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Chairman Grassley, Ranking Member Baucus, and members of the committee, thank you for the opportunity to testify before you today. My name is Barbara Coulter Edwards and I have served as the Director of Ohio's Medicaid and SCHIP programs since 1997. I have been asked to participate in your series of hearings by representing the perspective of state Medicaid programs regarding the use of intergovernmental transfers (IGTs) as part of the financing strategies used by states.

Ohio, like many states, uses intergovernmental transfers as a mechanism to facilitate a small portion of Medicaid financing involving public providers of Medicaid services. I am pleased to tell you that CMS has not identified Ohio as a state that may be making improper use of IGTs under Medicaid.

Bottom line, all of the dollars spent in the Ohio Medicaid program are used to provide or support allowable health care services or programs to real Medicaid enrollees: over 2 million low income parents, children, elderly, and disabled Ohioans. I think it's important for the Committee to recognize that states use IGTs or other revenue strategies (e.g., provider taxes, administrative claiming) with Federal approval and under the guidance of explicit federal regulations. These financing strategies <u>are not</u> <u>inappropriate</u> ways for states to accomplish the goals of the Medicaid health plan.

In general, states have built Medicaid programs on what we understood to be the rules of obtaining legitimate federal matching funds. In hindsight, some states may have gone beyond what Congress might have envisioned when the matching program was created, but, frankly, this in response to the entire Medicaid program growing far beyond its early design and role. In most, if not all, cases, states acted with either the explicit approval of federal oversight staff or at least within existing interpretations of federal regulations.

My plea to this Committee is to keep the issue of state financing strategies in the proper context. State efforts to maximize federal matching dollars are not the core problem in and of themselves. They are, in most cases, a symptom of much more fundamental program challenges that state Medicaid Directors must face every day.

State Medicaid Directors are responsible for maintaining the health care safety net that is not only supporting the poorest and sickest citizens but also simultaneously absorbing costs shifted from other parts of the US economy, including:

- Shrinking coverage in employer sponsored health insurance;
- Cost-shifting from Medicare for the poorest elderly and disabled citizens; and
- Middle and upper-income people legally divesting themselves of assets in order to obtain Medicaid long term care coverage while passing private wealth to family members or friends.

In addition to these significant challenges, our states have been in an economic recession. State revenues have been dropping while enrollment in the Medicaid health plan has been soaring. At the same time, Congress and the public have encouraged states to expand eligibility to reach more uninsured children, working adults, and uninsured women with breast and cervical cancer; to provide greater community long term care options for elders and children with disabilities in compliance with the Americans with Disabilities Act; and to support adults with disabilities who want to return to work. Compounding this even further is the impending reality of the aging "baby boomer" population and soaring medical inflation in pharmacy and other costs.

Now imagine managing these challenges in an environment where you cannot "deficit spend," but must instead balance your budget every year.

The reality from the state perspective is that Medicaid spending now accounts for up to 25 percent of most state budgets, exceeding spending on primary and secondary education in some states. Nationwide, Medicaid enrollment has grown over 40 percent during the last five years – an influx of 15 million new beneficiaries. Nevertheless, States have worked hard to keep the rate of Medicaid spending growth below the rate experienced in the private health care sector. Yet, in spite of our success in containing Medicaid spending growth, it has still been <u>double</u> the rate of state revenue growth, a pattern that has now been in place for many years.

In short, state Medicaid programs are caught between the proverbial "rock and a hard place." I suggest to you that using IGTs to maximize federal revenue is a symptom of a much larger issue: the fact that states are struggling with financing the health care costs of the sickest, poorest and most disabled of our citizens. Seventy-five percent of all Medicaid spending is for the 25 percent of enrollees who are aged, blind and disabled. Over 40 percent of total Medicaid spending is for a very small number of enrollees who are already insured through Medicare. And for many states, including Ohio, the new state obligations under the Medicare "Part D" pharmacy program will increase the state cost of providing drugs to the dually eligible population.

State options for controlling Medicaid costs are fairly bleak. Under the program's current configuration, states can control costs by:

- Cutting provider rates (and risk loss of access to needed services);
- Limiting optional benefits (which in many cases are cost effective when compared with mandatory benefits), or

- Eliminating coverage for optional population groups (like women with breast and cervical cancer, SCHIP children, working parents, people whose medical costs cause them to "spend down" into poverty).

Ohio will use all three of these tools to keep the rate of growth in Medicaid spending below four percent annually in our 2006-2007 biennial budget. In addition, we will expand the use of managed care arrangements for low income families and people with disabling conditions, and we will continue to aggressively manage pharmacy costs and utilization. Our savings target over the next two years is almost two billion dollars below the projected baseline. This will achieve more than one billion dollars in federal savings. But sadly, the human and economic cost of these savings will be:

- To increase the number of uninsured adult Ohioans,
- To reduce the scope of dental benefits for 800,000 adults,
- To freeze payments rates for hospitals and nursing homes and,
- For the eighth straight year, to provide no increase in Medicaid payments for primary care physicians and other community providers.

(Almost unbelievably, Ohio's one billion dollars in federal savings over the next two years will not be counted toward the ten billion dollar savings goal established by Congress, because apparently it isn't considered "scoreable" by CBO.)

I want to be clear: I firmly believe that states are obliged to be fiscally responsible in our relationship with the federal Medicaid program. In order to accomplish this goal, state Medicaid Directors ask that we have clear standards, formally promulgated rules that spell out the parameters of our fiscal responsibilities, and consistent application of the rules. There is widespread agreement that if the rules are to be changed, it should not be done mid-stream nor applied retroactively. In addition, if formerly allowable models must be replaced, it is important to recognize that states will need time to transition to alternate funding strategies. The reality is that, for most states, any reduction in federal Medicaid revenue will leave states no choice but to cut programs and services to the vulnerable citizens that Medicaid is intended to serve.

So it is in this context that I urge the members of this Committee not to blame states for somehow causing the financial crisis in this country's Medicaid program. To do so would divert our energy and attention away from the real work of re-conceptualizing and strengthening the viability of this vital health plan that provides health care to 53 million of our poorest, sickest, and most disabled citizens.

The National Association of State Medicaid Directors has joined in support of the National Governor's Association as the NGA has undertaken a serious and bipartisan effort to propose substantive Medicaid reforms. NASMD and the NGA are seeking reforms that will benefit both federal and state taxpayers while continuing to fulfill the purpose of the Medicaid health plan. States also look forward to partnering with Congress and CMS to achieve the goal of creating a sustainable Medicaid program.