 1996, the program is now available to children below age nineteen and includes inpatient health care services. CHIP is available only to children who do not have equivalent coverage under another plan. The program uses a sliding-fee scale, but there is no premium payment for children living in families with incomes below 100 percent of the FPL. Children living in families with incomes above 185 percent of the FPL pay the full cost of the premium. In addition to enrollee premiums, CHIP is funded by New York's Health Care Initiatives Pool that is supported by assessments on hospitals and third-party payers. The state contracts with nonprofit organizations to provide marketing and outreach services. These organizations, along with insurers, also work with community-based groups, such as churches and schools, to increase enrollment in CHIP.

The Children's Health Insurance Program (CHIP) provides comprehensive benefits to more than 40,000 children across Pennsylvania. Children receive health care services through a statewide system of managed care and indemnity plans provided by five regional grantees. Free health insurance is provided to children between the ages of one and fifteen living in families with incomes below 185 percent of the federal poverty level who are uninsured and do not qualify for Medicaid. Children below age six living in families with incomes between 185 percent and 235 percent of poverty are provided subsidies for their insurance. CHIP pays 50 percent of the cost of the premiums for the subsidized group. A family copayment is required only for prescription drugs. The program is financed through a tax on cigarettes. A family may be required to apply for Medicaid prior to enrolling in CHIP if family income is very close to Medicaid eligibility limits. Outreach efforts are funded through a requirement that the regional grantees match state dollars with in-kind contributions equal to

2.5 percent of their allotment. Numerous community-based and other groups are mobilized to conduct outreach, including religious organizations and churches, day care facilities, union and labor associations, county assistance offices, hospitals, and other health care providers.

Public-Private Partnerships

Increasingly, the public and private health care sectors have found mutual benefits in collaborating to provide and pay for health services.

Begun in 1993, the Colorado Child Health Plan (CCHP) targets children below age thirteen who live in rural counties in Colorado. The children must be ineligible for Medicaid and live in families with incomes below 185 percent of the FPL. The program is funded through private donations, modest participant fees, and a portion of the teaching allowance paid annually by the state Medicaid agency to the University of Colorado Hospital. In-kind contributions have been made by corporate partners, pharmaceutical companies, and community pharmacies. An extensive outreach campaign includes activities aimed at increasing the number of participating providers and increasing the enrollment of eligible children. Public service announcements are supplemented with newsletters and collaborative outreach efforts by local human services agencies. Automatic enrollment campaigns have also been arranged with WIC nutrition programs and the Title V Health Care Program for Children with Special Health Care Needs by virtue of similar income eligibility and enrollment criteria.

Colorado, Iowa, Kansas, Michigan, and Montana financially contribute to the Blue Cross and Blue Shield Caring Programs for Children in their states. Twenty-six Caring Programs make primary health care coverage available to uninsured children at no cost to their families. The typical benefits package includes immunizations, well-child care, sick child care, diagnostic tests, emergency accident and medical care, and outpatient surgery. Funding for the programs comes from philanthropic donations from businesses, churches, foundations, civic organizations, and individuals. In some programs, community contributions are matched by the participating Blue Cross and Blue Shield Plans, which cover the administrative costs for all Caring Programs.

Notes:* This *Issue Brief* simply highlights state approaches to improve children's access to health care services and is not based on a comprehensive survey of states.

This *Issue Brief* was prepared under a cooperative agreement with the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

Table 1. Expanded Medicaid Coverage of Pregnant Women, Infants, and Children, August 1996

State	Pregnant Women and Infants	Children Below Age Six	Children Ages Six and Above ^a	
	Greater than 133 percent of FPL ^a	Greater than 133 percent of FPL	Greater than 100 percent of FPL	and/or Ages 14 and Above
Alabama				
Alaska				
Arizona	140%			14
Arkansas				
California	200%			19
Colorado				
Connecticut	185%	185%	185%	
Delaware	185%			19
Florida	185%			
Georgia	185%			19
Hawaii ^b	300%	300%	300%	19
Idaho				
Illinois				
Indiana	150%			
Iowa	185%			
Kansas	150%			17
Kentucky	185%			
Louisiana				
Maine	185%		125%	19
Maryland ^c	185%	185%	185%	
Massachusetts	185%			
Michigan	185%	150%	150%	17 ^d
Minnesota	275%			
Mississippi	185%			
Missouri	185%			19
Montana				
Nebraska	150%			
Nevada				
New Hampshire	185%	185%	185%	19
New Jersey	185%			
New Mexico	185%	185%	185%	19
New York	185%			
North Carolina	185%			19
North Dakota				18
Ohio				
Oklahoma	150%			
Oregon				19
Pennsylvania	185%			
Rhode Island ^e	250%	250%	[250%] [100%] ^f	[8] [13] ^f
South Carolina	185%			
South Dakota				19
Tennessee ^g	400% ^g	400% ^g	400% ^g	
Texas	185%			
Utah				18
Vermont	[200%] [225%] ^h	225%	225%	18
Virginia				19
Washington	[185%] [200%] ⁱ	200%	200%	19
West Virginia	150%			19
Wisconsin	185%	185%		
Wyoming				
TOTAL	34 States	11 States	24 States	

Notes for Table 1

- FPL = federal poverty level.
- a. Under the Omnibus Reconciliation Act of 1990, states are required to provide Medicaid coverage to children ages six and older born after September 30, 1983—currently thirteen years old—living in families with income below 100 percent of the federal poverty level (FPL). This column indicates those states that cover (1) children ages 13 and under with incomes greater than 100% of poverty, (2) children greater than age 13 with incomes up to 100% of poverty, or (3) a combination of both.
- b. Hawaii's coverage of pregnant women and children is through Hawaii QUEST, a Section 1115 waiver managed care program. Income eligibility is established if income does not exceed 300 percent of the FPL. However, fully subsidized coverage is provided if income does not exceed 185 percent of the FPL. For children ages one through five, fully subsidized coverage is provided if income does not exceed 133 percent of the FPL. For children ages six and above, fully subsidized coverage is provided if income does not exceed 100 percent of the FPL. When income exceeds the applicable income limits of 185 percent, 133 percent, or 100 percent of the FPL for the respective groups, the recipient is eligible to participate in Hawaii QUEST but must cover the full cost of the premium.
- c. For children ages one through five, fully subsidized Medicaid coverage is provided in Maryland if income does not exceed 133 percent of the FPL. Children below age six receive a primary care benefits package if income is below 185 percent of poverty. For children ages six and above born after September 30, 1983, fully subsidized Medicaid coverage is provided if income does not exceed 100 percent of the FPL. Children ages six and above born after September 30, 1983, and whose income is below 185 percent of poverty receive a primary care benefits package.
- d. Defined in Michigan as being born after June 30, 1979.
- e. For individuals in family units with incomes between 185 percent and 250 percent of the FPL, cost sharing in Rhode Island is incorporated at the point of service or on a premium basis.
- f. In Rhode Island, children ages six or seven are covered at 250 percent of the FPL and children ages eight through twelve are covered at 100 percent of the FPL.
- g. Tennessee's coverage of pregnant women and children is through TennCare, a Section 1115 waiver program. Pregnant women and infants are automatically eligible if income is below 185 percent of the FPL. Children below age six are automatically eligible if income is below 133 percent of the FPL; children ages six and above born after September 30, 1983, are automatically eligible if income is below 100 percent of the FPL. Tennessee also covers individuals above the specified income thresholds who were uninsured as of March 1, 1993. When income exceeds the applicable income limits specified above, the TennCare recipient must pay premiums the subsidy for which is fully phased out at 400 percent of the FPL. Under certain conditions, Tennessee may suspend enrollment of expanded eligibility groups.
- h. In Vermont, pregnant women are covered at 200 percent of the FPL and infants are covered at up to 225 percent of the FPL.
- i. In Washington, pregnant women are covered at 185 percent of the FPL and infants are covered at up to 200 percent of the FPL.

Source: National Governors' Association, August 1996.

Table 2. Strategies to Streamline Eligibility, February 1996

STATE	DROPPED ASSETS TEST	PRESUMPTIVE ELIGIBILITY	SHORTENED APPLICATION	EXPEDITED ELIGIBILITY	MAIL-IN ELIGIBILITY	NEWBORN REFERRAL FORM
Alabama	X		X	X	X	X
Alaska	X		X	X		
Arizona	X			X		
Arkansas		X				X
California	X	X	X	X		
Colorado	X ^a	X	X		X	
Connecticut	X	X	X	X	X	X
Delaware	X		X	X	X	X
Florida	X	X	X ^b			X
Georgia	X	X	X	X	X	X
Hawaii	X	X	X	X		X
Idaho	X	X				X
Illinois	X	X	X		X	X
Indiana	X ^c				X	X
Iowa		X	X ^b			X
Kansas	X		X ^b	X		
Kentucky	X		X			X
Louisiana	X	X	X		X	X
Maine	X	X			X	
Maryland	X	X	X ^b		X	X
Massachusetts	X	X	X	X	X	X
Michigan	X		X		X	
Minnesota	X		X	X	X ^d	
Mississippi	X		X		X	
Missouri	X	X	X	X	X	X
Montana	X	X		X		
Nebraska	X	X			X	
Nevada					X	
New Hampshire	X	X	X	X	X	X
New Jersey	X	X	X ^b	X		X
New Mexico	X	X	X	X	X	X
New York	X	X	X			
North Carolina	X	X	X	X	X	X
North Dakota						
Ohio	X	X	X	X	X	X
Oklahoma		X	X ^b	X		X
Oregon	X		X	X	X	
Pennsylvania	X	X	X	X	X	X
Rhode Island	X		X	X		X
South Carolina	X		X		X	X
South Dakota	X		X	X		
Tennessee	X	X	X ^b	X		X
Texas	X	X	X ^b			X
Utah	X	X	X		X	
Vermont	X		X	X	X	
Virginia	X		X	X	X	
Washington	X		X ^b	X	X	X
West Virginia	X		X	X	X	X
Wisconsin	X	X	X			X
Wyoming	X	X	X ^b	X	X	
TOTAL	45	30	41	29	30	30

Notes:

^aColorado has dropped the assets test only for pregnant women.

^bThese states have developed shortened Medicaid application forms for their entire Medicaid population.

^cIndiana is reinstating the assets tests for pregnant women.

^dMinnesota now has mail-in eligibility on a pilot status and on a limited basis.

Source: National Governors' Association, 1996.