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NEWS RELEASE

NATIONAL COMMISSION URGES CHANGES IN MEDICAID

The Advisory Commission on Intergovernmental Relations, meeting in San Francisco September 20, recommended "adherence" to the goals of the Congressional established Federal-State Medicaid program--comprehensive medical care for "substantiallyall" of the poor and near poor by 1975--but proposed several important changes in the way the program now is operated. The Commission also urged the Federal Government to take account of the heavy fiscal burdens imposed on State and local governments by the program and to consider broadening Medicaid's financial base through increased involvement of the private sector through an employer-employee contributory health insurance system or other appropriate means.

Farris Bryant, Chairman of the Advisory Commission and former Governor of Florida said, "The report identifies the many points of strain revealed during the first two and a half years of Medicaid's operation, and offers ways of easing them, consistent with effective and economical medical care." It particularly addresses itself to the 50-fold unmanageable state & local fiscal burden.

The 26-member Commission is a bipartisan body established by Federal law in 1959 to maintain continuing review of the relations among Federal, State and local governments. Its membership consists of governors, mayors, county officials, State legislators, and representatives of both Houses of Congress, the Federal Executive Branch, and the general public. [Editor: Roster of Commission members attached.]

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The Advisory Commission proposed that the Federal Government make Medicaid money available to States for coverage of some groups of needy now excluded; that States be given more flexibility in adapting the Medicaid program to their individual needs and resources; and that States be permitted to experiment with allowing Medicaid applicants to use a simple declaration of financial status in establishing their financial eligibility. The Commission opposed any attempt by the Federal Government to make such a declaration procedure mandatory, however.

The Commission's study of Medicaid focused mainly on basic policies affecting Federal, State and local sharing of responsibility for financing Medicaid. It accepts Medicaid as an intergovernmental program for providing medical care to the needy and medically needy--a joint program in which financing comes basically from public funds and eligibility for services is based on a "means test." In so confining the study's scope, Chairman Bryant said that the Commission implies no opinion on the merits and demerits of major alternative systems of financing medical care for the needy and medically needy.

Among the significant findings and conclusions of the report are the following:

-- Policy-makers at all governmental levels were largely unprepared for the magnitude of the fiscal impact of Medicaid. The program has tripled federally assisted medical vendor payments from

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$1.4 billion in 1965 to an estimated $4.2 billion in fiscal year 1968-69.

-- As a consequence of this impact, Congress in 1967 imposed limits on Federal sharing in the cost of medical care for the medically needy. These cutbacks forced about a dozen States to restrict the number of eligibles covered or make other program adjustments.

-- For the States, the first two and a half years of Medicaid produced a wide variation in the scope of the program and its fiscal impact. Thirty-eight States had initiated the program; 12 and the District of Columbia had not. Thirteen of the 38 States had programs for the needy, but not for the medically needy. Seventeen provided some degree of at least 11 of the 14 medical services specified by law for both the needy and medically needy. For 27 Medicaid States with programs in effect for all of 1967, the change in total medical vendor payments between 1965 and 1967 varied from an increase of 371 percent in Delaware to a decline of 15 percent in West Virginia, with an average increase of 56 percent.

-- In a few States new or higher State level taxes were linked in part to Medicaid programs; in others, higher taxes were forestalled by postponing initiation of a Medicaid program or by restricting the program's scope.

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-- A key contributor to the rising curve of Medicaid expenditures was the increase in medical costs. Medical prices increased 6.6 percent in 1966 and 6.4 percent in 1967, compared to rises of 3.3 and 3.1 percent in the overall consumer price index.

-- Among the nonfiscal problems in the Medicaid program most concerning the States are difficulties in coordinating the administration of Medicare and Medicaid, the inflexibility of the law and guidelines, and difficulties in imposing adequate controls over charges for services.

The Commission found that the legislative history of Medicaid and Congressional attitudes toward further cost escalation of the program raise doubts about the strength of the Federal Government's commitment to the law's requirement that the States provide comprehensive care to "substantially all" the needy and medically needy by July 1975. The Commission, however, endorsed the 1975 goal. At the same time, a two-year postponement of Medicaid's 1970 target date for all States to initiate a program was recommended.

The Commission also called for shifts in the sharing of fiscal responsibility among Federal, State and local governments. It urged:

-- greater State discretion in determining lien and recovery provisions; and

-- tighter Federal standards for evaluating State limitations on the amount of cash assets they allow Medicaid recipients to retain.

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The Commission rejected proposals to put Medicaid on a closed-end appropriation basis and to mandate nationwide eligibility standards for recipients. In connection with the latter, however, greater interstate uniformity in eligibility requirements was supported as a long-range goal.

Reflecting concern over the need to control Medicaid costs, the Commission recommended that the Secretary of HEW rescind regulations requiring hospital inpatient services to be reimbursed under Medicaid on the same basis as under Medicare, thus avoiding imposition of an uneconomical "cost-plus" feature on Medicaid. It also urged the States to move vigorously to experiment with methods of increasing the efficiency and economy of health services under Medicaid. Suggested techniques include reimbursing hospitals contingent on their efficient operation, expanding prior authorization for elective surgical procedures, basing payment for physicians' services on other than "usual and customary" charges, and use of copayment or "deductible" provision.

In order to give States greater flexibility in developing a program of medical services for their needy and medically needy within limitations of State resources, the Commission proposed that, subject to approval of the Secretary of HEW, States be allowed to vary services among different groups served.

Finally, the Commission urged States to move vigorously to experiment with simplified procedures for establishing financial qualifications for medical assistance under Medicaid, designed to remove the administrative complexity and the stigma attached to the present system of establishing applicants' financial status. The Commission further

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recommended that State medical assistance officials be given access, under safeguards, to Federal income tax returns for purposes of verifying applicants' statements.

(NOTE: A digest of the recommendations adopted at the September 20 meeting is attached.)

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