

Virginia has the seventh lowest federal grant per person in poverty. Virginia is below the national average in state Medicaid spending per beneficiary. 75% of its Medicaid expenditures are on mandatory services and 25% are on optional services . . . this is below the national average.

(States must offer a minimum acute care benefit package to their eligible populations. They can cover other acute services at their discretion. States vary widely in their coverage of optional acute services.)

Virginia has established tight eligibility standards. Thus, although Virginia has a higher poverty rate than Connecticut, Massachusetts and Rhode Island (and closely trails New York), Virginia covers less than half of its poor residents in Medicaid, while these other states have enrolled 60-90% of their poor.

DISPROPORTIONATE SHARE PAYMENTS TO HOSPITALS

In the early 1990's, some states aggressively pursued DSH money in order to leverage more federal dollars. DSH payments were intended to help hospitals serving high volumes of uninsured and Medicaid patients. They did this by adding money generated from hospital assessments and "voluntary payments" from hospitals and adding that to state funds, in order to leverage more federal matching funds, and then paid back that money to those hospitals. Until these schemes were controlled in 1993, many states received huge amounts of federal Medicaid dollars, which they spent on general state needs. Two-thirds of DSH spending is concentrated in 8 states. DSH payments to Northeast high cost states are 6-16 times higher than in Virginia.

Virginia chose not to participate in aggressively capturing DSH dollars, as they felt it was an inappropriate use of federal funds.

The proposed Medicaid block grants lock the DSH inequities into place, leaving Virginia with only a small amount of DSH funds. Those states like NH, LA, NY, CT, NJ, will continue to receive significant DSH dollars under the block grant.

DEMOGRAPHICS

The block grant does not take into consideration the changing demographic trends in Virginia. The population is aging and the percentage of older Americans moving into Virginia from other states is increasing.

By 2020, the total population of VA. will number 8.4 million, up from 6.5 million in 1990. The elderly are the fastest growing segment of the population. Residents older than 65 will increase from 7.3% to 15.7% of the total population. There will be five times as many Virginians older than 75 and nine times as many Virginians older than 85 as there were in 1960. The elderly are the heaviest users of health care; it is reasonable to assume a growing percentage of this population will become Medicaid-dependent for nursing home care and other long term care services at an increasingly high cost.

WHAT HAS THE STATE DONE TO MAXIMIZE ITS MEDICAID DOLLARS?

Virginia has implemented a number of cost containment techniques to improve "efficiency" of the Medicaid program. The Va. Dept. of Medical Assistance estimated in 1994 that since 1982, Virginia has realized about \$217 million dollars annually in savings and cost avoidance through cost containment measures including:

- Medicaid managed care
- Moratorium on nursing home construction
- Limits on inpatient hospital admission before non-emergency surgery
- Expanded use of generic drugs
- Utilization management for hospital and other services

Preadmission screening for nursing home applicants

Adult day care alternatives to nursing home placement

24-hour obstetric discharge using a home health alternative

As a result of improved efficiency, Virginia has not required continued large increases in federal matching dollars. Yet, the state will be penalized for prudent and judicious use of Medicaid money. Those states with inefficiently run programs that are high cost to the federal government, including those states that illegally garnered DSH dollars, will continue to receive the highest contribution. The current Medicaid program is flexible enough to allow Va. to receive more federal dollars as the needs and available resources change. The proposed block grant proposal bases consideration of future federal funding on current levels, regardless of each state's future needs.

What should be incorporated into the Medicaid block grant is an effort to move all states to an equitable level of federal financial support per capita. That is not unlike the policy in place for the Medicare program. When that program moved from a cost-based reimbursement to reimbursement by diagnosis-related group, formerly vastly different rates paid to providers were moved to a national rate adjusted only by the special labor costs within regions. This uniformly provides the same incentives to all states to operate efficient Medicaid programs.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. HANSEN (at the request of Mr. ARMEY), after 12:30 p.m. today, on account of personal reasons.

Mr. EMERSON (at the request of Mr. ARMEY), for today, on account of a doctor's appointment.

Ms. HARMAN (at the request of Mr. GEPHARDT), for today, on account of personal business in the district.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. DOGGETT) to revise and extend their remarks and include extraneous material:)

Mr. POSHARD, for 5 minutes today.
 Ms. NORTON, for 5 minutes today.
 Ms. SLAUGHTER, for 5 minutes today.
 Mr. ROEMER, for 5 minutes today.
 Mr. GENE GREEN of Texas, for 5 minutes today.

Mr. DOGGETT, for 5 minutes today.
 Mrs. SCHROEDER, for 5 minutes today.
 Mr. BROWN of Ohio, for 5 minutes today.

Ms. DELAURO, for 5 minutes today.
 Mr. BENTSEN, for 5 minutes today.
 Mr. FALEOMAVEGA, for 5 minutes today.

Mr. VOLKMER, for 5 minutes today.
 (The following Members (at the request of Mr. TIAHRT) to revise and extend their remarks and include extraneous material:)

Mr. GOSS, for 5 minutes today.
 Mr. LEWIS of Kentucky, for 5 minutes today.

Mr. MANZULLO, for 5 minutes today.
 Mr. COX of California, for 5 minutes today.

(The following Member (at his own request) to revise and extend his remarks and include extraneous material:)

Mr. MORAN, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

(The following Members (at the request of Mr. DOGGETT) and to include extraneous matter:)

Mr. BONIOR.
 Mr. FRANK of Massachusetts.
 (The following Members (at the request of Mr. TIAHRT) and to include extraneous matter:)

Mr. HERGER.
 Mr. SAXTON.
 (The following Members (at the request of Mr. ABERCROMBIE) and to include extraneous matter:)

Mr. FIELDS of Texas.
 Mr. HASTERT.
 Mr. RUSH.
 Ms. VELÁZQUEZ.
 Mr. REED.
 Mr. BARRETT of Wisconsin.
 Mr. POSHARD.
 Mr. WILSON.
 Mr. BILIRAKIS.
 Mr. ROYBAL-ALLARD.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 1331. An act to adjust and make uniform the dollar amounts used in title 18 to distinguish between grades of offenses, and for other purposes; to the Committee on the Judiciary.

S. 1465. An act to extend au pair programs; to the Committee on International Relations.

ENROLLED BILLS SIGNED

Mr. THOMAS, from the Committee on House Oversight, reported that that committee had examined and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 325. An act to amend the Clean Air Act to provide for an optional provision for the reduction of work-related vehicle trips and miles travelled in ozone nonattainment areas designated as severe, and for other purposes; and

H.R. 1240. An act to combat crime by enhancing the penalties for certain sexual crimes against children.

ADJOURNMENT

Mr. ABERCROMBIE. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 5 o'clock and 31 minutes p.m.), the House adjourned until tomorrow, Friday, December 15, 1995, at 10 a.m.