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THE NEED FOR MEDICAID REFORM: A STATE PERSPECTIVE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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THE NEED FOR MEDICAID REFORM: A STATE PERSPECTIVE

WEDNESDAY, JUNE 12, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room 2322 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Whitfield, Shimkus, Murphy, Blackburn, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Upton (ex officio), Pallone, Dingell, Capps, Schakowsky, Green, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Staff present: Gary Andres, Staff Director; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Julie Goon, Health Policy Advisor; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Alli Corr, Democratic Policy Analyst; Amy Hall, Democratic Senior Professional Staff Member; Elizabeth Letter, Democratic Assistant Press Secretary; and Karen Nelson, Democratic Deputy Committee Staff Director for Health.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. This subcommittee will come to order. The chair will recognize himself for an opening statement.

Medicaid was designed as a safety net for the most vulnerable Americans, including pregnant women, dependent children, the blind and the disabled. With more than 72 million Americans, or nearly one in four, enrolled in Medicaid at some point in fiscal year 2012, we need to closely examine the quality of care the program provides, reduce the cost of the program to both the federal government and the States, and encourage bold, new state innovations to better serve this population.

Those enrolled in Medicaid today face significant difficulties in accessing care. According to a recent analysis, while 83 percent of physicians are accepting Medicare patients, only 70 percent of physicians are accepting those in the Medicaid program. Other studies

have shown that compared to those with private insurance, Medicaid beneficiaries find it more difficult to schedule follow-up visits after initially seeing a doctor; are twice as likely to report difficulty in accessing primary care services including prevention services; and are twice as likely to visit the emergency room. Clearly, we are failing those most in need of our help. And we are spending enormous amounts of money for substandard care, and in some cases, worse outcomes than those with no insurance at all.

On average, States are spending approximately 25 percent of their budgets on Medicaid, and this percentage will only grow as the Affordable Care Act's Medicaid expansion goes into effect in many States in 2014. In my home State of Pennsylvania, we are already spending nearly one-third of the entire State budget on Medicaid alone. This crowds out investments in transportation, education, public safety and other vital areas. And over the next 10 years, the federal share of Medicaid expenditures is estimated at $5 trillion, with States spending nearly another $2.5 trillion over that same time period.

Medicaid is in trouble. It has been on the Government Accountability Office's high-risk list for nearly two decades, and the Office of Management and Budget reported nearly $22 billion in improper Medicaid payments in 2011.

But we don't have to settle for subpar care or limited access and exploding costs. Many States have embarked on innovative Medicaid reforms to improve the quality of care and modernize their programs, ranging from payment incentives, to coordinated care, to consumer-driven options, to added services for their beneficiaries and more. This has been possible, in part, through the use of State demonstration waivers, but it can take years for the Centers for Medicare and Medicaid Services to approve these waivers. We need to provide States with the flexibility to pursue these options, not lock them in a one-size-fits-all model dictated by Washington.

Several reforms have been outlined by this committee in a recent policy paper issued by Chairman Upton and Senator Hatch. The Making Medicaid Work blueprint is a product of significant input from the States that merits bipartisan consideration and legislative action.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

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Other studies have shown that, compared to those with private insurance, Medicaid beneficiaries find it more difficult to schedule follow-up visits after initially seeing a doctor; are twice as likely to report difficulty in accessing primary care services, including prevention services; and are twice as likely to visit the emergency room.

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This has been possible, in part, through the use of state demonstration waivers, but it can take years for the Centers for Medicare and Medicaid Services (CMS) to approve these waivers

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Several reforms have been outlined by this Committee in a recent policy paper issued by Chairman Upton and Senator Hatch. The Making Medicaid Work blueprint is a product of significant input from the states that merits bipartisan consideration and legislative action.

I look forward to hearing from our witnesses today.

Thank you, and I yield the remainder of my time to Rep. _____.

Mr. PITTS. I look forward to hearing from our witnesses today. Thank you, and I yield the remainder of my time to the vice chair of the subcommittee, Dr. Burgess.

Mr. BURGESS. I thank the chairman for yielding.

We are here today to discuss Medicaid, and of course, Medicaid is a shared federal and State partnership but there are wide differences amongst the States with the populations served and this underscores the need for flexibility within the program's administration. But as we ensure its flexibility, we certainly can't ignore the problems that have perpetually plagued the Medicaid system including insufficient access to care for beneficiaries, lack of continuity of care, and rapid growth in the program costs, and I would add to that as the chairman rightfully mentioned, the difficulties with diversion of funds for activities which might be deemed as inappropriate. I applaud the way the States have implemented innovative reforms but state flexibility will not solve all of the problems that we face.

One of the biggest is Medicaid reimbursement. Medicaid reimbursement rates are already embarrassingly low, forcing many providers to refuse new Medicaid patients. In Texas, only 31 percent of physicians in Texas currently accept new Medicaid patients. This trend only foreshadows the threat to access for millions of new Medicaid beneficiaries beginning next year. To sustain provider and plan buy-in, we must demand accountability from both the federal and State partners. That is the purpose of this hearing today. That is what we are investigating this morning. I certainly look

forward to the testimony of our witnesses, and I will yield back to the chairman.

Mr. PITTS. The chair thanks the gentleman and now yields 5 minutes for an opening statement to the ranking member, Mr. Pallone.

OPENING STATEMENT OF HON. FRANK PALLONE JR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

More than 70 million Americans depend on Medicaid services every year, and recipients are often low-income families or individuals with disabilities with long-term needs who would otherwise not have access to insurance because it is unaffordable, unavailable or inadequate. Providing affordable health coverage is crucial not only to protect the vulnerable population but also to keep health care costs down. By providing affordable essential health benefits, emergency room visits and hospitalizations, which are more expensive, can be reduced.

I fought hard to make sure that the expansion of Medicaid was included in the Affordable Care Act because it will not only improve access to health care for individuals across the country but it will improve States' economic health as well. While we expect all States to participate in the Medicaid expansion because it is an advantageous fiscal arrangement, I am troubled and discouraged that there are many who still have not decided to expand. I do believe, however, that eventually all States will recognize the importance of this provision to the health care system as a whole.

Nearly half of all States recognize that the Medicaid expansion under the ACA is a good deal and have indicated that they will expand, and I anticipate that our witness, Mr. Joe Thompson from Arkansas, will share with us why his State opted for expansion. And let me tell you that from New Jersey's perspective, expanding Medicaid just makes sense and that is why Governor Christie chose to expand. It will save New Jersey billions of dollars while providing care to an estimated 300,000 new Medicaid beneficiaries. With all of New Jersey's pressing needs right now, it is assuring that the billions in savings will help us to devote more resources towards building our economy and creating jobs.

Now, while Republicans will tell you that States need greater Medicaid flexibility, I would argue that under the current law, a great deal of flexibility exists while simultaneously providing a baseline of protections for beneficiaries. States have the ability to manage the design of their Medicaid programs. Within federal guidelines, they can alter benefits or change cost sharing and premiums. The concept that States have significant flexibility in the management of their programs is reflected by the fact that States when they want to are taking on innovative approaches to improve their Medicaid programs. For example, States are experimenting with programs to reduce expensive and unnecessary hospital readmissions, programs to improve health and promote prevention and medical home models as well.

So let me talk for a moment about the Republicans' proposal, which I believe has been presented under the guise to provide

greater flexibility. I am extremely concerned that their proposal will simply lead to higher premiums and greater financial burdens on low-income elderly or disabled Medicaid beneficiaries. Their call for block grants or a per capita cap on future Medicaid funding would reduce federal beneficiary protections currently in Medicaid since States would be permitted to eliminate benefits or restrict enrollment eligibility. While examining costs and exploring the relationship between the federal government and States is clearly important, we must be sure that we do not strip away protections from Medicaid recipients who depend on the program for access to quality, affordable health care.

Thank you, Mr. Chairman. Before I yield, I would like to ask unanimous consent to enter into the record an article or testimony, I should say, from Carter C. Price from the RAND Corporation on expanding Medicaid and the financial options for States.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the chair of the full committee, Mr. Upton, 5 minutes for opening statement.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Chairman.

You know, it has been years since President Johnson signed the 1965 Social Security Amendments into law, and as many historians have noted, those high-profile negotiations centered mostly on Medicare with Medicaid out of the spotlight. While Medicaid covered approximately 4 million people in the first year, there were more than 72 million individuals enrolled in the program at some point in fiscal year 2012—nearly one in four Americans.

Those enrollment figures on their own, and their potential drain on the quality of care of the Nation's most vulnerable folks is cause for alarm. But once the President's health care law is fully implemented, another 26 million more Americans could be added to this already strained safety net program.

Medicaid enrollees today already face extensive difficulties finding a quality physician because, on average, 30 percent of the Nation's doctors won't see Medicaid patients, and studies have shown that Medicaid enrollees are twice as likely to spend their day or night in an emergency room than their uninsured and insured counterparts.

Instead of allowing State and local officials the flexibility to best administer Medicaid to fit the needs of their own populations, improve care and reduce costs, the federal government has created an extensive, one-size fits-all maze of federal mandates and administrative requirements. With the federal debt at an all-time high, closing in on $17 trillion, and States being hamstrung by their exploding budgets, the Medicaid program will be increasingly scrutinized over the next 10 years. Its future ability to provide coverage for the neediest kids, seniors and disabled Americans will depend on its ability to compete with State spending for other priorities in-

cluding education, transportation, public safety and economic development.

Energy and Commerce Committee Republicans remain committed to modernizing the Medicaid program so that it is protected for our poorest and sickest citizens. We will continue to fight for those citizens because they are currently subjected to a broken system. The program does need true reform, and we can no longer tinker around the edges with policies that add on to the bureaucratic layers that decrease access, prohibit innovation and fail to provide better health care for the poor.

In May, last month, Senator Hatch and I introduced Making Medicaid Work, a blueprint and menu of options for Medicaid reform that incorporated months of input from State partners and policy experts from a wide range of ideological positions. My hope is that this morning's hearing is the next step in discussing the need for reform so that we can come together in finalizing policies that improve care for our most vulnerable citizens. Washington does not always know best. We have a lot to learn from our States, and that is what this is all about, and I yield the balance of my time to Dr. Cassidy.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

It has been nearly 50 years since President Johnson signed the 1965 Social Security Amendments into law. As many historians have noted, those high profile negotiations centered mostly on Medicare—with Medicaid out of the spotlight.

Surprising to most, however, Medicaid today covers more Americans than any other government-run health care program, including Medicare.

While Medicaid covered approximately four million people in its first year, there were more than 72 million individuals enrolled in the program at some point in Fiscal Year 2012—nearly 1 in 4 Americans.

Those enrollment figures on their own, and their potential drain on the quality of care of the nation's most vulnerable folks is cause for alarm. But once the president's health care law is fully implemented, another 26 million more Americans could be added to this already strained safety net program.

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Instead of allowing state and local officials the flexibility to best administer Medicaid to fit the needs of their own populations, improve care, and reduce costs, the federal government has created an extensive, "one-size fits-all" maze of federal mandates and administrative requirements.

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nerable citizens. Washington does not always know best—we have a lot to learn from our states.

Thank you, Mr. Chairman and I yield my remaining time to ——————.

Mr. CASSIDY. Thank you, Mr. Chairman.

For 20 years, I have treated patients in a safety-net hospital. For 20 years, I have seen politicians over-promise and underfund, and as I do so, it is the patient that suffers.

Now, the federal government spends almost half of every dollar on health care payments for Medicaid and Medicare. These programs are breaking federal and State budgets and they are unsustainable in current form. On behalf of my patients, I know that we must change them so that they become sustainable.

Now, in Washington, Medicare reform has been greatly considered but thoughtful solutions from Medicaid not so much. Now that Obamacare has added 20 million Americans to the Medicaid roles, it is imperative that Congress begin to address the sustainability of this important safety-net program.

Now, I will say I think that States are the best innovators for cost containment, far better equipped to offer thoughtful solutions addressing unique patient needs. One size does not work. The federal government should construct thoughtful incentives encouraging States to take an active role in restructuring Medicaid. I am pleased that the Energy and Commerce Committee has started to shed light beginning with this hearing. I look forward to hearing from the witnesses today, and I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman. I want to thank you for holding this hearing. I welcome and look forward to hearing from all our witnesses today. I am particularly interested in the testimony of Mr. Thompson of Arkansas on how his State has been working to reform the delivery system and how the Affordable Care Act will positively affect his State's residents.

There are different paths we can take to ensure long-term health and to promote innovation and efficiency within the Medicaid program. States can and do innovative actions today, and they do it without undermining critical protections for patients.

On the other hand, what my Republican colleagues have proposed in their two recently released reports is a cost shift to States, patients and providers, and abdication of federal responsibility. Block grants, per capita caps and increases in beneficiary premiums and copays do not reduce health care costs; they simply shift costs on to the beneficiaries, the providers and the States, and they make it less likely that people will be able to access care when they need it.

The Medicaid program operates with efficiency. Medicaid costs are nearly four times lower than average private plans. Over the next decade, annual Medicaid per capita costs are expected to grow by only 3.2 percent compared to 6.9 percent in the private market.

Additionally, the Congressional Budget Office's most recent estimates of projected Medicaid spending have dropped by $200 billion through 2020. This refutes the claim that burgeoning Medicaid spending is compromising the program's mission and therefore necessitates funding redesign and cost shifting to our Nation's most vulnerable.

Let us face the realities at hand and not myths. The issues are that millions of Americans who were previously shut out of having insurance, particularly the working poor, will now have access to Medicaid coverage beginning in 2014.

Unfortunately, a number of States have not yet opted to provide insurance coverage for their residents. A RAND study estimates that these States will leave 3.6 million people uninsured, and these people will continue to seek high-cost services in the emergency department of a hospital and experience increased hospitalizations from lack of primary and preventive care. As a result, the study estimates that these States should expect to spend $1 billion more annually on uncompensated care. So much for the States that choose not to cover their very poor people under Medicaid even with 100 percent federal financing for the first several years.

There are things we could do to improve the program. Certainly, for example, we should extend the Medicaid primary care payment increase that is helping bring Medicaid rates on par with Medicare rates. Any member concerned about access to doctors for Medicaid beneficiaries should surely embrace that. Additionally, we can continue to improve care for the dual eligibles who comprise 15 percent of the Medicaid population but account for nearly 40 percent of its expenditures. We can target prevention including obesity and smoking to keep people healthy.

The alternative path that we began in 2010 with passage of the Affordable Care Act is entitlement reform in a thoughtful way through delivery system reform that improves both efficiency and quality. The Affordable Care Act includes incentives to reward physicians and other providers for better coordinating care and improving health. It also includes policies to cut waste and inefficient care. But above all, it improves access to care, particularly preventive care, that saves dollars and lives.

Reviewing the facts, we see that health reform is entitlement reform. It is this kind of reform that builds a better health care system for all Americans at the same time that it lowers costs and helps support the long-term sustainability of our public health care programs.

Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman. That concludes our opening statements. We have one panel with us today, three witnesses. I will introduce them at this time.

On our panel today, we have Ms. Seema Verma, consultant with the Strategic Health Policy Solutions. We have Dr. Joseph Thompson, Surgeon General of the State of Arkansas, Director of the Arkansas Center for Health Improvement, and we have Mr. Tony Keck, Department of Health and Human Services from the State of South Carolina.

Thank you each for coming. Your written testimony will be made a part of the record. You will be given 5 minutes to summarize

your testimony. So at this time, the chair recognizes Ms. Verma for 5 minutes for opening statement.

STATEMENTS OF SEEMA VERMA, MPH, CONSULTANT, SVC, INC.; DR. JOSEPH W. THOMPSON, SURGEON GENERAL, STATE OF ARKANSAS, AND DIRECTOR, ARKANSAS CENTER FOR HEALTH IMPROVEMENT; AND ANTHONY E. KECK, DIRECTOR, SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF SEEMA VERMA

Ms. VERMA. Good morning, members of the committee. My name is Seema Verma. I am the President of SVC, Inc., a policy consulting company, and in this role have been advising governors' offices, State Medicaid programs and State departments of health and insurance. I have worked in a variety of States including Indiana, South Carolina, Maine, Nebraska, Iowa and Idaho. I am also the architect of former Indiana Governor Mitch Daniels' Healthy Indiana Plan, the Nation's first consumer-directed health plan for Medicaid beneficiaries.

Designed in 1965 for our most vulnerable populations, the Medicaid program has not kept pace with the modern health care market. Its rigid, complex rules designed to protect enrollees have also created an intractable program that does not foster efficiency, quality or personal responsibility. The impact of these issues is more pronounced as States are entrenched in the fierce debate around Medicaid expansion. Reluctance to expand is not indifference to the plight of the uninsured, but trepidation for the fiscal sustainability of the program and knowledge that expanding without reform will have serious consequences on Medicaid's core mission to serve the neediest of Americans.

Medicaid comprises nearly 24 percent of State budgets, and its costs are growing. This is due to growth, population demographics and federal requirements. The aging baby boomer population will soon require expensive long-term care. The Affordable Care Act requires maintenance of effort and implementation of hospital presumptive eligibility, modified adjusted gross income that eliminates asset tests for the non-disabled, and the ACA insurer tax will cost States an estimated $13 to $14.9 billion. Additionally, there is the clawback provision burden where States have an unprecedented requirement to finance the Medicare program.

Despite growing outlays of public funds, a Medicaid card does not guarantee access or quality of care. In a survey of primary care providers, only 31 percent indicated willingness to accept new Medicaid patients. In 2012, 45 states froze or reduced provider reimbursement rates. Medicaid access issues are tied to undercompensation of providers. On average, Medicaid payments are 66 percent of Medicare rates and many providers lose money seeing Medicaid patients. Medicaid beneficiaries struggle to schedule appointments, face longer wait times and have difficulty obtaining specialty care. These access challenges will be more pronounced as Medicaid recipients compete with the tens of millions of newly insured under the ACA. Studies also show Medicaid coverage does not generate significant improvements in health outcomes, de-

crease emergency room visits or hospital admissions, and participants have higher ER utilization rates than other insured populations.

At Medicaid's core is a flawed structure. While jointly funded, by the federal and state governments, it is not jointly managed. States are burdened by federal policy and endure lengthy permission processes to make routine changes. Notwithstanding the cumbersome procedure, 1115 waivers provide a pathway for State innovation. However, the approval route is so daunting that States often abandon promising ideas if a waiver is necessary. Absent are evaluation guidelines, required timelines, and there is a capricious nature to the approvals, as waivers do not transfer from one State to another. Even with positive outcomes, a new Administration has the authority to terminate a waiver. Despite intense federal oversight, results vary substantially and there are no incentives for States to achieve quality outcomes. For example, the average cost to cover an aged Medicaid enrollee is roughly $5,200 in New Mexico versus almost $25,000 in Connecticut, and annual growth rates also very. Replacing oversight of day-to-day administrative processes, the federal and State governments should collaborate to identify program standards and incentives. States should be provided with flexibility to achieve these goals, and successful States should be rewarded with reduced oversight.

Medicaid's uncompromising cost-sharing policies are illustrative of a key failure. These regulations disempower individuals from taking responsibility for their health, allow utilization of services without regard for the public cost, and foster dependency. While some policies may be appropriate for certain populations, in an era of expansion to non-disabled adults, they must be revisited. Revised cost-sharing policies should consider value based benefit design and incent enrollees to evaluate cost, quality and adopt positive health behaviors. Indiana's Healthy Indiana Plan waiver applied principles of consumerism with remarkable results, lowering inappropriate ER use and increasing prevention.

Congress should reform Medicaid to assure long-term fiscal sustainability and access to quality services that improve the health of enrollees. A fundamental paradigm shift in management is required and the program should be reengineered away from compliance with bureaucratic policies that do not change results to aligning incentives for States, providers and recipients to improve outcomes. States are positioned to develop policies that reflect the local values of the people they serve and should be given the flexibility to do so. Thank you.

[The prepared statement of Ms. Verma follows:]

The Need for Medicaid Reform: A State Perspective

Testimony Presented by Seema Verma
SVC, Inc.
June 12, 2013

DRAFT

Summary

Medicaid has undoubtedly played a considerable role in the lives of many, providing access to health care for our nation's most vulnerable populations. There is no question it has helped many of its participants. However, designed in 1965 the program has not kept pace with the modern health care market. Its rigid, complex rules designed to protect enrollees have created an intractable program that does not foster efficiency, quality or personal responsibility for improvement in health status. Escalating state costs have not translated into quality or consistent outcomes.

Failure to reform the program will jeopardize states' ability to care for those Medicaid was envisioned to serve including low income children, pregnant women, and the aged, blind and disabled. While the program is jointly funded by the state and federal government, it is not jointly managed. States are largely dependent on federal policy, regulation and permission to operate their programs. Administrative review and approval processes add layers of administrative bureaucracy to the program that thwart states' ability to innovate.

Notwithstanding the cumbersome regulatory review process, there are many examples of state innovation that have emerged. To transform Medicaid, states must be given the flexibility and opportunity to innovate without these undue federal constraints. Reform efforts should center, at minimum, around encouraging consumer participation in healthcare, holding states accountable based on quality outcomes versus compliance with bureaucratic requirements, encouraging flexible managed care approaches and allowing states to use flexible funding mechanisms.

INTRODUCTION

Good morning members of the Committee. My name is Seema Verma. I am the President of SVC Inc, a policy consulting company and in this role have been advising Governor offices, state Medicaid programs, and state Departments of Health and Insurance. I have worked in a variety of states including Indiana, South Carolina, Maine, Nebraska, Iowa and Idaho. I am also the architect of former Indiana Governor Mitch Daniels's Healthy Indiana Plan, the nation's first consumer directed health plan for Medicaid beneficiaries.

OVERVIEW

Designed in 1965 for our most vulnerable populations, the Medicaid program has not kept pace with the modern health care market. Its rigid, complex rules designed to protect enrollees, have also created an intractable program that does not foster efficiency, quality or personal responsibility. The impact of these issues is more pronounced as states are entrenched in the fierce debate around Medicaid expansion. Reluctance to expand is not indifference to the plight of the uninsured, but trepidation for the fiscal sustainability of the program and knowledge that expanding without reform will have serious consequences on Medicaid's core mission to serve the neediest of Americans.

INCREASING COSTS OF MEDICAID & STATE BUDGETS

Medicaid comprises nearly 24%[i] of State budgets, and its costs are growing.[ii] This is due to enrollment growth, population demographics, and federal requirements. The aging baby boomer population will soon require expensive long term care. The Affordable Care Act (ACA) requires maintenance of effort and implementation of hospital presumptive eligibility, Modified Adjusted Gross Income which eliminates asset tests for the non-disabled, and the ACA insurer tax will cost states an estimated $13.0

to $14.9 billion.[iii] Additionally, there is the clawback provision burden where states have an unprecedented requirement to finance the Medicare program.

ACCESS & QUALITY

Despite growing outlays of public funds, a Medicaid card does not guarantee access or quality of care. In a survey of primary care providers, only 31% indicated willingness to accept new Medicaid patients.[iv] In 2012, 45 states froze or reduced provider reimbursement rates,[v] Medicaid access issues are tied to under compensation of providers; on average Medicaid payments are 66% of Medicare rates[vi] and many providers lose money seeing Medicaid patients. Medicaid beneficiaries struggle to schedule appointments, face longer wait times, and have difficulty obtaining specialty care.[vii] These access challenges will be more pronounced as Medicaid recipients compete with the tens of millions of newly insured under the ACA. Studies also show Medicaid coverage does not generate significant improvements in health outcomes,[viii] decrease emergency room (ER) visits, or hospital admissions, [ix] and participants have higher ER utilization rates than other insured populations.

STATE CONSTRAINTS

At Medicaid's core is a flawed structure. While jointly funded, by the federal and state governments, it is not jointly managed. States are burdened by federal policy and endure lengthy permission processes to make routine changes. Notwithstanding the cumbersome procedure, 1115 waivers provide a pathway for state innovation. However, the approval route is so daunting that states often abandon promising ideas if a waiver is necessary. Absent are evaluation guidelines , required timelines, and there is a capricious nature to the approvals, as waivers do not transfer from one state to another. Even with positive outcomes, a new administration has the authority to terminate a waiver.

Despite intense federal oversight, results vary substantially and there are no incentives for states to achieve quality outcomes. For example, the average cost to cover an aged Medicaid enrollee is $5,247 in New Mexico versus $24,761 in Connecticut,[x] and annual growth rates also very.[xi] Replacing oversight of day to day administrative processes, the federal and state governments should collaborate to identify program standards and incentives. States should be provided with flexibility to achieve these goals and successful states should be rewarded with reduced oversight.

Medicaid's uncompromising cost-sharing policies are illustrative of a key failure. These regulations disempower individuals from taking responsibility for their health, allow utilization of services without regard for the public cost and foster dependency. While some policies may be appropriate for certain populations, in an era of expansion to non-disabled adults, they must be revisited. Revised cost-sharing policies should consider value based benefit design and incent enrollees to evaluate cost, quality and adopt positive health behaviors. Indiana's Healthy Indiana Plan (HIP) waiver applied principles of consumerism with remarkable results; lowering inappropriate ER use, and increasing prevention.

CONCLUSION:

Congress should reform Medicaid to assure long-term fiscal sustainability and access to quality services that improve the health of enrollees. A fundamental paradigm shift in management is required and the program should be reengineered away from compliance with bureaucratic policies that do not change results to aligning incentives for states, providers and recipients to improve outcomes. States are best positioned to develop policies that reflect the local values of the people they serve and should be given the flexibility to do so.

[i] National Governors Association & National Association of State Budget Officers. (2012). The Fiscal Survey of States. Retrieved online: http://www.nasbo.org/sites/default/files/Fall%202012%20Fiscal%20Survey.pdf

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[vi] Kaiser Family Foundation. Medicaid-to-Medicare Fee Index. Retrieved online: http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

[vii] Bisgaier, J, & Rhodes, K. (2011). Auditing Access to Specialty Care for Children with Public Insurance. *The New England Journal of Medicine, 324(24)*, 2324-33. Retrieved online: http://www.nejm.org/doi/pdf/10.1056/NEJMsa1013285

[viii] Baicker,K., Taubman, S., Allen, H., Bernstein, M., Gruber, J., Newhouse, J., Schneider, E., Wright, B., Zaslavsky, A., & Finkelstein, A . (2013). The Oregon Experiment – Effects of Medicaid on Clinical Outcomes. *New England Journal of Medicine, 368,* 1712-22. Retrieved online: http://www.nejm.org/doi/full/10.1056/NEJMsa1212321#t=abstract

[ix] *Ibid.*

[x] Based on Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2009 MSIS and CMS-64 reports, Retrieved online: http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee-fy2009/

[xi] Based on Urban Institute estimates from CMS Form 64. Retrieved online: http://kff.org/medicaid/state-indicator/growth-in-medicaid-spending-fy90-fy10/

DRAFT

Mr. PITTS. The chair thanks the gentlelady and now recognizes Dr. Thompson 5 minutes for an opening statement.

STATEMENT OF JOSEPH THOMPSON

Dr. THOMPSON. Thank you, Mr. Chairman, members of the committee. I am Joe Thompson. I am a pediatrician and member of the faculty of the University of Arkansas for Medical Sciences. I direct the Arkansas Center for Health Improvement and have served as the lead candidate level advisor of surgeon general, first under Republican Governor Mike Huckabee and now under Democratic Governor Mike Beebe. I had the opportunity to work with two Administrations in the federal government.

Our entire health care system has changed dramatically over the last five decades since the inception of Medicaid with increased therapeutic and diagnostic opportunities, increased treatments. The costs have grown, and with that have grown the cost on both the public and the private sector. Our private-sector costs in Arkansas have doubled over the last decade from $6,000 to 12,000 for a family of four's premium. The costs have also increased for Medicare and Medicaid. As you have discussed, I want to commend this committee. The Medicaid partnership in funding for States and federal government is under intense duress and significant tension.

But I would like to back up. It is not just a Medicaid problem. Our entire health care system is under a cost threat that threatens our families, our communities, and indeed, the economic vitality of our Nation. It is not a new issue, it has been growing, but suddenly we are forced to face it, and if I can, we started off with private insurance, largely through employers, and Medicaid for the vulnerable, the poor and the disabled. I will leave Medicare off because that is not the topic of your discussion. Over time as we grew the therapeutic and diagnostic opportunities, we grew the ability to do things to and for people, and the costs grew and the valley of the uninsured, people who could not afford care, grew also, so we started having more and more uninsured individuals. Private costs went up but the private employers or affluent families could continue to afford those costs. The Medicaid program did not keep pace with those costs, and neither federal government nor State government budgets could afford it, and so we ended up with a huge, large valley of the uninsured. We ended up with expensive private insurance that some can afford, and we have Medicare programs that cannot afford either on the federal or State budget, so we end up with what is a problem of the iron triangle: cost, access and quality. If we are not willing to pay, we are going to have access problems. If we have access problems, we suddenly have quality problems. This is not a single issue about Medicaid. This is a systemic issue about our failure to gain control of rapidly rising health care costs that have outpaced federal and State budgets, that only a few employers and families are able to continue to afford and that have grown the valley of the uninsured.

So with that backdrop, let me share with you our experience in the State over the last 10 years. As of last year, we were operating nine different waiver programs designed by the State and approved by the federal government to provide Arkansans with better access, higher quality and more cost-effective care. Under the past Admin-

istration, President Bush's Secretary successfully supported our proposal to develop a waiver for support of small businesses for businesses with fewer than 10 employees who virtually had no option for private employer-based health insurance coverage. This small business was titled the AR Health Networks Program. It was a low-cost, limited-benefit program, largely successful at maximum uptake. It will be absorbed into the Affordable Care Act now for small business support going forward, but we started that in 2005, eight years before the implementation of the Affordable Care Act will go into place.

Four years ago, we started to tackle the issue of cost containment. Our Governor, our private sector recognized that the costs in the fee-for-service system were largely the cause for outpacing the growth potential of our revenue streams. So we understood a payment improvement initiative led by Medicaid which changed from a fee-for-service service to an outcomes-based incentives system with upside and downside risk for providers based upon what the outcome of the patients were so there would be engagement with patients. This required federal government approval, which we got through a State plan amendment within 2 months. It was an achievable goal because it was a programmatic need.

More recently, our Republican legislature and the general assembly with the Governor's support authorized use of the Affordable Care Act Medicaid programmatic funds to offer a totally new premium assistance program to buy health insurance premiums through the health insurance exchange, not to expand the Medicaid program in the traditional way, essentially to fill that valley in with private insurance, not to expand a State-run Medicaid program fraught with some of the issues that Ms. Verma alluded to. We will need to get a streamlined waiver from the Administration this summer. We have already started on that, and we have not identified a barrier to being able to do that at this point. So moving forward, we anticipate that of our 25 percent of the uninsured, we may have as many as a quarter million or almost 8 percent of our population not be in the Medicaid program but be in the private health insurance program.

In conclusion, our State is not alone, other States need help, but it is a partnership based upon a long-term history that must be brought into the 21st century, not abandoned because we didn't bring it into the 21st century. Thank you.

[The prepared statement of Dr. Thompson follows:]

Medicaid and Health System Transformation in Arkansas

Statement of Joseph W. Thompson, MD, MPH
Surgeon General for the State of Arkansas
Director, Arkansas Center for Health Improvement

Before the U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
"The Need for Medicaid Reform: A State Perspective"
June 12, 2013

1401 West Capitol Avenue • Suite 300, Victory Building • Little Rock, Arkansas 72201

Medicaid and Health System Transformation in Arkansas

Summary

Federal programs, such as Medicaid, are essential in helping our most vulnerable citizens receive essential health care. Dramatic changes in our nation's health care system—rising costs, expanding need for government assistance, and increasing numbers of low-income uninsured—have put tremendous strains on not only the federal–state partnership through Medicaid, but also on Medicare and private insurance programs. The systems, as they are currently designed, are not sustainable. Thus, it is essential that the federal government work as a partner with the states to transform the health care system of our nation.

Arkansas has begun a major transformation of its health care system, implementing episode-based bundled payments in lieu of fee-for-service standards, in an effort to align payment incentives with improved health care quality, better outcomes, and lower or contained costs. This transformation is made possible by Centers for Medicaid and Medicare Services' (CMS) approval of Arkansas's state Medicaid plan. Further, Arkansas's General Assembly recently passed a state law to create a "private option" that will enable expansion of private health care coverage to low-income (under 139 percent of the federal poverty level) through Medicaid-supported premium assistance.

State-plan amendments and Medicaid program waivers are essential tools available to the federal government and to states that can be used to accomplish broad health care system transformation. Only through innovative transformations such as those being deployed in Arkansas will our system once again become viable and be able to provide efficient, accountable, and responsive delivery of health care to our citizens.

Importance of Medicaid in our Nation's Changing Health Care System

Since their inception in 1965, Medicaid and Medicare have provided critical support for individuals to receive life-saving health care and manage life-altering diseases. For nearly five decades Medicaid—as a partnership between the federal and state governments—has been the primary and often the only source of health care coverage for the poorest, sickest, and most disabled Americans. Many of these citizens are those most in need of coverage, having multiple and complex health conditions but lacking the financial resources to secure private-market health insurance. The comprehensive scope of services and limited cost-sharing design was intended to address the complex health needs of low-income populations, including the chronically ill and individuals with severe physical and mental disabilities.

Over these five decades, the U.S. health care system has changed dramatically. Along with increased diagnostic and therapeutic options, we have an expanded ability to extend life, resulting in increased costs of care. Life expectancy has increased by nearly 10 years since the 1960s. At the same time, health care costs now represent 17 percent of the gross domestic product and place the nation and our economic competitiveness at risk. Private health insurance costs, Medicare costs, and Medicaid costs have consistently outpaced economic growth by every indicator. In Arkansas, private premiums for family coverage have nearly doubled from ~$6000 to ~$12,000 in the past decade. Similar inflationary increases have been felt in Medicaid programs across the country, exacerbated by the economic downturn that has increased the number of individuals relying on the program for basic health care services.

Thus, the Medicaid program is one major component of a health care system entering a necessary transition—one that achieves accessible, high-quality care at a cost that is sustainable. This challenge is in no way limited to Medicaid. Private insurance, Medicare, and self-insured employers are each faced with similar challenges. However, the shared financial obligation

between the federal government and states is unique to Medicaid and too frequently places tension on the partnership relationship that must be productive to be successful. This tension should result in reinforcing support for change, not evisceration of the federal government's responsibility to achieve that change.

Health System Transformation in Arkansas

Arkansas Payment Improvement Initiative

Arkansas has tackled the challenge of system reform and demonstrated the ability to have Medicaid lead a creative new strategy for health care system transformation by utilizing tools that are available today. Starting three years ago, the Arkansas Payment Improvement Initiative, led by Medicaid, began to establish a multi-payer effort to realign payment incentives to improve quality, achieve better outcomes, and contain costs. This initiative created a transition from a fee-for-service system to an incented episode-based model with both upside and downside risk on providers, with incentives paid through the Medicaid program. Accomplishing this required both state legislative and federal Centers for Medicaid and Medicare Services (CMS) approval. Using the state-plan amendment process, Arkansas gained federal approval within two months of submitting its plan. In large part, this approval was due to the demonstrated benefit and safeguards for the patient, the alignment of payment incentives for outcomes, and the potential to improve the system of care. As we extend this initiative by implementing new bundled episodes of care for various health conditions, we anticipate generating shared savings—savings for providers and savings to the state and federal governments.

Private Option in Arkansas

Most recently, the Arkansas General Assembly authorized the use of Medicaid funding through the Patient Protection and Affordable Care Act (PPACA) to provide premium assistance

to individuals under 139 percent of FPL for the purchase of private insurance qualified health plans (QHPs) via the new marketplace, or the Arkansas Health Connector.

Nationwide, Medicaid has historically used three mechanisms to finance and deliver health care for eligible individuals—direct provider payments (primary method used by Arkansas), competitive contracts directly with Medicaid managed care companies, or premium assistance through employers (limited to select cases where employer coverage was more cost effective). Arkansas's new approach is essentially premium assistance through the newly established marketplaces, achieving equivalent access for Medicaid beneficiaries and the privately insured while also incorporating private-sector cost-containment mechanisms. The explicit intent of the Republican leadership in our state legislature is to transform Medicaid and the Arkansas health care system into a more efficient, accountable, and responsive delivery system. Secretary Sebelius and CMS are working closely together to achieve successful implementation through necessary state plan amendments and/or waivers under her authority.

Role of Waivers in Transforming Health Care

As of 2012, Arkansas Medicaid was operating nine waiver programs designed by the state and approved by the federal government to provide Arkansans with better access, higher quality, and more cost-effective care. Among these is the ARHealthNetworks program, which is a low-cost, limited, health-care benefit program aimed at providing financial access to working-age adults and designed specifically for small businesses and self-employed individuals without medical coverage.

Arkansas is not alone among states in either seeking or obtaining flexibility through waivers to innovate and provide better value through Medicaid. Nearly every state in the union operates a waiver program. Currently 381 active waivers provide states with flexibility, enable the provision of services through managed care delivery systems, test new financing and delivery

models, or modify administrative processes and improve program integrity. While still recognizing the need for accountability for significant federal expenditures via waivers, CMS is working to streamline the waiver application process and to provide greater flexibility in light of the creativity of states and the rapidly changing marketplace. In addition, the new Center for Medicaid & Medicare Innovation has established more than 40 models for system transformation available to providers, communities, and states. These innovations are beginning to gain traction under the current partnership model where the risk of innovation is shared by the federal and state governments.

A call for block grants or "capped" exposure by the federal government to states is frequently cloaked in the justification of needed state flexibility but stems from a desire to limit federal fiscal exposure to the Medicaid program, with the possibility of curbing the very innovation that needs to be encouraged.

Conclusion

Accelerated change is needed in the Medicaid program but more importantly in the health care system itself. Medicaid, as a substantial purchaser of health care services that shares risks with states, is in a position to lead.

Tools exist now to achieve federal support of states when the approach to changing Medicaid includes recognition of the needs of low-income and disabled beneficiaries; the changes are part of a long-term state strategy to improve quality outcomes and costs; and the proposed changes offer an advance to the system. Now is not the time to weaken the federal-state partnership within Medicaid. It is the time to align federal and state commitments to achieve a high-quality health care system for all, inclusive of those who are most vulnerable.

Mr. PITTS. The chair thanks the gentleman and now recognizes Mr. Keck 5 minutes for an opening statement.

STATEMENT OF ANTHONY E. KECK

Mr. KECK. Good morning, Mr. Chairman and members of the subcommittee. My name is Anthony Keck. I am the South Carolina Director of Health and Human Services, the State Medicaid agency. I appreciate the invitation to discuss my thoughts on improving health through Medicaid.

While we don't run a $6 billion agency on anecdote, I would like to share a simple story with you that sums up our common challenge. I once ran a community clinic in a poor but vibrant and politically active New Orleans neighborhood known as the St. Thomas/Irish Channel. During that time, I took part in a focus group of pregnant teenage girls enrolled in Medicaid who were participants in a separate citywide program that matched each girl with a doula—a birthing coach—to help her better connect to the health care system and prepare for motherhood. One conversation still stands out. Paraphrasing her almost 20 years later, one of the participants said with exasperation near the end of our time together "Look, I love my doula and my doctor and I appreciate all the help they give me, but I've slept on a different couch almost every night for the past 3 weeks, and that's why I'm having a really hard time."

The limits of our programs, expressed in the statement of that teenager, are clear. She needed stable housing; what we had were doulas. She probably needed both. Her personal struggle captures the truth that years of public health research on social determinants of health has revealed: the primary drivers of health and well-being are income, education, community and family support, personal choices, environment, race, and genetics, while health care services contribute to a much lesser extent.

Yet our health system is built on the tenuous logic model that health insurance leads to access to effective health care services, which then leads to health. We are so beholden to this common wisdom that even though the Institute of Medicine estimates up to 30 percent of all health care spending is excess cost, we now spend almost 18 percent of our paycheck, payrolls and government budget on health care services while we fall further and further behind on health status compared to the rest of the world.

David Kindig, one of the country's leading public health researchers, recently wrote that for all of our health spending, mortality increased for women in 43 percent of U.S. counties between 1992 and 2006 with no correlation to medical care factors such as health insurance status or primary care capacity. He calls for a robust strategy to address this appalling trend, and I quote, "Such a strategy would include redirecting savings from reductions in health care inefficiency and increasing the health-promoting impact of policies in other sectors such as housing and education." He goes on to say that "Each county, not each State, each county needs to examine its outcomes and determinants of health to determine what cross-sectoral policies would address its own situation most effectively and quickly."

Yet Medicaid today operates under the default position that different populations and geographies face similar challenges and equity in health insurance benefits is the goal of the program rather than improvement in population health. Medicaid currently treats States more like subcontractors operating at a discount than partners contributing over 40 percent of the bill. Deviations from the norm require State plan amendments and special waivers. This may give the illusion of accountability, but promotes neither quick or effective local solutions nor cross-sectoral solutions, which consider public health, education, housing, employment, food security, personal responsibility and community action as important contributors to achieving better health and well-being for individuals and communities.

The truth is there are few, if any, long-term population health goals currently negotiated between States and the federal government so it is no wonder that we cannot agree on Medicaid's value. In addition, for all the federal efforts to manage expenditures through maintenance of effort requirements, limiting state revenue maximizing strategies, and focusing on fraud and abuse, the program continues to grow while access to health services suffers.

I believe there is a developing bipartisan interest among States for flexibility to manage programs locally in exchange for more accountability for improved health and more predictability in expenditures at the State and federal level. I ask you to consider the proposals both before you and in development that would accomplish this goal. Thank you.

[The prepared statement of Mr. Keck follows:]

Anthony Keck, Director, South Carolina Health and Human Services
Summary of Testimony to the Subcommittee on Health, Committee on Energy and Commerce
Wednesday, June 12, 2013

- The Institute of Medicine estimates up to 30 percent of health care spending is waste while we fall further behind on health status compared to the rest of the world.
- Years of public health research concludes the primary drivers of health and well-being are income, education, community and family support, personal choices, environment, race, and genetics. Health care services contribute to a much lesser extent.
- Despite this evidence, our health system is built on the tenuous logic model that health insurance leads to access to effective health care services, which leads to health. Health care spending crowds out other important personal, business, and government spending.
- We need to pursue strategies that according to David Kindig, et al. "include redirecting savings from reductions in health care inefficiency and increasing the health promoting impact of policies in other sectors such as housing and education," and promote local examination of "outcomes and determinants of health to determine what cross-sectoral policies would address its own situation most effectively and quickly."
- Medicaid currently treats states more like sub-contractors operating at a discount than partners contributing over 40 percent of the bill. Deviations from the norm require state plan amendments and special waivers, which may give the illusion of accountability, but promote neither quick and effective local solutions nor cross-sectoral solutions.
- Currently there are few, if any, long-term population health goals negotiated between states and the federal government. Despite federal efforts to manage expenditures through maintenance of effort requirements, limiting state revenue maximizing strategies, and focusing on fraud and abuse, Medicaid spending grows as access to health services suffers.
- There is developing interest among states for flexibility to manage programs locally in exchange for more accountability for improved health and more predictability in expenditures at the state and federal level.

Anthony Keck, Director, South Carolina Health and Human Services
Testimony to the Subcommittee on Health, Committee on Energy and Commerce
Wednesday, June 12, 2013

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One conversation still stands out. Paraphrasing her almost 20 years later, one of the participants said with exasperation near the end of our time together "Look, I love my doula and my doctor and I appreciate all the help they give me, but I've slept on a different couch almost every night for the past three weeks, and that's why I'm really having a hard time."

The limits of our programs, expressed in the statement of that teenager, are clear. She needed stable housing, what we had were doulas. Her personal struggle captures the truth that years of public health research on social determinants of health has revealed: the primary drivers of health and well-being are income, education, community and family support, personal choices, environment, race, and genetics, while health care services contribute to a much lesser extent.[i]

Yet our health system is built on the tenuous logic model that health insurance leads to access to effective health care services, which leads to health. We are so beholden to this common wisdom that even though the Institute of Medicine estimates up to 30 percent of all health care spending is waste[ii], we now spend almost 18 percent of our paycheck, payrolls, and government budget on health care services[iii] while we fall further and further behind on health status compared to the rest of the world.[iv]

David Kindig, one of the country's leading public health researchers, recently wrote that for all of our health spending, mortality increased for women in 43 percent of US counties between 1992 and 2006 – with no correlation to medical care factors such as health insurance status or primary care capacity. He calls for a robust strategy to address this appalling trend:

> "Such a strategy would include redirecting savings from reductions in health care inefficiency and increasing the health promoting impact of policies in other sectors such as housing and education."

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> "Each county...needs to examine its outcomes and determinants of health to determine what cross-sectoral policies would address its own situation most effectively and quickly."[v]

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Medicaid's value. In addition, for all the federal efforts to manage expenditures through maintenance of effort requirements, limiting state revenue maximizing strategies, and focusing on fraud and abuse, the program continues to grow while access to health services suffers.

I believe there is a developing bi-partisan interest among states for flexibility to manage programs locally in exchange for more accountability for improved health and more predictability in expenditures at the state and federal level. I ask you to consider the proposals both before you and in development that would accomplish this goal.

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[i] Centers for Disease Control and Prevention. *Social Determinants: Frequently Asked Questions.* Retrieved online: http://www.cdc.gov/socialdeterminants/FAQ.html

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Mr. PITTS. The chair thanks the gentleman. I will begin the questioning and recognize myself 5 minutes for that purpose.

First, if you listen to many, you would think that all it took for our most vulnerable to be healthy was a Medicaid card. Yet as Ms. Verma notes in her testimony, despite more spending, a Medicaid card does not guarantee access or quality of care. We know how difficult it is for States to customize care in a way that makes sense for each enrollee not under a one-size-fits-all approach, and I believe the best way to improve the care of the 72 million Americans on Medicaid is through local action on the ground in a way that empowers States to work with stakeholders, providers and patients.

Ms. Verma, States often ask the federal government to cut the useless red tape that strangles innovation. Would you be specific? What specific bureaucrat hurdles are at the top of your wish list that you would like to see removed for States in an effort to improve care and reduce cost?

Ms. VERMA. Thank you for the question. I think first of all, there has got to be some sort of a triage process if there are routine changes, changes in rates, changes in benefits, so these are routine changes, that some changes shouldn't require permission from the federal government, and I think we need to understand or to define what requires permission and what requires just informing the federal government that the State is making a change. So that would be the first one. I think the other piece in terms of especially around innovation and around waivers is to have some very defined criteria about how these waivers and State plan amendments are going to be evaluated, what the timelines are. I think it is very important for a State for planning purposes to be able to know if they submit a waiver, you know, when they can expect to receive a response from the federal government, and also how that is going to be evaluated. I think reciprocity is also important, and I think if a waiver has been granted to one State or a State plan amendment in one State, that that should be applied to another State and that would also reduce some of the timelines there.

Mr. PITTS. Mr. Keck, do you want to add to that list? Specific bureaucrat hurdles.

Mr. KECK. Yes. First, I want to echo exactly what Seema said, that reciprocity is important. We spent a lot of our time trying to figure out what other States have negotiated with their regional office or with the federal office, and many times we know that our State has been denied. I think deadlines are important. We run on a State fiscal year, and when I need to respond to my legislature's budgeting process and their requirements to implement policies I cannot do that very effectively when we operate on such long timelines with the federal government. I have a waiver issue that is being resolved right now that has taken 5 years to work through the system, and it involves $3 million worth of federal money but it has taken years to negotiate and hundreds, if not thousands, of hours of staff time.

And then finally, template changes. I believe there are a series of routine changes related to rates, related to quality measures and so on, that States are fully capable of making on their own. It is actually rare that they get denied but we spend many, many

months and many, many man-hour responding to questions and so on, and again, being on a State fiscal year where we have to get changes implemented on a timely basis, it adds significant problems in our operations.

Mr. PITTS. If you will continue, Mr. Keck, many private employers and insurers have successfully lowered health care costs and improved patient outcomes through value-based insurance design—VBID. States have often asked for greater flexibility to offer VBID plans to Medicaid enrollments. What is South Carolina doing to ensure patients can achieve better health outcomes?

Mr. KECK. We are strong believers in the VBID concept, and actually we are the first State to work with the University of Michigan Value Based Insurance Design Institute on implementing a VBID program in Medicaid. When we first met the folks that run this program, it was a Mill Bank conference and they were talking about the possibilities for VBID to work in State employee benefit programs. And along with one of my State senators, I raised my hand and said well, what about Medicaid because Medicaid is one of the most important payers in the country, if not the most important, and they said well, we don't do anything with Medicaid because the restrictions are so strong and Medicaid folks don't contribute to their premiums and they generally don't' have copays that are enforceable so we just ignored it, and we pushed them during that 2 days and said you can't just ignore it, we have to be able to build these concepts into Medicaid. The problem is, they are generally one-sided. When you talk to VBID folks, it is a set of carrots and sticks, and they have different effectiveness in different situations but unfortunately, generally in Medicaid, it is all carrots, and sometimes you need sticks, but right now we are generally stymied. There has been some recent flexibility that has been granted by the federal government related to copays but we are still convinced we need to go much further, and so in the next several months we will be approaching CMS with some of our ideas out of the VBID concepts.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I wanted to ask some questions of Dr. Thompson.

You and I both have a number of concerns about some of the proposals to convert Medicaid to a block grant program or a system of per capita caps while a block grant or per capita cap would save federal dollars by cutting payments to States caring for vulnerable families. Those dollars would be saved on the backs of the most vulnerable members of our communities. In addition to the very real risk of beneficiaries being subjected to reduced health care coverage and increasing personal health care costs, you also commented in your testimony that both of these proposals are likely to curb innovation. So could you explain what you mean when you say that these proposals will curb innovation and also share your thoughts more broadly about the potential impact of these proposals?

Dr. THOMPSON. Thank you, Mr. Co-Chair. Our health care system is incredibly complex, and I think what we see in short-term fixes are essentially what has been around for a long time. It is an

easy fix, which rarely works in a complex situation. We have found that when we bring to the Administration, and it has not mattered which Administration, an approach that is inclusive of the needs of the low-income and vulnerable population that is part of the long-term State strategy and that moves the system forward, we have been able to work through the regulatory challenges that are there. It is not always with the speed, and I think there are some comments by Ms. Verma and Mr. Keck that could be incorporated, are being incorporated by this Administration on streamlined waivers. But I think if we don't take the root problem that our payment system is causing us to have a growth in health care that does not equal value or outcomes, then we are not going to have a quick fix that increased flexibility. We will squeeze the balloon in one place and it will open up in another place, probably on State budgets or at the expense of the vulnerable and poorest of our citizens.

Mr. PALLONE. Now, in the end, won't capping federal support for the program merely shift costs elsewhere on private businesses, patients and providers as well as State governments? I mean, you sort of suggested that but if you could just answer.

Dr. THOMPSON. This is what led our Republican leadership in part to take advantage of the Affordable Care Act. We have 25 percent of our Arkansas 19- to 64-year-olds that are uninsured. We have 40 percent, approaching 40 percent in some counties. Those individuals are not well. Fifty percent of our population has a chronic condition. They are seeking care. They are using the emergency room in an inefficient way. And so by taking advantage of the Affordable Care Act but, importantly, tying it to our payment reforms and putting it in the private sector with the new cost sharing and copayments, which we intend to push on and expand, we hope that we can actually design a new and sustainable health care system inclusive of Medicaid and one that rewards providers for the care that they give and achieves equal high-quality care for all regardless of income.

Mr. PALLONE. Thank you. Can I ask you, what was your experience as far as the flexibility, responsiveness, timeliness of CMS, you know, the Centers for Medicare and Medicaid Services, when you applied for the State plan amendment for this?

Dr. THOMPSON. Our State plan amendment went through in roughly less than 2 months, and this was from our inception to our successful achievement. It was like Mr. Keck mentioned, important to be timely because we were concurrently running rules and regulations in our general assembly, so we had to get both general assembly through rule and regulation and federal government support, and I think it is important for the feds and for the local general assemblies to recognize those are often in concert, not totally separate issues. But we successfully got approval to have upside and downside risk on our providers within 2 weeks of request from the Centers for Medicare and Medicaid Services.

Mr. PALLONE. All right. Thank you very much. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the vice chair of the committee, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman. I will try to make good use of Mr. Pallone's time that he yielded to me.

Mr. Keck, I have got to ask you, for the good of the committee and our general knowledge, spend just 2 seconds and tell the committee what a doula is.

Mr. KECK. A doula is essentially a birthing coach that is of the committee that generally she but sometimes he works in to help——

Mr. BURGESS. Not a medical person?

Mr. KECK. Not a medical person.

Mr. BURGESS. So not a midwife?

Mr. KECK. That is right.

Mr. BURGESS. Basically someone who daubs a forehead and says it will be all right. Is that correct?

Mr. KECK. Well, and also helps a woman connect with the health care system that is sometimes very difficult.

Mr. BURGESS. So is it correct to think of a doula as sort of a navigator or a precursor to a navigator?

Mr. KECK. I would consider them a community health worker but to help navigate the health system because it is so complex.

Mr. BURGESS. And no disagreement there. And in fact, so good to have all of you all at this hearing. I cannot tell you the number of times we had hearings in 2007 and 2008 where you wondered where Mitch Daniels was when we were having all the discussions how to provide more for less, and you correctly identified Governor Daniels as being a leader in this issue, and he found that something magic happens when people spend their own money for health care, even if it wasn't their own money in the first place. Would that be a correct observation of the Healthy Indiana program?

Ms. VERMA. Yes, that is correct. I mean, within the Healthy Indiana Plan, participants are required to make contributions into an account. The State also funds that account, and then they use those dollars to cover their first $1,100 of health care services, and if they complete their preventive health care, then at the end of the year whatever money is left in that account rolls over and it decreases the amount that the person would have to pay in the subsequent years. And so we have had great results, lower emergency room, higher generic use.

Mr. BURGESS. And this is the Medicaid population, not the State employee population that also was written about in the Wall Street Journal. Is that correct?

Ms. VERMA. That is correct.

Mr. BURGESS. And what kind of savings did you achieve in the Medicaid program with Healthy Indiana?

Ms. VERMA. I think what we have seen in the Healthy Indiana program in terms of savings is a real shift in patient behavior. We have seen patients——

Mr. BURGESS. May I interrupt you there for a moment because that is the important point, and the Commonwealth Fund, I don't generally agree with everything they talk about, but a few months ago they talked about the concept of an activated patient being one where health care expenditures were reduced, and essentially that is what you found, isn't it?

Ms. VERMA. That is correct. I mean, I think that so many of the policy changes or regulations are aimed at providers, they are

aimed at insurance companies, pharmaceutical companies, but we sort of miss the point that the individual has a very significant role to play in controlling health care costs, and that is not just for commercial populations but even the low-income population. They are perhaps the best consumers of a dollar. They have had experience stretching a dollar, and I think when you empower them that they start to make decisions about where to seek their health care, how to seek care in more appropriate ways and seeking more preventive care.

Mr. BURGESS. Yes, I liked everything about your testimony except that you were way too nice, and you need to be a little harsher in your assessments than saying there is trepidation about the future fiscal sustainability. Governors are scared to death, and I could use another word there, but I will be nice, they are scared to death about what is going to happen by taking on this obligation. The federal government has proven itself to be an absolutely unreliable fiscal partner when it comes to health care. Ask any doctor out there who takes Medicare what has happened to their reimbursement.

Let me just for a moment, you have identified something that is, I think, to Healthy Indiana, and that is the participation in the preventive programs. Is that a correct observation?

Ms. VERMA. That is correct.

Mr. BURGESS. And the reason that that is so important, of course, is, we will all talk about it here in glowing terms that an ounce of prevention is worth a pound of cure, and so we are basically paying for that ounce of prevention but we want to see the pound of cure. It is important because I am told by my staff that the total federal spending over the next 10 years, combined federal and State spending over the next 10 years for Medicaid is $7.5 trillion, $750 billion a month. I mean, that a phenomenal amount of money. If we could even bend the cost curve just a little bit with preventive care, that ounce of prevention, that is a hell of a pound of cure.

Let me just ask you this. What is Indiana doing as far as Medicaid expansion is concerned?

Ms. VERMA. Well, I would defer to the State of Indiana to answer that officially but I think in the comments that I have read, I think that Governor Pence has indicated that he wants to understand what the future of the HIP program is before he can make a determination about what his position will be on the Medicaid expansion.

Mr. BURGESS. Thank you. Mr. Chairman, I just have to observe that I was there on the second day of the Supreme Court oral arguments, and the discussion from the Solicitor General was repeatedly, it is the cost of these free riders that are driving up our health care. No. We reimburse so poorly in Medicaid that the patients can only do what they have always done, which is go to the emergency room, the highest point of contact. If we expand the program, we are going to expand the problem. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the distinguished ranking member of the full committee, the Ranking Member Emeritus, Mr. Dingell, 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy and I thank you for holding this hearing.

Medicaid is an important and timely topic, especially as we are about to greatly expand eligibility of the program as a part of the Affordable Care Act. Some of our colleagues here continue to ask for flexibility for the States to experiment with new and innovative methods of care. However, much flexibility already exists in the program, and many States are making significant changes using this. These questions are for Dr. Thompson, Surgeon General of the State of Arkansas.

Doctor, I want to commend you for your helpful testimony. Doctor, did Arkansas recently implement the Arkansas Payment Improvement Initiative after receiving approval from the federal government? Yes or no.

Dr. THOMPSON. Yes, sir.

Mr. DINGELL. Doctor, how long did it take for Arkansas to get that approval?

Dr. THOMPSON. We worked 3 years on the development within the State but the approval itself was relatively rapidly received in 2 months.

Mr. DINGELL. What does that mean? How relatively rapid?

Dr. THOMPSON. Two months after our request.

Mr. DINGELL. OK. Doctor, did this new initiative begin to transition away from the fee-for-service models towards a more value-based payment model? Yes or no.

Dr. THOMPSON. Yes, sir.

Mr. DINGELL. And I happen to think, and will you confirm or deny this, that that is the direction we are going to have to go because one of the things about our system is it is broken because we are paying for work done and not for results achieved?

Dr. THOMPSON. I believe we must align the financial incentives for the outcomes that we want, not for the services that are provided, and I think that is one of the fundamental issues that has yet to be resolved in our health care system.

Mr. DINGELL. Thank you. Doctor, have the reforms implemented in Arkansas resulted in cost savings which can be quantified? Yes or no.

Dr. THOMPSON. Through the first three quarters of the year since we implemented this, we have seen a dramatic reduction in growth in the Medicaid program. It is lower than it has been in the last 25 years.

Mr. DINGELL. Would you submit this for the record? I gather the answer to that is yes.

Dr. THOMPSON. Yes.

Mr. DINGELL. And would you please submit that for the record? Because I have got a lot of questions and very little time.

Dr. THOMPSON. Yes, sir.

Mr. DINGELL. Doctor, could you now please submit for the record a detailed explanation of the initial results following the implementation of this new Arkansas plan, please?

Dr. THOMPSON. I would be glad to.

Mr. DINGELL. Doctor, in your testimony you mentioned that nearly every State has a Medicaid waiver and that there are current 381 active waivers. Is that correct?

Dr. THOMPSON. To the best of my knowledge, yes, sir.

Mr. DINGELL. It seems to me that the States currently have a viable existing pathway to get some flexibility under Medicaid. Do you agree with that statement?

Dr. THOMPSON. I agree that they have that flexibility.

Mr. DINGELL. Now, this leads me to questions of how many of the reforms proposed in a recent report issued by my good friend, Chairman Upton, and my other good friend, Senator Hatch, titled "Making Medicaid Work." This report proposes to eliminate the medical loss ratio provision in the Affordable Care Act, which gave the consumers over $1 billion in rebates in 2011. The report also suggests that we repeal the maintenance-of-efforts provision in ACA, which would allow the States to restrict eligibility for the program and would reduce access to care. Finally, instead of turning Medicaid into a block grant, as has been proposed in years past, this year the proposals are a per capita cap on Medicaid spending. Now, Doctor, would this new proposal still result in the loss of coverage and benefits for beneficiaries? Yes or no.

Dr. THOMPSON. Well, sir, I think the report that you allude to has several recommendations that I would concur with. The three that you identified, I would agree have potential problems for the States. A per capita block grant to the States in the face of escalating health care costs that are not contained is a cost transfer to the State for future rate increases on health care.

Mr. DINGELL. It should scare the hell of the States, shouldn't it?

Dr. THOMPSON. My advice to any governor for a block grant is watch out because you are getting a transfer of responsibility without control of future rate increases. We have to control the cost increases on health care before we can actually transfer fiscal responsibility or block off fiscal responsibility in the Medicaid partnership.

Mr. DINGELL. Now, Doctor, do you believe that the per capita would actually cause innovation by the States or would it cause a disruptive nature which would place consumer protection of our most vulnerable citizens at risk? I gather you agree with that statement, yes?

Dr. THOMPSON. I have concerns, and I think I share those with others, that caps of any kind without a long-term strategy to assure quality while maintaining cost is a risk to the beneficiary and it is a transfer of financial and responsibility risk to whoever is being capped.

Mr. DINGELL. I am going to make a quick statement and ask this. I have the impression that our system is broken because we are paying for work done and not for accomplishments and for completion of assuring health for the people and that we are trying to figure a way to transfer from the current system to a system which recognizes the need to get results as opposed to just paying for work.

Now, Dr. Verma and Dr. Thompson and Mr. Keck, do you agree with that statement? Yes or no.

Mr. KECK. Yes.

Mr. DINGELL. Yes?

Ms. VERMA. Yes.

Mr. DINGELL. The reporter doesn't have a nod key so you have to say yes or no.

Ms. VERMA. Yes, I do.

Mr. DINGELL. Have you all agreed with that?

Dr. THOMPSON. I will be the third to agree, yes.

Mr. DINGELL. Thank you. Mr. Chairman, I thank you for your courtesy to me.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Dr. Thompson, I want to follow up on Mr. Dingell's, your little discussion there. You said how many waivers you asked for? Three hundred and eighty?

Dr. THOMPSON. No, that is the total number that are active across the United States from the most recent information we had from the Centers for Medicare and Medicaid Services.

Mr. SHIMKUS. And so you all have submitted——

Dr. THOMPSON. We have 12.

Mr. SHIMKUS. You have 12. And were those 12 active waivers all adjudicated or decided in that 2-month window of approval?

Dr. THOMPSON. No, some of those waivers took much longer. Some of the waivers, as Mr. Keck alluded to, in the past have taken years to get conclusion on.

Mr. SHIMKUS. Go back through your timeline. Developing your program by the State of Arkansas took how long?

Dr. THOMPSON. So specific to the payment improvement program, which is the most current experience that we have— our Medicaid expansion will be this summer's experience—we started off with advice that Mr. Dingell alluded to. My advice to the Governor was that our fee-for-service system was broken 3 years ago. So we spent 2 or 3 years working with both the public and private sector. We have Medicaid, we have Blue Cross, we have Qual Choice of Arkansas. We have had Walmart as a self-insured company join because of their interest in changing the way the health care system works. Last October, we had Medicare join in our patient-centered medical home effort. So we have been developing this over the last 3 years. This summer because we were changing the way that we were going to incentivize providers to engage with patients to increase the individual accountability of patients and also the outcomes availability of the providers, we needed to get a State plan amendment from the Centers for Medicare and Medicaid Services. We applied in, I can't remember if it was June or July but within two months had approval from CMS to implement those changes, and we started aligning different incentives on providers in October.

Mr. SHIMKUS. So if nationwide there is 380, on average seven-plus waivers applications per State in the process, my interest is, obviously I am from the State of Illinois. In my personal opinion, we have done a very poor job, and what the State did last year, $1.6 billion of cuts to Medicaid program and established a moratorium on expansion for 2015, even though then we increased enrollment by 15 percent, and by the beginning of 2013 the State had a funding gap of $3 billion. Just last week, the State received yet another credit rating downgrade. It is our second. This is all the cost of a burden of States of pension and Medicaid benefits. These

are real life stories so Illinois has now another credit downgrade, which means the cost of borrowing goes up.

So if you were in the position of the State of Illinois, because we are going to expand its Medicaid under ObamaCare, bringing on new applicants to a system that is already spending $5 billion more, is already expanding our roles, what would you suggest the State of Illinois do? Let us go left to right, rapidly, because my time is——

Ms. VERMA. OK. I mean, I think you need to take a look at managing care, putting in more managed care. I think looking at expansion without addressing the core issues and where they are spending their money. I think they need to explore different innovations, value-based purchasing that we have talked about, you know, some sort of a reform on how providers—but I think it is also very critical to include the individual in that.

Mr. SHIMKUS. The individual has to be in the process of——

Ms. VERMA. The individual has to be part of the equation.

Mr. SHIMKUS. Dr. Thompson?

Dr. THOMPSON. My quick advice to any governor, including my own, was, expansion without efforts to contain costs is a budgetary as well as a State failure.

Mr. SHIMKUS. I will take that. Mr. Keck?

Mr. KECK. I hesitate to make a suggestion for Illinois but——

Mr. SHIMKUS. Please. We need any help we can get.

Mr. KECK. We want to meet our commitments, and I think we are not meeting our current commitments, and what we have told our legislature is, we have to pay for our current commitments before we expand.

Mr. SHIMKUS. And just to finish with Dr. Thompson on this. So the way Arkansas has approached this, since ObamaCare has really—we are buying off expansion with a promise of federal dollars which we will then walk away from the new expansions after that. So your bet is, you are going to have a reformed system within your State that is able to carry the increased Medicaid individuals past a time frame when ObamaCare and the additional dollars are gone?

Dr. THOMPSON. We undertook payment improvement 3 years ago, so it predates our expansion that will go into effect this year. Your premise is correct. It is not just for the Medicaid program, however. It is that we think our private sector, that our business sector, that our economic attractiveness will outpace with all due respect our sister States around us because we are going to both expand and get coverage in place at the same time we are reforming the payment system to make sure that it is sustainable.

Mr. SHIMKUS. I appreciate that. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from California, Ms. Capps, 5 minutes for questions.

Mrs. CAPPS. Thank you, Mr. Chairman, and thank you all for being here today and for your testimonies.

As we know, Medicaid is a critical program. It serves over 70 million families, seniors and individuals with disabilities. I think it is important to keep in mind that it is a safety net for these people who are otherwise shut out of private insurance, either because it is unaffordable, unavailable to them or doesn't cover the benefits

that they need. So we know that individuals with Medicaid are more likely to receive preventive health care and less likely to have medical debt than their uninsured counterparts. Medicaid, like private insurance and Medicare, is trying to confront the same challenges of improving quality and cost. So a dialog today about improving the system to provide cost-effective, high-quality health care to many of these individuals who need it is really a valuable discussion to have.

But I think we must be mindful about exactly who will be impacted by the decisions that we make or that Congress makes, and if we are truly improving care or just passing the buck to States, persons with disabilities, seniors, and struggling families, in other words, the vulnerable. We have a responsibility, I believe, to make our best-faith effort to improve the system on behalf of these individuals while protecting their access to affordable care. With the flexibility provided by Medicaid, a number of States have initiated quality improvement activities to improve access to preventive services, increased chronic-disease management and prevention, and addressed population health.

So Dr. Thompson, you are here because the Arkansas Medicaid program has had great success in collaborating with health care providers and the Arkansas Foundation for Medical Care to improve quality of care and health outcomes. What are the quality issues? I know you have talked about this, but if you don't mind restating them, the quality improvement initiatives and how do you rank your success to date?

Dr. THOMPSON. Well, our State is burdened with a heavy risk burden in our population. Fifty percent of our citizens have a chronic disease. Our QIO, the Arkansas Foundation for Medical Care, has worked closely with our providers, both physicians and hospitals, particularly on the hospital side, reductions in readmissions, improvements in outcomes after delivery, more recently, efforts to reduce premature delivery that then result in negative neonatal outcomes. So there are real interests and opportunities with providers if the engagement is right, if the incentives are aligned correctly to move the system forward in a positive way.

Mrs. CAPPS. So that is exactly what I was hoping we could get at. Could you speak to the success of this program and the ways that you have seen care coordination improve across the Medicaid providers, and do you believe this program, some of the models that you are using, could be enhanced and expanded so that other States could take advantage of it?

Dr. THOMPSON. What we have done is, we have taken what was a quality improvement effort, which is what I have just described, and we have now tied the payment mechanism for providers to reinforce quality outcomes. We have actually taken, for example, our hip and knee surgeries and we have said there is a responsibility of the surgeon from 30 days before to 90 days after for the outcome, and now their payment is tied to what the outcome for that patient is. It increases engagement with the patient, it increases the decision process of the team, and we think it will reduce the cost and inefficiencies in the system over time.

Mrs. CAPPS. Wow. And you have seen some indications that it is working?

Dr. THOMPSON. We are starting to see provider behavior change, both within the OB episodes, within the hip and knee episodes, within the hospitalization episodes, and as we talk to providers, almost every association says there is 20 to 30 percent waste in the system but nobody has ever aligned the financial payment mechanisms to have providers lead in eliminating that waste.

Mrs. CAPPS. That is a good thing to discuss, ways to do that without making it seem punitive and punishing. Well, anyway, I wanted to get one last question on the table. The initiatives that you have undertaken, have they all been done within the current statutory and regulatory framework of the Medicaid statute? In other words, what kind of waivers have you used, how much of this have you been able to do straightforward?

Dr. THOMPSON. Well, I hope they are all within the regulatory and statutory framework of the current Medicaid program, or somebody is in trouble. No, we have been able to do it. I think it is not an easy path. I think the current Administration is streamlining that path, and our recent experience has been much better than our past experience. Again, that is not with any prejudicial interest on prior State or federal Administrations.

I do think that when a State has a desire to come with a plan that safeguards the beneficiaries and their needs, that fits into a long-term State plan and that moves the Medicaid system as a whole forward, is a prerequisite for successful negotiations between the federal and State government.

Mrs. CAPPS. Thank you, Mr. Chairman. This was good to hear.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Mr. CASSIDY. Thank you, Mr. Chairman.

Dr. Thompson, I notice you are wearing Arkansas colors in your tie, so I will just say, I am an LSU guy, I couldn't help but notice that.

Listen, I was very intrigued by your testimony. You say that the State of Arkansas is contracting on a per-beneficiary payment to managed care companies. They are at upside and downside risk, correct?

Dr. THOMPSON. We do not use a managed care mechanism so it is the State itself that is at risk for cost increases or cost savings.

Mr. CASSIDY. But there is a per-beneficiary amount, because you mentioned there is an upside and a downside.

Dr. THOMPSON. The upside and downside risk that I mentioned was actually what we have now shifted to our episodes of payment to providers. Providers now have the responsibility, upside and downside, for the outcomes of the episodes as I mentioned.

Mr. CASSIDY. And I am sure they protested, but on the other hand, as you point out, they have been able to achieve cost savings and increased efficiency.

Dr. THOMPSON. Actually, our providers are relatively, I will say with some caveat, supportive of our effort. They knew the system had to change. They did not want another bureaucrat layer put on top, and they said we will take responsibility for that clinical——

Mr. CASSIDY. I don't mean to interrupt. So, if you will, you are capping the amount of money that goes per episode, and I guess

the point I am trying to make is that whenever my colleagues on the other side tend to suggest that any sort of cap whatsoever is going to be deleterious, in reality, you all have caps and you have actually seen success?

Dr. THOMPSON. In actuality, sir, we have not capped anything. The providers——

Mr. CASSIDY. So when there is a bundle-of-care payment, that is not really a capped amount but rather it can be——

Dr. THOMPSON. It is not a cap.

Mr. CASSIDY. So there is not a true upside and downside?

Dr. THOMPSON. There is a target that the lead quarterback for the team will have financial impact, but every member of the team is still paid.

Mr. CASSIDY. I understand they are still paid, but if they exceed that target, do they lose money?

Dr. THOMPSON. Not the members of the team but the quarterback does.

Mr. CASSIDY. The quarterback does. Yes, so for that particular quarterback, there is a cap.

Dr. THOMPSON. There is a target.

Mr. CASSIDY. I think we must be using terminology because if there is a downside for them, then effectively there is a cap.

Dr. THOMPSON. Again, sir, I would be glad to share, but we have not capped any provider's payment. We have set goals that they share in the gains——

Mr. CASSIDY. Then somebody I don't understand how your downside works, but let me ask, Mr. Keck speaks about how really on a county-by-county basis for somebody, there should be variability. I have to imagine our States are similar, that in the Delta there is a different patient population and different structure of health care as opposed to Fayetteville.

Dr. THOMPSON. And without question, different health care needs.

Mr. CASSIDY. With that said, who is better equipped to make that determination? The county or the State official or rather somebody in Washington, D.C.?

Dr. THOMPSON. Well, I would say it would be a local provider, local community.

Mr. CASSIDY. That seems right. So I think when Mr. Keck speaks about the flexibility, I think that is something we can all agree on.

Next I would ask, on the other side there is a lot of defense of the status quo in terms of Medicaid, but Dr. Thompson, would you agree, I mean, are you aware that some States really manipulate the Medicaid system in order to maximize federal payments to their State? For example, New York, which has half the population of California, gets 33 percent more federal payments than California.

Dr. THOMPSON. I am aware of different strategies that States have employed that don't necessarily tie directly to patients.

Mr. CASSIDY. Yes, some people call it gaming, and that seems to be the legal way to describe it. I am struck that even the Democratic witness would agree that there is some problems with the status quo, which it seems as if the other side doesn't want to admit. In fact, I noticed that you were nodding your head yes when

Ms. Verma stated that when Medicaid empowered patients to consider cost savings, there was actually good results that result from that. Could you accept what Ms. Verma was saying?

Dr. THOMPSON. Well, I think our approach through our Medicaid expansion will have cost sharing on individual patients.

Mr. CASSIDY. So I was struck that Mr. Waxman suggested if any of that occurs, it is going to be terrible for the patient, but in reality, I think I am hearing from the witnesses that there is actually some positive things that happen both for the patient as well as for cost savings.

Dr. THOMPSON. But it is with safeguards on the patient.

Mr. CASSIDY. Of course. Everybody accepts safeguards, but on the other hand, status quo is status quo, and right now if we can do something different, we may improve. I think even our Democratic witness is not agreeing with Mr. Waxman on that one.

Mr. Keck, you seem to suggest that the States could accept some limitations on payments as long as they had flexibility and net they would come out better. Would you agree with that?

Mr. KECK. And that is how we pay our managed care plans. We capitate them and give them a lot more flexibility and negotiate rates, to change benefit structures. They take significant risk. We are able to put high accountability on them in terms of performance measures.

Mr. CASSIDY. So when Mr. Waxman suggests that any cap whatsoever is unworkable and any flexibility given to the States to manage is going to be terrible for patients, you are saying that wouldn't necessarily be the case?

Mr. KECK. I don't believe that would be the case at all.

Mr. CASSIDY. You have experience in two States with high poverty levels, both Louisiana and South Carolina, so you really are where the rubber meets the road, not an ivory tower in Washington, D.C., but really where you have to see those patients in New Orleans get care. Is that a fair statement?

Mr. KECK. The rubber meets the road in both South Carolina and Louisiana.

Mr. CASSIDY. OK. I am out of time, and I yield back. Thank you.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Green, for 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

I know our committee started out with concerns about the reimbursement rates. I assume reimbursement rates in Indiana, South Carolina and Arkansas are the same as in Texas. Reimbursement rates for Medicaid are set by the State, correct?

Ms. VERMA. That is correct.

Mr. GREEN. And I know the pecking order. You know, you have private insurance here, you have Medicare here, you have Medicaid here, and I found out when we started mobilizing our reserves in Houston 10 years ago how low TriCare reimbursed our physicians and hospitals. But that is set by the State.

The other issue was, I don't think that in 3 years the federal government is going to walk away from—now at 3 years it is 100 percent and after that is 90 percent reimbursement. Is that correct?

Ms. VERMA. Yes.

Mr. GREEN. I wouldn't quite call that walking away from the Medicaid responsibility. But anyway, just so we know that.

I have a district in Texas, a very urban district, and one of the highest uninsured rates in the country. I am disappointed our legislature did not do something with expanding Medicaid similar to what Arkansas has worked on, and every once in a while I am jealous of Arkansas's football program too when they beat a Texas school. But I would hope we would see that change.

One of my concerns is the churning rate, and in Texas we make folks come in for Medicaid every 6 months and even for the SCHIP program. Do any of your States have a longer term for enrollment than 6 months? Does Indiana have 6 months or a year? Arkansas?

Mr. KECK. We make people redetermine every 12 months, but if they have a change in status——

Mr. GREEN. Oh, sure, if they have a change in status, but you don't make them show up and redo it every 6 months?

Mr. KECK. No, and we do redeterminations through express-lane eligibility, which we found to be very effective.

Mr. GREEN. What about Arkansas?

Dr. THOMPSON. Ours is 12 months. I think important to your churning question, our expansion effort, which will use private plans, we believe will largely eliminate the churn process entirely. People will stay in the plan. The plan will re-enroll them. They will not have to touch the Medicaid program.

Mr. GREEN. Ms. Verma, what about Indiana?

Ms. VERMA. Yes, in Indiana they have continuous eligibility. If there a change, it has to be reported.

Mr. GREEN. Sure. That seems reasonable. If there is a change, you have the opportunity to go in and check it and do that.

Congressman Barton and I both identified that as one of the concerns we have because as a former State legislator, I also know we can quantify if we do it every 6 months and 1 year as compared to a year how much money we can save over that period of time making Medicaid recipients come back and sign up, and I have seen the lines out in front of the offices. So hopefully we will look at that piece of legislation to have that, unless it is changed circumstances. That is the issue.

Let me talk about Arkansas a little bit. Again, congratulations, Dr. Thompson, on some of the considerations. What do you think the consequence of not expanding Medicaid would have been for Arkansas?

Dr. THOMPSON. I believe our health care system was at a tipping point. I mentioned earlier we had 25 percent uninsured statewide. We had some counties that were approaching 40 percent of the 19- to 64-year-olds. These people were consuming care but not able to pay for it. Our providers were not able to stay in business to provide it. I think we were at a tipping point that the opportunity under the Affordable Care Act, which I won't speak for or against, but as an implementer of the Affordable Care Act, I think it led a safe line, particularly for our rural health care providers where the uninsurance rates were much higher.

Mr. GREEN. Well, and again, I am concerned because our percentages are the same as Arkansas but with a lot more folks that are losing that kind of opportunity to have it.

Mr. Keck, South Carolina has both a lower rate than Texas for churn because you do it on a year. Mr. Keck, in addition to the CHIP law, Congress enacted provisions that provide bonus money for States to go out and exceed expectations on enrolling low-income Medicaid children. I understand South Carolina received CHIP bonuses in 2011 and 2012. Would you agree that the bonus program is good and positive incentive for States to find and enroll lower-income children?

Mr. KECK. Yes.

Mr. GREEN. Do you know how much money the South Carolina program received? Because all that money goes back into Medicaid, I assume.

Mr. KECK. We don't have our latest bonus calculated but we are committed to—when our legislature sets an eligibility limit, we are committed to getting everybody enrolled under that eligibility limit.

Mr. GREEN. And again, I know private-sector employees offered health care benefits with continuous coverage for their employees as long as they remain there, and again, Mr. Chairman, I would hope we would look at considering that bill that Congressman Barton and I have, and I yield back my time. Thank you for being here.

Mr. PITTS. The chair thanks the gentleman. The chair recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you, Mr. Chairman. I welcome the panel, particularly Dr. Thompson. I come from a long list of Murphys in Pennsylvania who are physicians: Garland Murphy, Dodie Murphy of Springdale, and I don't know if you know any of those but if you do, please extend my greetings to them.

I wanted to ask you first, Dr. Thompson, some questions about where Arkansas stands. Your state has recently agreed to this Medicaid expansion proposal that carries with it the assumption that HHS will let you have approval. Now, my understanding is, HHS and CMS have consistently noted publicly that nothing is approved for your State. In fact, Administrator Tavenner recently said before the Senate Finance Committee: "We haven't approved anything." So could you outline for this committee what Secretary Sebelius in coordination with OMB has explicitly agreed to allow Arkansas to do in 2014 as it relates to individuals not currently enrolled in your Medicaid program under 138 percent of federal poverty level?

Dr. THOMPSON. First, let me deal with the approval issue. Approval for a State-federal waiver is actually a financial contract. So until it is signed by both parties at the end of the process, there is no approval. Where we are in our process, what we call the private option on Medicaid expansion, which is to take Medicaid dollars and use them essentially for premium assistance on the private health insurance exchange is an accepted concept. Premium assistance has been used before by Medicaid programs in limited way to buy private employer-based coverage when it was more efficient, effective and cost beneficial to the Medicaid program. We are extending that in concept to be premium assistance for all newly eligibles on the newly established insurance exchange. We think that by harmonizing both the cost sharing on individuals above and

below the Medicaid eligibility line, that we will educate our Medicaid eligibles on how to use the health care system as they then go up into the health insurance system. They will be better informed and prepared to use the health care system in a more appropriate way. We will eliminate churn, as we talked about before, because people will be in a health plan and probably stay in a health plan year after year. The health plan will want them to.

So where we are now is, we have a conceptual agreement of where we are going. We are working through the specifics of what will end up being a streamlined waiver to get to the essentially contractual agreement between the State and the federal government on guarantees of coverage and the financial aspects of the agreement.

Mr. MURPHY. Let me add one other thing that you can provide for us as a follow-up, that is, to provide us with updated projected State and federal 10-year costs if Arkansas did not expand and thus the individuals above 100 percent of federal poverty level acquired private coverage, and two, expanded and every individual would be under traditional Medicaid below 130 percent of federal poverty level, and three, to move forward under the legislature per your proposal. That is information I would like you to get for us in the future.

Dr. THOMPSON. Sure.

Mr. MURPHY. Mr. Keck, I think in your testimony you said that 30 percent of health care is waste?

Mr. KECK. According to the Institute of Medicine and many other sources. That is the latest estimate.

Mr. MURPHY. Let me ask you this. When Medicaid dollars come through in the federal government, the State level and other things, what percent of that is spent on a wide range of administrative costs that never get to actual patient care? Do you have some estimates of that? Under the current way things are spent, do you have any idea?

Mr. KECK. Well, if you just look at the Medicaid expenses in terms of administering the program on the fee-for-service side, it is about 3–1/2 percent. On the managed care side it is about 9–1/2 percent with a percent of that at risk, but that additional expenditure is because they are managing the care better.

Mr. MURPHY. So when that is being, rather than that being seen as three times the cost and they manage the care better, there is an actual difference in improved health care outcomes when they specifically coordinate that care of that patient?

Mr. KECK. Absolutely. I mean, on an annual basis, our legislature requires that we compare the cost of our managed care programs on a per-member per-month basis to that of the fee-for-service program, and even with the additional costs, managed care is cheaper than fee-for-service and it produces better outcomes.

Mr. MURPHY. One of the things I look upon, when the managed care movement hit in the 1990s, I didn't care much for it because much of that was managed money and not managed care. That is why I like it at more as coordinated care where physicians and nurses are in charge of decisions.

Let me ask another way this can be coordinated. The Federally Qualified Community Health Centers, can you tell me how your

State may work with them with Medicaid to make sure, because I am concerned, a lot of people on Medicaid don't really have a primary person they keep going to as their home. Too often their lives are disrupted. They go from person to person to person. Can you give me as an example if that is something you work with in your State to help coordinate that?

Mr. KECK. Absolutely. I mean, in a broad sense, we are working with all primary care providers. We are now making patient-centered medical home incentive payments. If you become certified, you get a per-member, per-month bump to encourage people to become certified and eventually we will convert that into broader care management payments to these folks. But specific to the Federally Qualified Health Centers, I think when we talk about the rates of uninsurance, we forget that in most States we have very robust networks of Federally Qualified Health Centers that were chartered to serve these folks, and we spend a lot of money on them and are a great resource, and this year in South Carolina we are actually putting quite a bit of additional investigation, probably the largest single investment that has been made by the State in the history of the Federally Qualified Health Centers to expand the presence of those and their ability to work with patients.

Mr. MURPHY. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Virgin Islands, Dr. Christensen, for 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Just for informational purposes, I noted from a Kaiser report that in 2001, there were 36.6 million people enrolled in Medicaid, and by 2009, there was as many as 62.9 million. That was the year that President Obama took office. Just for informational offices.

Dr. Thompson, as a person who worked with some of my colleagues when we were drafting the Affordable Care Act who advocated for everyone to participate in the exchange including those who were previously on Medicaid, I was really pleased to read and hear from you that you are transitioning to premium assistance, and so you are really demonstrating flexibility and the support over the last 3 years of CMS and the Department. So I want to applaud Arkansas's creativity and I want to say that I enjoyed being in Little Rock last year when the University of Arkansas and the Clinton Foundation joined several of us in having the conference on health disparities in Little Rock last year. So thank you for that.

Are you using navigators of any kind as you plan that transition? Because many of the Medicaid beneficiaries would not have much experience in going to a private insurance market.

Dr. THOMPSON. Since the action of our general assembly, we have actually increased the number of navigators our health insurance department planned to hire on a short-term basis to reach the lower-income community, communities of color, those that are Medicaid eligible in a more successful way. We are also looking at information we now have inside the Department of Human Services, for example, parents of children that are on the Our Kids program so that we may have already determined who is likely to be eligible for the private option, if you will, through the exchange that we have already done an income eligibility assessment.

Mrs. CHRISTENSEN. And when we were talking about this back 4 years ago or so, there was concern about wraparound services in Medicaid that might be lost. Are you seeing that your Medicaid patients would lose anything by going to the exchange?

Dr. THOMPSON. This is one of the issues that we are in negotiations with CMS about. All of the Medicaid eligibles are eligible for wraparound services. However, a majority don't use those. They are able-bodied, working individuals that are just low income, and so it is those individuals that we anticipate putting into the private market, letting them have a private experience, not be, if you will, managed by the State, but for those whom the private market is not going to be best mechanism, we will retain them in the State Medicaid program, assure them of the wraparound services and make sure that they get the guaranteed benefit as required under federal law.

Mrs. CHRISTENSEN. Thank you. And in the wake of the Newtown shooting, again to Dr. Thompson, last fall, and the recent shootings in Santa Monica, our Nation remains concerned with access to mental health services to people with mental illness. Congress passed mental health parity legislation in 2008 and additional provisions were included ensuring parity for mental health services in the Affordable Care Act. A significant barrier to access is, of course, not having health insurance, so how do you anticipate the Medicaid expansion will help Arkansas to address the issue of access to mental health services and what challenges do you see in the State for improving that access?

Dr. THOMPSON. Yes, I believe the requirements under the essential benefit plan of the Affordable Care Act and our actions on the Medicaid program to buy into that essential benefit plan will singularly help both the mental health and the substance abuse community because it brings to true parity finally the financing mechanism for those services. It will have an effect on our workforce. We are going to have to look at the organization of our mental health workforce to make sure they are in the right place because rural Arkansas does not have as deep a bench when it comes to that workforce but I think financial barriers have been the number one reason we haven't had the right providers and the right place at the right time, and through we are trying to solve that first barrier.

Mrs. CHRISTENSEN. Thank you, and I am sure you have seen this report by NAMI, the National Alliance for Mental Health, titled "Medical Expansion and Mental Health Care." They quote an analysis by SAMHSA that shows that if all States proceed with expanding Medicaid, as many as 2.7 million people with mental illness who are currently uninsured could get coverage that includes almost 1.3 million with serious mental illness, and Mr. Chairman, I would like to submit this report for the record.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mrs. CHRISTENSEN. Thanks. I also want to agree with your statement, Dr. Thompson, that caps of any kind are a risk to the beneficiary, and I would like to add my own point of view that not setting the FMAP according to the jurisdiction's average income also presents a risk, and I want to thank the committee for, one, in-

creasing our cap in the territories although we did not remove it entirely but I am still asking the committee to help me in passing my bill to change the match to give the territories State-like treatment. It costs nothing to the federal government but it saves lives and decreases the risk for our beneficiaries.

Thank you. I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentlelady and now recognize the gentlelady from North Carolina, Mrs. Ellmers, for 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you to our panelists today for this important subcommittee hearing.

I am a representative of North Carolina. North Carolina has chosen not to opt in to the Medicaid expansion, and I applaud that decision that Governor McCrory and the State legislature made. Just to quote Governor McCrory, "The federal government must allow North Carolina to come up with its own solutions." It is a $13 billion program and he refers to it routinely as "broken", and because of that does not want to expand a system that is in much need of fixing.

So with that, and again, I appreciate your testimony today on this issue, I have a question for Ms. Verma and Dr. Thompson in relation to what Director Keck has basically said in his testimony, notes that he sees an opportunity for bipartisan agreement that States need more flexibility to manage programs locally in exchange for more accountability to improve health and reduce costs. Ms. Verma and Dr. Thompson, do you agree that Washington's approach, you know, this far with Medicaid is outdated, and do you also believe that States have the ability that they can with outcome measures and greater flexibility improve care and reduce costs?

Ms. VERMA. Yes, I do.

Mrs. ELLMERS. Thank you.

Dr. THOMPSON. I think the whole health care system is going through a great transition and that States are bringing innovative ideas. I think this Administration and the new Center for Innovation has 41 different models for States to choose from, and I think the partnership between the federal and State government should be maintained because that is how we are going to get the whole U.S. health care system to a different place.

Mrs. ELLMERS. I also have a question, Mr. Keck, for you. In South Carolina, I know that South Carolina is working with CMS right now on integrating physical and long-term care services for 65,000 enrollees. Can you speak to the status of those negotiations and maybe give a little bit of a timeline where we may go with that in implementation?

Mr. KECK. Well, we are very supportive of the dual integration to manage Medicaid and Medicare patients together under a cap, I might add, per member. We have a good working relationship with the Office of Dual Eligibles and are working hard on that, but to be honest, it is a very, very slow process. I think that is the experience that most States have encountered, and it is primarily because of working with the particular restrictions that Medicare has on the program, but we hope to get to a memorandum of understanding by the end of this month or the end of July and go live by the middle of 2014, which is about 6 months behind schedule,

but we think it is a good effort, and it is a needed effort. The dual eligibles are a very large portion of our expenditures, and for both Medicare and Medicaid, we have been doing great disservice to the taxpayers and to the individuals to not manage these folks together.

Mrs. ELLMERS. I agree. Thank you so much.

And my last question, I have about a minute left. Ms. Verma, can you elaborate a little more on some of the innovations that your State is making right now to improve upon the Medicaid system?

Ms. VERMA. I work with a lot of different States, so it is kind of hard specifically, but I will take the Indiana example because I think that is the one that I have worked extensively, and I think other States are looking at Indiana because of some of the innovations it has done. I think what they have really done, as we discussed earlier, is trying to empower the individual and have the individual as part of the equation. I think some of the cost sharing policies are where Indiana and other States are seeking waivers, and it is not—you know, the cost-sharing policy is not to burden the individual or to, you know, try to ration care or limit them from getting care. I think it is to incentivize them and to empower them to be a part of the equation. And so I think that that is where a lot of States are very interested in those types of programs that really do put that individual in the position of focusing on prevention, focusing on outcomes, and I think a lot of the programs, you know, that are based on the physicians—we have talked a lot today about outcomes and physician outcomes. Well, the individual has to be a part of that. The physician is not going to be able to achieve those without it, and I think outcomes are also not just for the physicians but even for States, and we need to hold states accountable for outcomes as well, and so we need to align the providers, the individuals and States together in the same direction.

Mrs. ELLMERS. Thank you so much for your testimony, and I see my time is expired. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Well, thank you, Mr. Chairman, and thank you very much to the panel today.

Over the past decades, the federal-State partnership that is Medicaid has evolved and it has changed into more of a managed care system. More States have adopted managed care. CMS has been granted great flexibility for States to tailor managed care Medicaid services.

I am concerned, though, that we lose some control to the managed care companies, some accountability. Could you all give me your opinion and identify the most effective waiver conditions, oversight initiatives in the states to ensure that our tax dollars actually go to medical care and health services and not to excessive administrative costs or to excessive profits for insurance companies and HMOs?

Ms. VERMA. I think there are a lot of strategies that States can take in their managed care contracting, and it all has to do with how that contract is set up. I think they can put in medical loss ratio requirements that would limit the amount of dollars that are

spent on administration and on profit. There are outcomes measures, and I think that is one of the main differences between State government and contracting out with a managed care company is that you can require outcomes of managed care companies. You can have standards for access, standards for maternal and child health outcomes in terms of low-birth-weight babies. You know, whatever a State wants to attach to the contract, they can in terms of outcomes, and that is something that you don't have with, say, government with its regular fee-for-service within the Medicaid program there is no accountability for the outcomes they achieve.

Dr. THOMPSON. I would concur with Ms. Verma. I would add, I think it is important to start with what the beneficiaries' needs are and make sure that the outcome indicators, the expectations of the managed care plan, a managed care plan that covers both an urban and a very rural area, network adequacy is an important issue so that access issues become important, and I think in the 30, 35 States that have large rural areas, an important aspect is, how are we going to actually manage care in a decentralized, relatively fragmented health care system.

Mr. KECK. I would agree with both those statements. We have had much better luck actually assuring network adequacy in our State working with our managed care companies because they are able to negotiate individual rates and so if they are having a hard time getting a doctor in a particular area, they can pay more. We can't do that through our fee-for-service program. So we are very specific and spent a lot of time understanding our network through geo coding and so on. And we also put our plans at financial risk now for outcomes, and they have both incentives and they have withholds.

Ms. CASTOR. So if they drop the ball, they are not providing the services. Are there penalties built into the waiver conditions or the contracts, and are you aware of States really holding their feet to the fire and providing proper oversight?

Mr. KECK. We don't operate our managed care under a waiver but through the contracts, we do hold their feet to the fire, and the amount of potential penalty that we have this year on our managed care plans could potentially be their entire profit margin, and so we are moving forward very aggressively with that. Some States are even more aggressive. But again, we clearly measure our outcomes and our cost per member per month, and we know that managed care, coordinated care is making a difference. We think there is a long way to go in terms of better managing care on the ground but this is the tool to do it.

Ms. CASTOR. Dr. Thompson?

Dr. THOMPSON. I think we are taking a little bit different, maybe a next-generation approach with our payment improvement initiative. We are asking the lead provider to manage the clinical risk and to have financial incentives, upside and downside, while we are retaining the actuarial risk, kind of the chance that somebody who has a hip replacement also has a heart attack back with the insurance company or with the State. So I think both are actually trying to put alignment of financial incentives with the outcomes that the State, the Medicaid program, the federal government de-

sire, and I think we need to probably accentuate the sharpness of our knife that we start looking.

Ms. CASTOR. In Arkansas, do you all have managed care or waiver for the elderly population, skilled nursing and services that keep folks out of—because Florida is about to embark on privatization of managed care for that population. That is news to us. All of the providers are scared to death. They don't want to go through a gatekeeper. What has your experience been?

Dr. THOMPSON. We have not used a third party, a managed care entity, to exercise that option. We do have a waiver, our home- and community-based service waiver, that allows the family to use the allocated resources that would have been spent inpatient in a nursing home for skilled or family-assisted living to help them stay at home. So we have a waiver in place. It is actually high sought after by our families to keep their loved one at home. It does not use a third-party manager in a manager care type of arrangement.

Ms. CASTOR. Thank you very much.

Mr. PITTS. The chair thanks the gentlelady. I recognize the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman. I appreciate that.

According to the CBO, Medicaid will cost the federal government $5 trillion over the next 10 years with as much as $638 billion of that directly linked to the expansion of Medicaid from PPACA. Recently, the Governor of my State, Governor Bob O'Donnell, laid out the need for vast reform to make Virginia's Medicaid program more cost-effective before the Commonwealth can consider an expansion. The State legislature set up a system where they can consider expansion if these reforms are met, and there were five tenets that he laid out for Medicaid reform: one, service delivery through efficient market-based system including more managed and coordinated care; two, reducing financial burdens to the State by getting assurance from the federal government that expansion will not increase the national debt; three, maximize the waivers that currently exist to achieve administrative efficiency through streamlining of payment and service delivery; four, obtain buy-in from health care stakeholders in the State for statewide reform; and five, achieve greater flexibility by changes to federal law including value-based purchasing, cost sharing, mandatory engagement in wellness and preventive care, the development of high-quality provider networks and flexibility around essential health benefits. That is a mouthful. The bottom line is, these reforms that Virginia is now discussing are on part with the plan laid out by Chairman Upton and Senator Hatch to provide States with more flexibility to implement their Medicaid programs in a way that makes sense for them while better controlling costs.

Ms. Verma, how do you feel about these Medicaid reforms that Virginia is currently exploring? What can we do to help the States better service the vulnerable populations that need Medicaid while giving the States the flexibility that improves the quality of their program, promotes access and gets costs under control?

Ms. VERMA. I think that Virginia has all the right elements there. I think they have covered the span of identifying incentives for providers and individuals but I think the key part there is that they are going to need flexibility from the federal government to

implement those pieces, so that will be a critical component. But I think they have the required elements of a reform package.

Mr. GRIFFITH. So you think that that is a good first step?

Ms. VERMA. I think it is a good approach. I am, you know, glad to hear that they have also included the individual in that piece. I think that is important. They have got the providers. They are looking at the benefits. And I think they also recognize the important role that the federal government plays in this to making that happen.

Mr. GRIFFITH. Now, as a part of that flexibility for the States, how do you feel about the situation where, you know, yes, we want to reward folks for doing the right things but what if they consistently do the wrong things? Do you think there ought to be some kind of a stick that can also be applied in that flexibility if somebody continually goes to the most expensive health care provider because they just don't seem to care that they are running up the cost?

Ms. VERMA. Absolutely, but you have to use those sticks appropriately. You have to be mindful of the population. I think that the carrots and sticks work differently, the different populations. I think a disabled population, those are a little bit harder to apply. However, as we are talking about Medicaid expansion and able-bodied individuals, I think those are probably more appropriate populations that those could be effective.

Mr. GRIFFITH. And that does make sense.

For everyone, there is always a lot of debate around when States can and cannot implement cost sharing. From your perspectives, when does cost sharing work and what can be done to really allow the customization of cost sharing at a local level?

Ms. VERMA. I think cost sharing needs the most work. I know CMS did put some proposed rules out that increased the cost-sharing levels. I think it is a very rigid structure. It only requires copays. There is no opportunity to enforce premiums for people below 100 percent of poverty. There is no flexibility to do value-based where you would be able to vary the copays depending on the types of services. And I think the enforcement piece of critical. I mean, what happens with copays and the way that they have it structured is that it ends up being a decrease in the provider reimbursement because providers can't collect it.

Mr. GRIFFITH. And let me go to the others. I only have about 45 seconds left.

Mr. KECK. I will add to that. My hospitals would be remiss if to that particular question about cost sharing, I didn't mention that we need to do some reforms to EMTALA because EMTALA has turned into sort of a blanket reason to be able to use the emergency room without regard for appropriate use.

Mr. GRIFFITH. Sure. Dr. Thompson?

Dr. THOMPSON. I think we are on a path to change the Administration's proposed rule, which we have incorporated into our private option. It is on the right path. I think it is a complex system, and at some point, cost sharing, if you are only making $6,000 a year, does become a barrier to access. The other piece that we have had to work with on our providers and our workforce strategy, if you are working an hourly job and the doc is only open 8 to 5, you

are going to end up going to the emergency room. So we need our docs have an after-hours clinic and weekend clinics where people are going to do exactly what you would expect them to do. They are not going to lose an hour's wage to go to the doctor in the middle of the day when they can go to the emergency room at night. So this is part of a total system change. It involves workforce, it involves access, and most importantly, it does involve finance.

Mr. GRIFFITH. I thank you all for being here. Mr. Chairman, I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman. I yield my 5 minutes to Dr. Burgess.

Mr. BURGESS. I thank the gentleman for yielding.

Dr. Thompson and Mr. Keck, really to both of you, there seems to be a good deal of antipathy toward the fee-for-service system, and yet the fee-for-service system is what many doctors have grown up with, what we rely upon. I would submit—and I realize that the Medicaid system is not directly analogous to the food stamp system but I suspect that if you tried to do a food stamp system that was not fee-for-service based, taking the basket to the marketplace and not paying a fee for every service that you loaded into the cart would be problematic. Is that an unfair observation?

Mr. KECK. Well, I think fee-for-service is not universally the cause of all our problems, and there is actually within the system places where you want to use fee-for-service to encourage volume and productivity, and there are other areas where you want to use bundled payments and capitation and so on to encourage parsimony in the use of services.

Mr. BURGESS. Dr. Thompson, do you have an observation on that?

Dr. THOMPSON. Yes. I would just offer, our payment improvement still pays claims in the same way that we did under a fee-for-service system, so we are still paying providers for the care at the point of delivery when they have care. What we have done is, we have put a quarterback on the team that now has the responsibility for the outcome.

Mr. BURGESS. Let me ask you a question about that. Is the quarterback always a physician? You referenced prenatal care. Is the quarterback always the OB doctor in that instance?

Dr. THOMPSON. The quarterback has been decided by our multipayer effort to date consistently. It is the provider who has the most influence on the system, the most ability to make change and the most financial interest. It is usually the physician. With respect to congestive heart failure readmission rates, it is the index hospital because they know when they are discharging the patient and——

Mr. BURGESS. But they own all the doctors now so there is no—it has to be the hospital. There is no other entity to be identified.

Well, you know, when I think about the food stamp system and the Medicaid system, when I go to my market at home and I am behind someone in line who has the Lone Star code, which in Texas is the food stamp, the way that is utilized, there oftentimes will be

a brief discussion between the cashier and the individual buying the products, and, you know, they have identified out of a large bill, here is a certain number of dollars of things you have picked up that are not covered and you will have to pay cash for those, and there is no effort to embarrass the person. It is just simply they pay the dollars that are required. Why would it be hard to construct a system like that within the Medicaid system? That is, the patient comes and in fact some of the bill could be borne by the patient. You referenced the harshness of copayments or people who would have to pay some of their own money, but it seems like there has got to be a happy medium there where some additional money can be brought to the system by the person who is ultimately utilizing the system.

Dr. THOMPSON. Well, let me use your food stamp example. Our payment improvement effort is like sending a nutritionist through the aisle with the patient, with the individual, so we are actually putting a nutritionist with that food stamp recipient as they buy their food. To your issue on sharing, that is exactly what the Affordable Care Act does through the exchange. We set an essential benefit plan. There is a tiered level of coinsurance, co-risk that decreases the lower a family's income is. What we have done in our State is, we have layered one more layer underneath that that says for the poorest of the poor, we will put some cost sharing in place but we are going to offer some protections.

Mr. BURGESS. And let me ask you a question about the concept of premium support because, I mean, to some degree that has gotten a bad rap here in Congress. It is called a voucher, and it is talked about in a derogatory term, but it sounds like you are using that to your advantage. Premium support is part of your so-called private option. Is that not correct?

Dr. THOMPSON. We believe, our Republican leadership and our Democratic Governor believes using the private sector with competition for provider rates and with competition for patients essentially is the best way to consider expanding Medicare because it is not a traditional State Medicaid expansion. It does not have the cliff of people then wanting to stay on Medicaid and not moving to private insurance.

Mr. BURGESS. Let me ask you this, because Dr. Murphy asked a question about the Federally Qualified Health Centers. The liability coverage is handled differently in a Federally Qualified Health Center. Texas several years ago experimented with providing the first $100,000 of liability coverage to a provider who was doing a certain percentage of Medicaid in their practice. Have you looked at that in Arkansas as a possibility? You need to bring providers into the system. Most of us recognize that it is that first $100,000 of liability that is where the real vulnerability exists. Medicaid patients do sometimes carry higher liability risk. Have you looked at that in Arkansas?

Dr. THOMPSON. We have not looked at that as a way of recruiting providers. We have a relatively high provider participation rate because we use electronic payment within 72 hours of service delivery. So our discounted prices we have combated with increased cash slow and responsiveness to treatment, but that has been our

tool. I think your suggestion would be very open to our medical society and probably our Medicaid program.

Mr. BURGESS. Is that something you are willing to look at?

Dr. THOMPSON. I would be glad to.

Mr. BURGESS. Thank you.

Mr. Chairman, I have a series of questions on Medicaid as the payer of last resort. I guess the appropriate think would be to submit that for the record because I would like each of you to respond to that. The Government Accountability Office did a study back in 2006 and looked at the States that were collecting from—that were covered under Medicaid but also had simultaneous coverage under either an individual plan or a group plan. For each of your States, it is about a 10 percent rate of people who are covered, have dual coverage, and I would just be interested in your thoughts as you expand managed care, are we going to make that problem worse, and how can we get at—I mean, when you talk of $750 billion a year, 10 percent of that is a lot so we really ought to attempt to—we can't just leave that money on the table. If it is owed by private insurers, it should be paid by private insurers. But I will submit that in writing. I would each of your responses to that.

And finally, Mr. Chairman, I would like to ask unanimous consent to put into the record an article from the New England Journal of Medicine titled The Oregon Experiment: Effects of Medicaid on Clinical Outcomes.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. That concludes the questions from the members. The members will have additional questions that we will ask them to submit in writing. We will ask the witnesses to please respond promptly.

Thank you very much for your testimony today, and let me remind members, they have 10 business days to submit questions for the record, and members should submit their questions by the close of business on Wednesday, June 26.

It has been a very informative hearing. Thank you very much. Without objection, the subcommittee is adjourned.

[Whereupon, at 11:50 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Testimony

Expanding Medicaid Is the Best Financial Option for States

Carter C. Price

RAND Office of External Affairs

CT-393

June 2013

Testimony submitted before the House Energy and Commerce Committee, Subcommittee on Health June 12, 2013

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Carter C. Price[1]
The RAND Corporation

Expanding Medicaid Is the Best Financial Option For States[2]

Before the Committee on Energy and Commerce
Subcommittee on Health
House of Representatives

June 12, 2013

In a study we recently published in the June edition of the journal Health Affairs, Christine Eibner – an economist at RAND – and I used the RAND COMPARE microsimulation model to estimate the likely effects if 14 states choose not to expand Medicaid under federal health care reform. Among the measures studied were the impacts of Medicaid expansion on insurance coverage, federal payments into the states and state spending on care for the uninsured.

The states studied were Alabama, Georgia, Idaho, Iowa, Louisiana, Maine, Mississippi, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas and Wisconsin. Although governors in additional states oppose expanding Medicaid, the 14 states in the study were the first whose governors said they would not expand Medicaid. At the time of the analysis, these were seen as the least likely to expand Medicaid.

We found that states that choose not to expand Medicaid under federal health care reform will leave millions of their residents without health insurance and increase spending, at least in the short term, on the cost of treating uninsured residents.

If 14 states decide not to expand Medicaid under the Affordable Care Act as intended by their governors, our analysis found that those state governments collectively will spend $1 billion more on uncompensated care in 2016 than they would if Medicaid is expanded.

In addition, those 14 state governments would forgo $8.4 billion annually in federal payments and an additional 3.6 million people will be left uninsured.

Our analysis showed it is in the best economic interests of states to expand Medicaid under the

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[2] This testimony is available for free download at http://www.rand.org/pubs/testimonies/CT393.html.

terms of the federal Affordable Care Act. States that do not expand Medicaid will not receive the full benefit of the savings that will result from providing less uncompensated care.

Furthermore, these states will still be subject to the taxes, fees and other revenue provisions of the Affordable Care Act, without reaping the benefit of the additional federal spending which will costs those states economically.

Last summer's U.S. Supreme Court ruling on the Affordable Care Act gave states the ability to block the law's expansion of Medicaid, the federal-state program that provides health insurance to low-income families. The Affordable Care Act provides support to expand Medicaid to include families that earn up to 138 percent of the federal poverty level.

The federal government will pay a much larger share of costs for the Medicaid expansion than it does for current Medicaid enrollees. It will cover 100 percent of the costs for expanding Medicaid beginning in 2014 through 2016, and then gradually decrease support to 90 percent of costs beginning in 2020. The federal government currently pays an average of 57 percent of the cost of Medicaid.

Our study found that the cost to states for expanding Medicaid generally would be lower than the expense state and local governments will face for providing uncompensated care to uninsured residents after implementation of the Affordable Care Act.

We estimate that increased insurance coverage triggered by health reform will reduce state and local spending on uncompensated medical care by as much as $18.1 billion annually across all states. Those savings may continue beyond 2020, when the states' share of Medicaid costs plateaus.

Our study suggests that changes could be made to the Affordable Care Act to help some people targeted by the Medicaid expansion to get health insurance coverage through other means. Those options include a smaller expansion of Medicaid or changes in the new state insurance exchanges to allow more poor people to purchase private health insurance.

The study shows the alternatives could help provide health insurance to some people targeted by the Medicaid expansion. But none of the options examined would provide health coverage to as many people as full Medicaid expansion.

We also outlined how failing to expand Medicaid could have more than financial consequences.

Based on a 2012 study in the New England Journal of Medicine showing that past expansions of Medicaid have led to decreases in deaths, we estimate that an additional 19,000 deaths could occur annually if the 14 states studied do not expand Medicaid.

Support for our study was provided by RAND's Investment in People and Ideas program, which combines philanthropic contributions from individuals, foundations, and private-sector firms with earnings from RAND's endowment and operations to support research on issues that reach beyond the scope of traditional client sponsorship.

RAND Health is the nation's largest independent health policy research program, with a broad research portfolio that focuses on health care costs, quality and public health preparedness, among other topics.

Medicaid Expansion & Mental Health Care

NAMI

National Alliance on Mental Illness

www.nami.org/healthcoverage

Medicaid Expansion and Mental Health Care
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NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

Acknowledgements and Gratitude
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Medicaid Expansion and Mental Health Care

Introduction

The tragic shooting in Newtown, Connecticut and others have stimulated public discussion about the failed mental health system in America. After cuts of nearly $4.35 billion to public mental health programs from 2009-2012[1], mental health services simply are not available to many Americans who need help. With fewer than half of Americans who live with mental illness getting any treatment[2], concern is growing about lack of access to mental health services. People are asking, "Where can I get mental health services if I don't have health insurance and can't afford care?"

As of the date of publication of this report, only 20 states and the District of Columbia have committed to expanding their Medicaid programs. The facts are clear – six out of ten Americans living with serious mental illness have no access to mental health care at all. Glaring gaps in treatment of this kind would not be tolerated for heart disease, cancer or diabetes and they should not be tolerated for mental illness either. States that decline to expand Medicaid will miss as good an opportunity as they may ever have to address this shameful void in access to mental health treatment. See Appendix V to check the status of Medicaid expansion in your state.

Hoping to improve access, some lawmakers are pledging to invest in mental health care. One significant step that states can take is to extend Medicaid to 138 percent of the Federal Poverty Level (FPL), an option available to states as a result of the health reform law, the Patient Protection and Affordable Care Act (ACA).

Medicaid is the most important source of financing for mental health services in America today, offering mental health services that would otherwise be out of reach for low-income people affected by mental illness. Medicaid's role in mental health care has increased, and today the federal/state health financing program pays for nearly half of all publicly-funded mental health services.

Expanding Medicaid will fill critical gaps in access to health and mental health care, reduce uncompensated crisis care and pave the way to recovery and economic self-sufficiency for millions of Americans.

A broad array of vital mental health services and supports are covered by Medicaid. For many, like Sharon's son, Medicaid mental health services are life-changing:

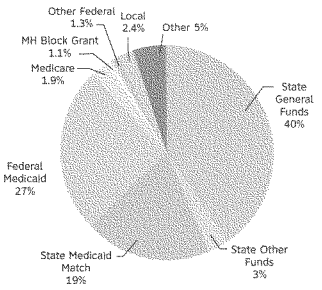
"Three years ago, my son was in a very dark place. He was flunking out of school and living a life of seclusion. He holed up in his room while the rest of the family walked on eggshells. Today, he is a completely different person. It took three years of counseling and finding the right medication for his bipolar disorder, but we did it. If we didn't have Medicaid, I don't know where he would be right now. He not only is doing fantastic in school and life, he has begun to really talk about his illness. He wants other kids to know that there is nothing to be ashamed of." – Sharon

A Snapshot of Medicaid Mental Health Benefits

Medicaid is a life-saving program that provides health and mental health care to low-income children, pregnant women, families, people 65 or older, and certain people with disabilities. Medicaid is particularly important for children and adults with mental illness, offering vital services and supports that are typically not covered by private insurance.

Medicaid is the most important source of funding for mental health services. In 2008, 46 percent of state controlled funds for mental health services came from Medicaid.

[1] Joel E. Miller, et al., November 2012. "The Waterfall Effect: Transforming the Cascading Impact of Medicaid Expansion on States," National Association of State Mental Health Program Directors.
[2] Substance Abuse and Mental Health Services Administration. (2012). Results from the *2010 National Survey on Drug Use and Health: Mental Health Findings*



State Mental Health Agency Controlled Revenues for Mental Health, FY 2008. National Association of States Mental Health Program Directors

Unfortunately, millions of low-income Americans with mental illness are currently shut out of Medicaid, excluded from the care that would help them rebuild their lives. This leaves many people without access to needed mental health services and supports.

"I was diagnosed with bipolar disorder in 2009. I'm trying to find help but it seems impossible. I called about Medicaid and was told that unless I'm over 65 or have kids, there's no chance of me getting it. That about sums it up." – Jessica

Most importantly, many states cover a broad array of community mental health services and supports in their Medicaid programs that are rarely, if ever, covered by private insurance. Although most Medicaid mental health services are optional, many states cover these services because it is well known that they enhance recovery from mental illness and prevent the horrendous, costly circumstances that occur when people living with mental illness do not receive needed treatment and supportive services. In addition to these "optional" Medicaid services, federal law requires state Medicaid programs to provide physician care, laboratory services, partial hospitalization and, for children under 21, Early and Periodic Screening, Diagnosis and Treatment (EPSDT).[3]

Medicaid programs employ many strategies to address the high rate of chronic medical conditions and early mortality among adults with serious mental illness.[4] Some of the current strategies include health homes, Accountable Care Organizations, co-location of health and mental health clinics, cross-training and credentialing of mental health and primary care providers and electronic medical record sharing.[5]

Impact of Medicaid Expansion on People Living with Mental Illness

For uninsured people living with mental illness, the impact of Medicaid expansion will be significant. If all states proceed with expanding their Medicaid programs, as many as 2.7 million people with mental illness who are currently uninsured could be added to the Medicaid rolls, according to the Substance Abuse and Mental Health Services Administration (SAMHSA).[6] For state-by-state estimates of people living with mental illness who could be added to Medicaid through expansion, see Appendix II.

"My mother was recently diagnosed with schizophrenia. She finally has medication that is working, but this is after a year and a half and four hospital visits. She needs some kind of coverage so badly, but she was turned down for disability. Sad stuff, but I guess you just have to keep fighting." – Tabitha

Expanding Medicaid Keeps People From Falling Through the Cracks

There are currently many Americans living with mental illness who do not have access to health insurance. Many of these individuals go without needed treatment. The consequences can be tragic.

[3] Federal law requires state Medicaid programs to provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT). This benefit is designed to ensure early assessment of children to identify the existence of illnesses, including mental illness. States are required to provide the treatment necessary for Medicaid eligible children to improve from the illnesses detected in the periodic screening process.

[4] Institute of Medicine. (2006) *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.* Washington, DC. National Academies of Sciences, 2006.

[5] Garfield, R (Sep. 2011) Financing Mental Health Care: A Primer. Kaiser Commission on Medicaid and the Uninsured. Accessed 4/3/13 http://www.kff.org/medicaid/upload/8182.pdf.

[6] Substance Abuse and Mental Health Services Administration. (n.d.) *Enrollment under the Medicaid Expansion and Health Insurance Exchanges. A Focus on Those with Behavioral Health Conditions in each State.* http://www.samhsa.gov/healthreform/enrollment.aspx.

7.6 million
Emergency department visits were for mental illness in 2007.
1 in 8
were uninsured.

- Over 7 million emergency department visits a year are made by people living with mental illness and more than one in eight is uninsured.[7]
- Mood disorders are the third most common reason children and adults to age 44 are hospitalized.[8]
- There are more than 38,000 suicides every year in America—more than double the number of homicides.[9]
- Over one in five people in jail and prison live with a mental illness. Many of these individuals would not have come into contact with criminal justice systems had they received timely and effective treatment.[10,11]
- 70 percent of young people in juvenile facilities have a diagnosable mental health condition.[12]

Expanding Medicaid will help people get mental health services before their symptoms get worse and they experience debilitating, or even tragic, outcomes.

Expanding Medicaid, a springboard to recovery

Medicaid coverage helps people stay healthy. A recent study of Medicaid expansion in Oregon found that people enrolled in Medicaid see their doctors more often, get more preventive care and report better health and financial stability.[13] A *New England Journal of Medicine* study found that expanding Medicaid reduces the death rate for adults, particularly for minorities and people living in low-income areas.[14]

Expanding Medicaid helps people get back to work and become self-sufficient. Many people living with mental illness want to work, but are afraid of losing their Medicaid coverage. By expanding Medicaid, people can go back to work yet stay in mental health care by transferring to a qualified health plan offered through their state's health insurance marketplace.

"For many of the people in the expansion population, particularly young people with mental illness or substance abuse problems, the new health coverage is expected to rapidly change their earning ability. You'll see many of them rocket out of poverty. If their treatments are interrupted because they lose Medicaid coverage, it could send them back into a downward spiral."
- Matt Salo, Director, National Association of Medicaid Directors[15]

In addition, expanding Medicaid will help many people who are reluctant to sign up for disability benefits or who experience challenges with an often daunting disability process. In states that expand Medicaid, it will be easier for people to get and keep coverage for mental health services.

[7] Pamela L. Owens, Ph.D., et al, July 2010. "Mental Health and Substance Abuse-Related Emergency Department Visits among Adults," Agency for Healthcare Research and Quality.
[8] LM Wier (Thompson Reuters), et al, 2011. "HCUP Facts and Figures: Statistics on Hospital-based Care in the United States, 2009," Agency for Healthcare Research and Quality.
[9] J.L. McIntosh, January 2012. "U.S.A. suicide: 2009 official final data," American Association of Suicidology.
[10] Kathleen Skowyra and Joseph J. Cocozza, Ph.D., June 2006. "A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System," National Center for Mental Health and Juvenile Justice.
[11] Doris J. James and Lauren E. Glaze, September 2006. "Mental Health Problems of Prison and Jail Inmates," Bureau of Justice Statistics Special Report.
[12] Teplin, L., Abram, K., McClelland, G., Dulcan,M., and Mericle, A. (2002). "Psychiatric disorders in youth in juvenile detention." *Archives of General Psychiatry*, 59, 1133-1143.
[13] Amy Finkelstein & Sarah Taubman & Bill Wright & Mira Bernstein & Jonathan Gruber & Joseph P. Newhouse & Heidi Allen & Katherine Baicker, 2012. "The Oregon Health Insurance Experiment: Evidence from the First Year," The Quarterly Journal of Economics, Oxford University Press, vol. 127(3), pages 1057-1106. Web. http://www.nber.org/papers/w17190.
[14] Benjamin D. Sommers, M.D., Katherine Baicker, Ph.D. and Arnold M. Epstein, M.D., September 2012. "Mortality and Access to Care among Adults after State Medicaid Expansions, New England Journal of Medicine, vol. 367, pages 1025-1034. http://www.nejm.org/doi/full/10.1056/NEJMsa1202099.
[15] Vestal, C. (Mar. 22, 2013) Ohio, Arkansas May Provide New Model For Insuring Low-Income Residents. Kaiser Health News. Accessed: 4/3/2013: http://www.kaiserhealthnews.org/Stories/2013/March/22/medicaid-expansion-private-insurance-states.aspx.

"After being diagnosed with schizoaffective disorder at the age of 19, I didn't know where to turn. I wasn't aware of mental illness and the impact it could have. I faced a long, uphill battle for years, including hospitalizations, homelessness and jail. I was reluctant to apply for SSI (Supplemental Security Income) because I didn't want to admit that I had a disability, but SSI and Medicaid have allowed me to get treatment and live a dignified life in the community." – Matthew

"I currently get Medicaid for mental health services, but it hasn't been so easy to accomplish. I have had to file for SSI benefits, go for evaluations and repeat every six months just to maintain my meds for bipolar disorder. This is an area that needs to improve." – Walter

Expanding Medicaid, a boost to state and local economies

Expanding Medicaid will bring federal dollars into state economies – dollars that are desperately needed to rebuild mental health services. State and local governments will save millions in reduced costs for uncompensated care as more people get health coverage. Federal dollars will pay 100 percent of the cost through 2016 for people who are eligible for Medicaid under new eligibility rules. Federal support will taper to 90 percent in 2020 and beyond, leaving states with only 10 percent of the cost.

If all states expand Medicaid eligibility they would get an estimated additional $800.2 billion in federal support from 2013 to 2022, over and above normal Medicaid growth.[16] At the same time, states would realize savings of $18.3 billion in reduced uncompensated care costs.[17] The increase in federal funds to states and uncompensated care savings will create jobs, generate economic activity and increase state and local tax revenues. For a chart showing the fiscal impact of Medicaid expansion on a state-by-state basis, see Appendix I.

4

Medicaid Expansion: Fiscal Impact 2013-2022

States	Increase in federal dollars	Uncompensated care savings
California	$68,750	$1,901
Florida	$66,113	$1,254
Texas	$65,619	$1,712
New York	$56,107	$426
Ohio	$53,341	$876

Medicaid Expansion: Challenges and Opportunities for Advocates

As described above, Medicaid expansion has many potential benefits for people living with mental illness and for society as a whole. However, people living with mental illness, families and advocates will face significant challenges in ensuring that Medicaid expansion will prove to be all that it can be.

- **Medicaid expansion in all states.** After last year's U.S. Supreme Court decision on the ACA, states now have the option of deciding whether or not to expand their Medicaid programs. As discussed above, states that do not expand their Medicaid programs will forfeit millions of dollars in federal subsidies. Despite this, only 20 states and the District of Columbia have committed to expanding their programs as of the date of publication of this report.

- **Coverage of evidence-based mental health services and supports in Medicaid expansion plans.** Although Medicaid will become available for millions of Americans who are currently not covered, there are no guarantees that these expanded Medicaid programs will cover the array of evidence-based mental health treatments and services that are covered in many existing Medicaid programs. The ACA specifies that Medicaid expansion plans must

[16] John Holohan, Matthew Buettgens, Caitlin Carroll and Stan Dorn, Stan, November 2012. ". (November 2012). *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis.* Kaiser Commission on Medicaid and the Uninsured.
[17] *Ibid.*

meet "benchmark" or "benchmark equivalent" standards that are modeled after private insurance plans. Medicaid expansion plans modeled on private insurance may limit coverage to traditional medical services such as inpatient treatment, outpatient counseling and medications. Services such as Assertive Community Treatment (ACT), psychiatric rehabilitation and housing supports, which are covered in many existing Medicaid programs, may not be covered.[15]

NAMI Policy Recommendation

Cover evidence-based mental health services in Medicaid expansion plans. Evidence-based mental health treatment and services have been identified with proven effectiveness in fostering recovery and preventing relapse. These include ACT, cognitive behavioral therapy (CBT), integrated treatment for mental illness and substance use disorders as well as others. These effective interventions are frequently covered by traditional (existing) Medicaid programs and should be covered in Medicaid expansion plans and in policies offered through state health insurance marketplaces.

NAMI calls upon the U.S. Department of Health and Human Services (HHS) to define a single comprehensive Essential Health Benefit in 2016 that ensures that an appropriate range of specific services are covered in every plan.

- **Exemptions for "medically frail" individuals, including adults with serious mental illness and children with serious emotional disturbances.** The ACA specifies that individuals who are "medically frail" or have "special medical needs" are exempt from mandatory enrollment in more limited Medicaid expansion plans. This includes "adults with serious mental illness" and "children with serious emotional disturbances."

Medically frail individuals, including those with mental illnesses, must be provided with the full benefits available in traditional Medicaid programs at the enhanced federal Medicaid matching rates designated in the Affordable Care Act.

- **The "welcome mat" effect.** When the ACA goes into effect in the states in 2014, it is expected that significant numbers of people will be identified who are already eligible for Medicaid but have never enrolled. Some states have raised concerns about this "welcome mat effect" (also referred to as the "woodwork effect") for fear that they will incur higher financial burdens. In fact, enrolling these individuals in Medicaid will have long term benefits associated with timely treatment and reduced medical or psychiatric emergencies.

- **Outreach and enrollment.** In states that expand their Medicaid programs, millions of uninsured individuals, including many living with mental illness, could be added to the Medicaid rolls. Enrolling all who are potentially eligible will present a formidable challenge, particularly for populations that are traditionally hard to reach. These populations include persons living with mental illness who are homeless, hospitalized, incarcerated or otherwise limited in access to information and services.

NAMI Policy Recommendation

Implement strategies to enroll hard to reach individuals living with mental illness in Medicaid expansion plans. The Centers for Medicare and Medicaid Services (CMS) recently announced the availability of $56 million to support navigators to help provide information to health care consumers about options available through state health insurance marketplaces, Medicaid and Children's Health Insurance (CHIP) programs. NAMI urges CMS to award navigator contracts to mental health agencies or advocacy organizations to conduct education, outreach and enrollment of hard to reach children, youth and adults with mental illness, including those who are in hospitals, homeless or involved with criminal justice systems.

- **State compliance with the EPSDT mandate.** States are required under Medicaid law to provide Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) for all children and youth enrolled in the Medicaid program. The EPSDT

[15] For a list of services that NAMI regards as essential for adults living with serious mental illness, see Array http://www.nami.org/Content/ContentGroups/Policy/Adult_Array.pdf. For a list of services that NAMI regards as essential for children and youth living with mental illness, see Array http://www.nami.org/Content/ContentGroups/Policy/C&A_Array.pdf.

mandate requires mental health screening for all Medicaid enrolled children and youth. If the screening shows signs of emerging mental illness, a further assessment must be provided along with all medically necessary mental health services and supports needed to effectively treat the mental illness. The early detection of mental illness and substance use disorders is important in the overall health of a child and helps to reduce and eliminate the long-term effects of these conditions. However, only a small number of states fully comply with the EPSDT mandate.

NAMI Policy Recommendation

Monitor states and provide guidance to ensure full compliance with the EPSDT mandate. Significant national attention has focused on the need for the early identification of emerging mental illness and early intervention. Guidance and technical assistance are needed from CMS to help states understand the scope of the EPSDT mandate, especially when it comes to mental health screening and the broad array of mental health services and supports that must be provided. CMS has issued some guidance to states, but far more is needed to help states understand how to create effective mental health screening programs. CMS should also monitor states to ensure that they are in full compliance with the broad EPSDT mandate.

- **Mental health and addictions parity.** The Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act of 2008 requires insurance plans that offer coverage for mental illness and substance use disorders to provide these benefits in a no more restrictive way than all other medical and surgical benefits. The ACA extended these requirements to all individuals and small employer health insurance plans offered through state health insurance exchanges as well as non-managed care Medicaid expansion plans. Final regulations defining the specific scope of mental health and addictions parity requirements have not yet been issued but are expected to be released before the end of 2013.

- **The Medicaid IMD exclusion.** When the Medicaid program was first created in 1965, the federal law contained a provision excluding coverage of treatment in freestanding psychiatric hospitals known as Institutions for Mental Diseases (IMDs). The policy was driven both by ideology, specifically the desire to incentivize community mental health treatment, and economics. Today, the IMD exclusion in Medicaid remains in effect and is one factor contributing to lack of inpatient beds for acute or emergency psychiatric treatment. The ACA authorized funding for Medicaid Emergency Psychiatric Demonstrations, a pilot project evaluating whether Medicaid "can support higher quality care at a lower cost" by reimbursing private psychiatric hospitals for acute psychiatric inpatient services. Grants have been awarded to 11 states and the District of Columbia to implement the demonstration projects.[19]

NAMI Policy Recommendation

Abolish the IMD exclusion. Preventing Medicaid reimbursement for psychiatric treatment of individuals between the ages of 22 and 64 in IMDs is outmoded and discriminates against people who require inpatient psychiatric care. It is time for Congress to eliminate the IMD exclusion and allow Medicaid dollars to be used for a range of effective mental health services, including inpatient treatment when needed.

- **Medicaid Health Homes.** The ACA created an option for states to establish Health Homes to better coordinate care for people with chronic conditions, including serious mental illness. Health Homes are not physical structures but are rather mechanisms for integrating primary and specialty care in a coordinated fashion for people with chronic illnesses. States are afforded flexibility in how they design these systems and receive an enhanced 90 percent

[19] Center for Medicare and Medicaid Innovation, "Medicaid Emergency Psychiatric Demonstration," http://innovation.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/.

federal Medicaid match for the first two years of implementation.[20] A number of states have implemented or are considering implementing Health Homes, with particular focus on serving individuals with serious mental illness.[21]

- **A new wave of privatization in Medicaid**
  Privatization of Medicaid is not a new concept. It dates back to the 1990s with the trend toward Medicaid managed care, but several states are considering new privatization arrangements as a way to implement Medicaid expansion. Specifically, some states are considering an approach called premium assistance, in which Medicaid funds are used to purchase private health insurance. To qualify, these plans must offer a set of benefits equivalent to the benchmark Medicaid expansion plan established in the state and must not cost beneficiaries any more in copays than they would owe under a more traditional Medicaid approach.

Conclusion

Medicaid is fundamental to mental health care in America. Medicaid coverage allows mental illness to be treated early, before symptoms worsen. Services available through Medicaid, and sometimes nowhere else, enable people who have been disabled by mental illness to rebuild their lives. When untreated, the human and fiscal impact of mental illness is felt. It is felt not only in uncompensated care costs for emergency room visits and psychiatric hospitalization, but also in school failure, reduced productivity, increased incarceration, homelessness and lost lives. By contrast, Medicaid coverage helps people with mental illness get services, stay healthy and contribute to the vitality of their communities.

In the aftermath of Newtown, many politicians and policy makers have promised to take steps to fix America's broken mental health system. Expanding Medicaid in all states would represent a significant step towards keeping those promises. For people living with mental illness, Medicaid expansion, including adequate coverage and aggressive enrollment strategies, can make the difference between dependency and independence, between misery and dignity. Now is the time to deliver on these promises.

"I have severe mental illness which requires ongoing therapy and medication. Without Medicaid, I would not be able to come close to affording my monthly cost of these much needed services. I am thankful for Medicaid and hope others have access to quality mental health services as well." – Nikkol

[20] Medicaid.gov, "Health Homes," http://www.medicaid.gov/Medicaid-CHIP-Program-information/By-Topics/Long-Term-Services-and-Support/integrating-Care/Health-Homes/Health-Homes.html.
[21] For an example of one such model, see Missouri Department of Mental Health, "Health Care Home," http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm.

Appendix I

Medicaid Expansion: Fiscal Impact 2013-2022

State	Increase in federal dollars [1]	Uncompensated care savings [2]
Alabama	$14,371	$512
Alaska	$1,458	$38
Arizona	$10,701	$50
Arkansas	$12,465	$257
California	$68,750	$1,901
Colorado	$10,308	$277
Connecticut	$8,159	$222
Delaware	$1,927	$18
District of Columbia	$852	$18
Florida	$66,113	$1,254
Georgia	$33,711	$726
Hawaii	$3,294	$101
Idaho	$3,280	$97
Illinois	$21,756	$953
Indiana	$17,322	$562
Iowa	$3,909	$13
Kansas	$5,270	$149
Kentucky	$17,832	$451
Louisiana	$15,786	$267
Maine	$3,124	$120
Maryland	$12,253	$178
Massachusetts	$7,270	–$1
Michigan	$17,512	$351
Minnesota	$5,597	$49
Mississippi	$14,499	$400
Missouri	$17,795	$385
Montana	$2,088	$56
Nebraska	$3,063	$97
Nevada	$5,620	$210
New Hampshire	$2,417	$62
New Jersey	$15,366	$296
New Mexico	$4,926	$104
New York	$56,107	$426
North Carolina	$39,638	$1,350
North Dakota	$2,357	$52
Ohio	$53,341	$876
Oklahoma	$8,561	$205
Oregon	$12,842	$280
Pennsylvania	$37,842	$878
Rhode Island	$2,935	$51
South Carolina	$15,827	$543
South Dakota	$2,110	$62
Tennessee	$22,541	$494
Texas	$65,619	$1,712
Utah	$5,274	$101
Vermont	$1,026	$5
Virginia	$14,665	$424
Washington	$8,406	$119
West Virginia	$8,744	$281
Wisconsin	$12,263	$247
Wyoming	$1,353	$28
United States	**$800,245**	**$18,308**

[1] Source: Holohan, John, Buettgens, Matthew, Carroll, Caitlin and Dorn, Stan. Kaiser Commission on Medicaid and the Uninsured. (November 2012). The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis. (Table 6).
[2] Source: Holohan, John, Buettgens, Matthew, Carroll, Caitlin and Dorn, Stan. Kaiser Commission on Medicaid and the Uninsured. (November 2012). The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis. (Table 14).

Appendix II

Medicaid Expansion Eligibility: Any Mental Illness*			
State	Medicaid eligibility: 2013 Childless adults (% of Federal Poverty Level)	Medicaid expansion: % of uninsured (ages 18-64 with any mental illness)	Medicaid expansion # of uninsured (ages 18-64 with any mental illness)
Alabama	Not eligible	22.6%	78,691
Alaska	Not eligible	16.8%	5,722
Arizona	100% FPL (closed)	11.7%	49,318
Arkansas	Not eligible[3]	23.2%	54,997
California	Not eligible[4]	10.4%	256,202
Colorado	10% FPL (closed)	12.2%	34,027
Connecticut	55% FPL	19.3%	18,216
Delaware	100% FPL	24.2%	6,795
District of Columbia	200% FPL	10.8%	1,536
Florida	Not eligible	15.9%	244,272
Georgia	Not eligible	10.2%	86,058
Hawaii	133% FPL	10.5%	3,229
Idaho	Not eligible[5]	20.9%	22,806
Illinois	Not eligible	12.1%	82,467
Indiana	Not eligible**	22.3%	86,574
Iowa	Not eligible[6]	21.0%	25,286
Kansas	Not eligible	13.2%	21,293
Kentucky	Not eligible	20.0%	64,608
Louisiana	Not eligible	17.0%	59,320
Maine	Not eligible**	21.4%	8,805
Maryland	Not eligible[7]	8.4%	16,425
Massachusetts	Not eligible[8]	6.3%	5,753
Michigan	Not eligible**	19.9%	105,352
Minnesota	75% FPL[9]	30.1%	42,918
Mississippi	Not eligible	16.2%	42,312
Missouri	Not eligible	15.5%	53,637
Montana	Not eligible	16.7%	9,886
Nebraska	Not eligible	30.1%	24,309
Nevada	Not eligible	13.2%	26,489
New Hampshire	Not eligible	15.0%	6,470
New Jersey	Not eligible[10]	10.0%	33,340
New Mexico	Not eligible**	11.2%	19,093
New York	100% FPL[11]	13.2%	96,825
North Carolina	Not eligible	12.8%	87,624
North Dakota	Not eligible	11.1%	2,850
Ohio	Not eligible	24.1%	136,765
Oklahoma	Not eligible[12]	20.1%	59,043
Oregon	Not eligible**	18.9%	50,231
Pennsylvania	Not eligible	14.2%	68,544
Rhode Island	Not eligible	20.0%	8,881
South Carolina	Not eligible	21.2%	72,038
South Dakota	Not eligible	21.3%	8,490
Tennessee	Not eligible	20.4%	83,312
Texas	Not eligible	11.2%	255,086
Utah	Not eligible**	20.3%	28,033
Vermont	150% FPL[13]	23.3%	2,934
Virginia	Not eligible	22.3%	76,974
Washington	Not eligible**	10.4%	36,427
West Virginia	Not eligible	22.1%	27,713
Wisconsin	Not eligible**	20.0%	42,287
Wyoming	Not eligible	17.9%	4,321
United States			**2,744,582**

[1] Source: http://www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4&print=1.
[2] Source: Substance Abuse and Mental Health Services Administration. (n.d.) *Enrollment under the Medicaid Expansion and Health Insurance Exchanges. A Focus on Those with Behavioral Health Conditions in each State.* http://www.samhsa.gov/healthreform/enrollment.aspx.
[3] Arkansas offers limited subsidized coverage for individuals below 200% FPL who work for a qualifying, participating employer.
[4] California extends limited Medicaid coverage to adults up to 133% FPL.
[5] Idaho offers premium assistance to adults up to 185% FPL who work for a qualified small employer.
[6] Iowa extends limited coverage to adults up to 200% FPL.
[7] Maryland offers primary care services to childless adults.
[9] Massachusetts extends limited Medicaid coverage to certain childless adults to 100% FPL; adults up to 300% FPL are eligible for more limited subsidized coverage.
[9] Minnesota extends limited Medicaid coverage to adults to 200% FPL.
[10] New Jersey offers coverage to childless adults; the limit is $140 per individual or $210 for individuals who are unemployable.
[12] New York extends Medicaid coverage to childless adults to 78% FPL.
[13] Oklahoma offers limited subsidized coverage to adults meeting certain conditions up to 200% FPL.
[14] Vermont extends coverage to childless adults to 150% FPL; limited subsidized coverage is offered to adults up to 300% FPL.
* The term *any mental illness (AMI)* is defined by SAMHSA as "currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association [APA], 1994). Adults who had a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having AMI."
** State offers limited coverage or subsidies to higher incomes, but enrollment is closed to adults with no children.

Appendix III

Medicaid Expansion Eligibility: Serious Mental Illness*

State	Medicaid eligibility 2013 Childless adults	Medicaid expansion % of uninsured	Medicaid expansion # of uninsured
Alabama	Not eligible	13.5%	47,006
Alaska	Not eligible	2.7%	920
Arizona	100% FPL (closed)	4.1%	17,282
Arkansas	Not eligible[4]	10.8%	25,602
California	Not eligible[4]	4.4%	108,393
Colorado	10% FPL (closed)	5.0%	13,945
Connecticut	55% FPL	10.2%	9,627
Delaware	100% FPL	15.0%	4,212
District of Columbia	200% FPL	5.3%	754
Florida	Not eligible	7.8%	119,832
Georgia	Not eligible	3.2%	26,998
Hawaii	133% FPL	4.4%	1,353
Idaho	Not eligible[5]	11.4%	12,440
Illinois	Not eligible	4.9%	33,396
Indiana	Not eligible**	15.2%	59,010
Iowa	Not eligible[6]	11.3%	13,606
Kansas	Not eligible	3.9%	6,291
Kentucky	Not eligible	10.0%	32,304
Louisiana	Not eligible	8.5%	29,660
Maine	Not eligible**	9.1%	3,744
Maryland	Not eligible[7]	2.1%	4,106
Massachusetts	Not eligible[8]	N/A[13]	N/A[14]
Michigan	Not eligible**	9.5%	50,294
Minnesota	75% FPL[9]	18.9%	26,948
Mississippi	Not eligible	7.8%	20,373
Missouri	Not eligible	7.5%	25,954
Montana	Not eligible	8.9%	5,269
Nebraska	Not eligible	11.4%	9,207
Nevada	Not eligible	4.2%	8,428
New Hampshire	Not eligible	7.7%	3,321
New Jersey	Not eligible[10]	5.9%	19,670
New Mexico	Not eligible**	4.3%	7,330
New York	100% FPL[11]	4.3%	31,541
North Carolina	Not eligible	3.8%	26,013
North Dakota	Not eligible	4.7%	1,207
Ohio	Not eligible	12.4%	70,369
Oklahoma	Not eligible[12]	8.3%	24,381
Oregon	Not eligible**	10.2%	27,109
Pennsylvania	Not eligible	6.4%	30,893
Rhode Island	Not eligible	11.2%	4,973
South Carolina	Not eligible	12.7%	43,155
South Dakota	Not eligible	5.4%	2,152
Tennessee	Not eligible	7.9%	32,263
Texas	Not eligible	5.7%	129,820
Utah	Not eligible**	8.5%	11,738
Vermont	150% FPL[13]	15.9%	2,002
Virginia	Not eligible	11.5%	39,695
Washington	Not eligible**	5.1%	17,863
West Virginia	Not eligible	10.8%	13,543
Wisconsin	Not eligible**	12.2%	25,795
Wyoming	Not eligible	14.6%	3,525
United States			**1,285,313**

[1] Source: http://www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4&print=1.
[2] Source: Substance Abuse and Mental Health Services Administration. (n.d.) *Enrollment under the Medicaid Expansion and Health Insurance Exchanges. A Focus on Those with Behavioral Health Conditions in each State.* http://www.samhsa.gov/healthreform/enrollment.aspx.
[3] Arkansas offers limited subsidized coverage for individuals below 200% FPL who work for a qualifying, participating employer.
[4] California extends limited Medicaid coverage to adults up to 133% FPL.
[5] Idaho offers premium assistance to adults up to 185% FPL who work for a qualified small employer.
[6] Iowa extends limited coverage to adults up to 200% FPL.
[7] Maryland offers primary care services to childless adults.
[8] Massachusetts extends limited Medicaid coverage to certain childless adults to 100% FPL; adults up to 300% FPL are eligible for more limited subsidized coverage.
[9] Minnesota extends limited Medicaid coverage to adults to 200% FPL.
[10] New Jersey offers coverage to childless adults; the limit is $140 per individual or $210 for individuals who are unemployable.
[11] New York extends Medicaid coverage to childless adults to 78% FPL.
[12] Oklahoma offers limited subsidized coverage to adults meeting certain conditions up to 200% FPL.
[13] Vermont extends coverage to childless adults to 150% FPL; limited subsidized coverage is offered to adults up to 300% FPL.
[14] Data suppressed due to imprecision.
* The term *serious mental illness (SMI)* is defined by SAMHSA as "a designated term for persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities."
** State offers limited coverage or subsidies to higher incomes, but enrollment is closed to adults with no children.

Appendix IV

Race/Ethnicity Medicaid Expansion Eligible Uninsured Adults with Serious Mental Illness				
State	**Non-Hispanic White**	**Non-Hispanic Black**	**Other**	**Hispanic**
Alabama	72%	23%	1%	4%
Alaska	65%	2%	30%	3%
Arizona	59%	3%	10%	28%
Arkansas	78%	14%	2%	6%
California	45%	6%	11%	38%
Colorado	73%	4%	4%	19%
Connecticut	67%	12%	7%	14%
Delaware	64%	25%	2%	10%
District of Columbia	43%	42%	4%	12%
Florida	62%	18%	3%	18%
Georgia	59%	28%	3%	10%
Hawaii	49%	2%	46%	4%
Idaho	88%	1%	3%	8%
Illinois	60%	19%	5%	16%
Indiana	85%	9%	1%	5%
Iowa	87%	4%	3%	7%
Kansas	81%	6%	4%	9%
Kentucky	89%	7%	2%	3%
Louisiana	60%	34%	2%	3%
Maine	95%	1%	4%	0%
Maryland	54%	30%	5%	11%
Massachusetts	72%	9%	7%	13%
Michigan	81%	13%	2%	4%
Minnesota	75%	11%	7%	7%
Mississippi	61%	36%	1%	3%
Missouri	83%	12%	2%	3%
Montana	90%	0%	8%	1%
Nebraska	82%	5%	3%	10%
Nevada	65%	8%	7%	21%
New Hampshire	95%	1%	3%	1%
New Jersey	53%	14%	9%	23%
New Mexico	40%	2%	22%	36%
New York	55%	15%	10%	19%
North Carolina	66%	19%	3%	11%
North Dakota	77%	3%	19%	2%
Ohio	85%	12%	1%	3%
Oklahoma	77%	6%	9%	8%
Oregon	85%	2%	4%	10%
Pennsylvania	78%	14%	3%	5%
Rhode Island	74%	9%	3%	13%
South Carolina	65%	28%	1%	7%
South Dakota	70%	2%	26%	2%
Tennessee	80%	13%	1%	6%
Texas	47%	12%	4%	37%
Utah	79%	1%	5%	14%
Vermont	98%	0%	2%	0%
Virginia	70%	18%	4%	7%
Washington	77%	3%	8%	13%
West Virginia	95%	3%	1%	1%
Wisconsin	81%	8%	4%	7%
Wyoming	87%	0%	7%	6%

[1] Source: http://www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4&print=1.
[2] Source: Substance Abuse and Mental Health Services Administration. (n.d.) *Enrollment under the Medicaid Expansion and Health Insurance Exchanges. A Focus on Those with Behavioral Health Conditions in each State.* http://www.samhsa.gov/healthreform/enrollment.aspx.
[3] Data from Massachusetts is suppressed due to imprecision.

Appendix V

State Medicaid Expansion*
May 20, 2013

State	Medicaid Expansion
Alabama	No
Alaska	No
Arizona	Pending
Arkansas	Yes
California	Yes
Colorado	Yes
Connecticut	Yes
Delaware	Yes
District of Columbia	Yes
Florida	No
Georgia	No
Hawaii	Yes
Idaho	No
Illinois	Yes
Indiana	Pending
Iowa	Pending
Kansas	Pending
Kentucky	Yes
Louisiana	Pending
Maine	Pending
Maryland	Yes
Massachusetts	Yes
Michigan	Pending
Minnesota	Yes
Mississippi	No
Missouri	No
Montana	Pending
Nebraska	No
Nevada	Yes
New Hampshire	Pending
New Jersey	Yes
New Mexico	Yes
New York	Yes
North Carolina	No
North Dakota	Yes
Ohio	Pending
Oklahoma	No
Oregon	Yes
Pennsylvania	No
Rhode Island	Yes
South Carolina	Pending
South Dakota	No
Tennessee	Pending
Texas	Pending
Utah	Pending
Vermont	Yes
Virginia	Pending
Washington	Yes
West Virginia	Pending
Wisconsin	No
Wyoming	No

* Data derived from Vestal, C. (2013, May 20). *Medicaid Expansion by the Numbers.* Stateline. http://info.pewtrusts.org/site/R?i=H-gJtTalArWoXJqCQmzK9Q

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SPECIAL ARTICLE

The Oregon Experiment — Effects of Medicaid on Clinical Outcomes

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BACKGROUND

Despite the imminent expansion of Medicaid coverage for low-income adults, the effects of expanding coverage are unclear. The 2008 Medicaid expansion in Oregon based on lottery drawings from a waiting list provided an opportunity to evaluate these effects.

METHODS

Approximately 2 years after the lottery, we obtained data from 6387 adults who were randomly selected to be able to apply for Medicaid coverage and 5842 adults who were not selected. Measures included blood-pressure, cholesterol, and glycated hemoglobin levels; screening for depression; medication inventories; and self-reported diagnoses, health status, health care utilization, and out-of-pocket spending for such services. We used the random assignment in the lottery to calculate the effect of Medicaid coverage.

RESULTS

We found no significant effect of Medicaid coverage on the prevalence or diagnosis of hypertension or high cholesterol levels or on the use of medication for these conditions. Medicaid coverage significantly increased the probability of a diagnosis of diabetes and the use of diabetes medication, but we observed no significant effect on average glycated hemoglobin levels or on the percentage of participants with levels of 6.5% or higher. Medicaid coverage decreased the probability of a positive screening for depression (−9.15 percentage points; 95% confidence interval, −16.70 to −1.60; P=0.02), increased the use of many preventive services, and nearly eliminated catastrophic out-of-pocket medical expenditures.

CONCLUSIONS

This randomized, controlled study showed that Medicaid coverage

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TABLE 1

Characteristics of the 12,229 Survey Respondents.

TABLE 2

Mean Values and Absolute Change in Clinical Measures and Health Outcomes with Medicaid Coverage.

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generated no significant improvements in measured physical health outcomes in the first 2 years, but it did increase use of health care services, raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.

The findings and conclusions expressed in this article are solely those of the authors and do not necessarily represent the views of the funders.

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Members of the Oregon Health Study Group are listed in the Supplementary Appendix, available at NEJM.org.

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July 3, 2013

Ms. Seema Verma, MPH
SVC, Inc.
485 Bolderwood Lane
Carmel, IN 46032

Dear Ms. Verma:

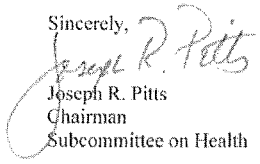
Thank you for appearing before the Subcommittee on Health on Wednesday, June 12, 2013, to testify at the hearing entitled "The Need for Medicaid Reform: A State Perspective."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Friday, July 19, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

The Need for Medicaid Reform: A State Perspective

Responses to Committee on Energy & Commerce -Subcommittee on Health
Prepared By Seema Verma
SVC, Inc.

The Honorable Joseph R. Pitts

1. **Most states have implemented Medicaid managed care to some degree, but there remain certain areas of the program that do not have much managed care penetration, such as long-term care and behavioral health. Obviously, there are valid concerns about these especially vulnerable populations, but as Medicaid costs continue to balloon, do you see a need for more managed care in these areas? If so, what kind of rules, if any, should the Congress or the Administration give states with regard to Medicaid managed long-term care and/or behavioral health? Are there particular state programs that serve as an effective model for how to implement managed care in these areas of Medicaid?**

   Medicaid managed care is an effective tool to achieve a variety of quality goals such as improved coordination of care and reduction in duplication of services. Managed care has also been utilized by states because it can provide budget certainty and assure adherence to specific goals and quality measures that may not exist in state run programs. Managed care can drive quality improvements due to introducing competition into the marketplace allowing health plans (MCOs) to compete for members by providing the best quality services at the most cost-effective price for the state. Managed care also allows the state to leverage private market innovation and introduce best practices to the Medicaid population. These innovations need to be paired with safeguards to assure that beneficiaries are appropriately served, quality is maintained, and utilization management efforts are not burdensome to providers. In managed care, the state retains control and has the ability to sanction or terminate MCOs that are not up to par with state standards giving even further focus on quality outcomes and compliance.

   These strategies can be successfully implemented by states to manage behavioral health and long term services and supports and should be encouraged. States have been increasingly turning to Medicaid managed long-term services and supports (MLTSS) with 26 states projected to have such a program by 2014.[1] Program design varies significantly across states with different approaches such as which populations are included, whether enrollment is mandatory and what services are covered under the managed care arrangement.

[1] Truven. (2012). The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update. Retrieved online: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf

The variation of program design across states is due in part to the current delivery system, funding mechanisms and political factors which vary across states. For example, MLTSS target populations are receiving services from a variety of providers and agencies; there may be multiple entities, providers and case managers engaged in managing care. Additionally, these services and provider types have complex funding mechanisms which vary by state and influence what services are carved-out, what populations are enrolled, how rates are set and how services are coordinated. Provider availability and the urban versus rural make-up of the state are also key factors in considering managed care. Due to the complexities and variation across states, the federal government must ensure rules are flexible and allow states options to develop programs which are aligned with the unique characteristics of their state, delivery system and financing models.

There are many examples of successful managed care programs, and there are key characteristics of an effective program that should be encouraged in all models. This includes reimbursement and payment structures that require adherence to quality and operational metrics and penalties for non-compliance. Contracts that include pay-for-performance, shared savings or capitation withholds and bonuses are also effective tools to assure quality. Additionally, where appropriate based on enrollee needs, program design should facilitate the use of home and community based services over reliance on institutional services. Program design should also facilitate comprehensive and integrated care to reduce the fragmentation of service delivery with sufficient flexibility to respond to unique enrollee needs.

The federal authority to operate an MLTSS program is very complex and can include a combination of waivers and Medicaid State Plan amendments. Typically the state is required to select an authority for managed care such as a Section 1115, 1915(b) or 1915(a) waiver as well as an authority for the long term services and supports such as Section 1915(c), 1915(i) or 1915(j). The selection of the operating authority is based on the program design and policy options selected by the state. This creates a lengthy and cumbersome approval process. Reform efforts should include allowing maximum state flexibility with a streamlined federal approval process.

Additionally, states must be given more flexibility to operate these programs. For example, there are complex Medicaid managed care regulations regarding populations which may be mandatorily enrolled, limits placed on cost-sharing and requirements on the number of plans that must be offered. Additionally, disabled children and duals are exempt from mandatory enrollment. States may seek waivers for these requirements, but as previously discussed this poses a significant burden. Each state has unique characteristics and must be given the flexibility to implement managed care accordingly, taking into account considerations such as rural versus urban issues and the prevalence of managed care entities within the state.

Finally, Medicaid managed care strategies should be hinged on quality outcomes. It would be helpful for CMS to provide technical assistance by identifying potential measures of quality

related specifically to MLTSS from which states can select measures identified as most appropriate for their program.

2. **Much news has been made in recent months about using Medicaid dollars to enroll individuals in private coverage through the state exchanges. What federal barriers exist for states to exercise this option, and what unanswered questions do states have with regard to premium assistance?**

States looking to use a premium assistance option to cover individuals eligible for Medicaid under the expansion may implement premium assistance either as a Medicaid State Plan option or through an 1115 waiver application. While a few federal barriers and outstanding questions are relevant to both options some requirements are unique to either the Medicaid State Plan premium assistance option or the 1115 waiver option.

Table 1: Federal Requirements to Premium Assistance Options for Individual Market Coverage

Requirements	Medicaid State Plan Premium Assistance	1115 Demonstration Premium Assistance Option
State must allow choice between premium assistance and traditional Medicaid coverage	X	
Burdensome and administratively complex application, reporting, and evaluation requirements		X
Option only available through 2016		X
Cost sharing limitations	X	X
Cost-effectiveness requirements	X	X
Wrap around services and payments	X	X
Coordination with qualified health plans	X	X
Medically Frail	X	X

Medicaid Expansion through Premium Assistance as a State Plan Option: Under the Medicaid State Plan premium assistance option to implement premium assistance for individual market health insurance, whether purchased inside or outside of an Exchange, enrollees must be offered a choice of the premium assistance option for a commercial market plan or coverage through Medicaid. Options implemented through the Medicaid State Plan are not subject to the same burdensome 1115 Waiver reporting and administration requirements; however, the federal requirement to offer individuals eligible for premium assistance through the individual market premium assistance a choice between the commercial market option and Medicaid effectively requires that the implementation of two programs, a premium assistance Medicaid expansion and a traditional Medicaid expansion.

Medicaid Expansion through Premium Assistance as an 1115 Demonstration Wavier Option: Under the 1115 demonstration waiver option a state may apply for a waiver to implement a premium assistance program for coverage in qualified health plans on the state Exchange. Through the waiver, a state may require eligible individuals to enroll into premium assistance for commercial market coverage provided that enrollees have the option of at least two commercial health plans. States apply to the Centers for Medicare and Medicaid Services (CMS) to receive 1115 demonstrations, and as a condition of the receipt of these demonstrations compile quarterly and annual reports for CMS, maintain a waiver program that is budget neutral, and conduct or contract for evaluations of the effectiveness of the innovations of the demonstration. Along with CMS, states have interest in understanding the effectiveness of their demonstrations and, in general, being able to identify what is working and what is not working and targeting areas for improvement are of key importance to all program administrators. However, the 1115 process from the initial application, to the negotiations with CMS, through program administration and reporting, can be a tremendous effort for state Medicaid agencies. Of key concern, is that in addition to the challenges of these requirements, guidance released in relationship to premium assistance demonstrations indicates that only a limited number of these demonstrations will be approved by CMS, that premium assistance demonstrations that are targeted to individuals with income between 100% of federal poverty level (FPL) and 133% of FPL[2] will be more likely to be approved, and that these demonstrations will only be approved through 2016, as states are eligible for innovation waivers beginning in 2017.[3]

Concerns With Premium Assistance Options: Under both Medicaid State Plan and 1115 Demonstration options for implementing Medicaid Expansions through premium assistance in the individual market, states must consider how they will address the restrictive federal cost sharing requirements, the requirement to provide wrap around coverage for Medicaid services that are not provided on the commercial market plan, determinations of cost-effectiveness, coordination with qualified health plans including receiving data for quality reporting, impacts to the qualified health plans on risk adjustment, reinsurance, and risk corridors, and requirements around medically frail individuals.

Cost sharing requirements

For premium assistance on the Medicaid State Plan, cost sharing may be no more burdensome for the enrollee than it would be under the Medicaid State Plan. While state Medicaid cost sharing amounts vary, the maximum amounts states may apply vary by FPL level and service description.

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[2] In 2013, 100% of FPL is $11,490 annually for an individual and $23,550 annually for a family of four; 133% of FPL is $15,282 annually for an individual and $31,322 annually for a family of four.

[3] http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf

Table 2: CMS Allowable Cost Sharing by FPL 42 CFR PART 447

	≤ 100% FPL	101% - 150% FPL	>150% FPL
Outpatient services	$4	10% of cost the agency pays	20% of the cost the agency pays
Inpatient stay	$75	10% of the total cost the agency pays for entire stay	20% of the total cost the agency pays for entire stay
Preferred drugs		$4	$4
Non-preferred drugs		$8	20% of cost the agency pays
Non-emergency use of the emergency department		$8	No Limit
Premiums		Not allowable	Allowable
Combined cost sharing may not exceed 5% of monthly or quarterly income.			

One of the key issues surrounding Medicaid expansion through premium assistance is the requirement that the commercial market health plans charge cost sharing that is no more than the limits under Medicaid. As commercial market health plans are developed to serve commercial market populations and not Medicaid plans, their cost sharing amounts are different than the Medicaid cost sharing amounts, and there is no 'Medicaid' cost sharing variation implemented for plans offered on the Exchange. Thus, implementing any cost sharing for participants under a premium assistance Medicaid expansion in a manner foreseen by CMS presents a challenge for states. Since cost sharing will be different than the CMS allowed amounts on the commercial individual market health plans, states have the options of (1) covering all member cost sharing, and charging cost sharing amounts to members on the back end after examination of claims data or (2) not requiring cost sharing for individuals in premium assistance. The first option is not only operationally difficult for states but also would result in individuals paying a copayment or coinsurance amount with a significant time-lag; this time-lag will make it less likely that members will associate the payment of the cost sharing with the service received and thus works against the intent of cost sharing which is to promote awareness among enrollees of the cost of care. The second option discounts the ability of cost sharing to impact care seeking behavior and potentially creates inequities between populations covered on traditional Medicaid that may be subject to cost sharing and the expansion group covered through premium assistance.

To make premium assistance demonstrations more attractive and more operationally feasible for states, federal policy needs to give states more flexibility in the area of cost sharing. There is a significant federal barrier in implementation of innovations around cost sharing under an 1115 demonstration with states not being able to receive cost sharing waivers for these demonstrations, especially as applies to monthly premiums or enrollment fees for enrollees

with income under 150% FPL. Cost sharing waivers that make the most sense in the context of a premium assistance demonstration are: (1) a waiver of all of the CMS allowable cost sharing amounts for the purpose of allowing the Exchange qualified health plans to charge Medicaid premium assistance enrollees the amounts charged to other enrollees of the same plan variation, limited to the enrollee's 5% of income out-of-pocket maximum amount and (2) implementing individual monthly financial contributions or premiums limited to the enrollees maximum 5% of income out-of pocket amount that could be paid to the Medicaid agency or the qualified health plan and would assure that the enrollee is contributing towards their health. The first option assures that individuals on premium assistance demonstration are treated similarly to individuals with slightly higher incomes covered through Exchange plans and will reduce the learning curve for individuals that churn from Medicaid premium assistance to premium tax credits and cost sharing reductions on the Exchange while simultaneously assuring that Medicaid premium assistance enrollees are protected by the 5% of income out-of-pocket limit. The second option ensures that all enrollees are contributing to their health care without creating additional burdens on qualified health plans to comply with Medicaid cost sharing requirements, or requiring enrollee payment of cost sharing for services after an extensive time-lag. In addition, a required monthly payment in place of the CMS allowable copayment and coinsurance schedule offers more predictable cost sharing for enrollees and required monthly payments may be more affordable for enrollees than the allowable CMS cost sharing amounts. Under this model states have the ability to implement innovative incentive programs that provide for the elimination or reduction of the required monthly cost sharing for the completion of targeted healthy behaviors. Monthly contributions may be a more beneficial and less burdensome implementation of cost sharing under a premium assistance Medicaid expansion for enrollees, states, and qualified health plans.

Wrap Around Services and Payments

For premium assistance Medicaid expansions implemented either through the Medicaid State Plan or through an 1115 demonstration waiver, CMS requires that states provide wrap around services to beneficiaries for benefits that are covered on the Medicaid State Plan but not on the commercial market qualified health plan. The services that may be required to be wrapped around include Early Periodic Screening, Diagnosis, and Testing (EPSDT) for individuals aged 19 and 20, assurance of non-emergency transportation services, and potentially behavioral health services. Individuals enrolled on premium assistance through state Exchange qualified health plans are receiving coverage that is deemed adequate for all individuals that qualify for a premium tax credit or cost sharing reduction. Individuals receiving premium tax credits and cost sharing reductions are not a substantially different population than the Medicaid expansion population that may receive premium assistance. Requiring these wrap around services creates administrative difficulties for states as individuals enrolled in premium assistance through qualified health plans would also have to be issued a Medicaid member card to access wrap around services. The ACA indicated that Medicaid expansion populations should be provided benchmark or benchmark equivalent coverage based on section 1937 of the Social Security Act;

these coverage packages are in general more aligned with commercial coverage than Medicaid coverage. The requirement to wrap benefits for benchmark or benchmark equivalent coverage basically makes this coverage equal to Medicaid coverage instead of being aligned with commercial coverage. This requirement also serves as a disadvantage to participants and may be confusing as they may remain in the same plan but will lose these benefits if their income increases and they become eligible for premium tax credits. In light of this and considering the similarity of the populations, especially the Medicaid expansion population with income from 100% to 133% of FPL that would be eligible for premium tax credits and cost sharing reductions if a state did not expand Medicaid, the requirement to offer wrap around services should be reconsidered.

In addition to the requirement to wrap around services, Medicaid programs that are interested in premium assistance expansions are required to wrap around payments to federally-qualified health centers. In Medicaid, these health centers are required to be paid based on the prospective payment system (PPS) which bases payment on the cost of providing services for the individual health center, not on the established Medicaid fee schedule. This policy assures that these essential community providers have sufficient funds to cover the cost of serving the low income populations. However, in the context of a premium assistance demonstration, this policy becomes redundant. Qualified health plans are required at 45 CFR §156.235(e) to pay federally-qualified health centers at least the Medicaid PPS rate or another mutually agreed upon rate that is not less than the PPS rate. When Medicaid enrollees are served through qualified health plans under premium assistance, any services they receive will already be paid at a minimum of the PPS rate, thus the requirement to wrap around payments to these health centers is an unnecessary. To streamline the process for states seeking premium assistance demonstrations, CMS should make clear that this requirement does not apply to individuals whose services at federally-qualified health centers are reimbursed by qualified health plans.

Coordination with Qualified Health Plans

Qualified health plans on state Exchanges that may be leveraged under a premium assistance expansion in an Exchange are required to meet quality, transparency, benefit, network adequacy and non-discrimination requirements. Qualified health plans may offer coverage to individuals that are eligible for premium tax credits and cost sharing reductions with income at or above 100% FPL. To assure that qualified health plans are willing and able to participate in Medicaid premium assistance demonstrations it is essential to minimize additional reporting or administrative requirements on these plans that are above and beyond what the qualified health plan would be required to report in the Exchange. It is currently unclear exactly what reporting will be required of qualified health plans serving Medicaid premium assistance recipients in an Exchange as CMS has not defined this; the guidance only indicates that 'appropriate data' will be required.[4] However, imposition of burdensome reporting

[4] http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf

requirements on qualified health plans that enroll Medicaid premium assistance enrollees would serve as a federal barrier to implementation of a premium assistance demonstration as qualified health plans may decline to accept Medicaid premium assistance enrollees.

Risk Adjustment, Reinsurance, and Risk Corridors

Risk Adjustment, Reinsurance, and Risk Corridors are programs initiated by the ACA that aim to stabilize premium cost. Risk Adjustment is a permanent program that transfers money from health insurance plans with lower enrollee morbidity to health insurance plans with higher enrollee morbidity and applies to all individual and small group health plans inside and outside the Exchange. Reinsurance is a temporary program that collects funds from all self-insured and fully insured commercial health insurance plans and uses these funds to provide reinsurance for high cost claims to individual market health insurance plans. Risk Corridors is also a temporary program that protects against losses for individual health insurance plans in the Exchange. How these programs apply in the context of utilizing Medicaid to provide premium assistance in Exchanges has not been clarified. For example, will Reinsurance apply for the Medicaid population enrolled into qualified health plans or are Medicaid agencies required to provide a similar program for the qualified health plans for their enrollees? Is the Medicaid population eligible for the Risk Corridor program and will they be included in the Risk Adjustment program? Will the federal government pay for costs related to these programs on behalf of States? For states interested in setting up premium assistance for Medicaid eligible individuals to enroll in state Exchanges these are key questions and without understanding the implications it may be difficult to attain the buy in of qualified health plans.

Medically Frail

All states implementing Medicaid expansions, whether through premium assistance or other methods, are required to come up with a definition for medically frail individuals and assure that these individuals are given a choice between Medicaid expansion coverage and coverage that offers all of the benefits available on the Medicaid State Plan. The importance of providing appropriate services and care coordination to individuals with serious or disabling health conditions is not questioned. Care that is not appropriate for individuals with serious and disabling health conditions can lead to increased cost and decreases in health outcomes. However, the CMS requirements around how states must treat populations considered 'medically frail' make it more difficult for states to appropriately address the needs of these populations.

While not mentioned in the ACA, in promulgating regulations for implementation of Medicaid expansions CMS updated the definition of medically frail individuals to make it more specific. In defining medically frail, based on the final regulations,[5] states must at least include individuals with: (1) a disabling mental disorder, (2) a chronic substance use disorders, (3) serious and

[5] 42 CFR §440.315(f)

complex medical conditions, (4) a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or (5) individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the Medicaid State Plan criteria.

Individuals qualifying as medically frail may not be mandatorily enrolled into an alternative benefit plan that provides less than the Medicaid State Plan benefits states, including the alternative benefit plan that would cover individuals receiving premium assistance in state Exchanges. To meet this requirement, states have to develop processes to identify medically frail individuals at enrollment, and will likely have to develop at least two alternative benefit plans, one indexed to the Medicaid State Plan for medically frail individuals and one indexed to the commercial market essential health benefits for individuals receiving premium assistance. Policies should be explored on how to ensure appropriate care for medically frail individuals though qualified health plans and states should be allowed more flexibility in designing programs for the medically frail. The current policy of requiring a choice between benefits equal to the Medicaid State Plan and the benefits offered to non-medically frail individuals in a Medicaid expansion creates additional complexity for states and enrollees but does not assure the provision of appropriate services to this population.

Cost- Effectiveness

Implementing a Medicaid expansion through premium assistance in the individual market either through the Medicaid State Plan or through an 1115 demonstration waiver requires that the state show that the coverage on the individual market is cost-effective when compared with Medicaid expansion coverage. Traditionally, cost-effectiveness has required that the commercial market coverage is no more expensive than Medicaid coverage, inclusive of administrative costs and any wrap around services or cost sharing. However, due to higher provider reimbursements and administrative costs among state Exchange qualified health plans, total health care costs in a state Exchange plan may be 20% to 40% higher than in a Medicaid operated plan.[6] While covering Medicaid individuals through Exchange plans may have benefits beyond total cost including improved access to providers, improved outcomes related to individuals that churn between Medicaid and Exchange coverage, and greater efficiency overall in the Exchange due to the provision of coverage for more Exchange lives, it is unclear how to incorporate these concepts under a traditional Medicaid premium assistance cost-effectiveness model.

For Medicaid premium assistance expansions implemented through 1115 demonstrations, alternative budget neutrality or cost effectiveness models have been developed that will allow states to include analysis of systematic impacts of premium assistance programs; however, what

[6] http://publications.milliman.com/publications/healthreform/pdfs/considerations-for-medicaid-expansion.pdf

the expectations will be for states regarding reporting and data analysis on cost-effectiveness if a demonstration premium assistance demonstration is approved remains unknown. In general, expectations around the budget neutrality process have been unclear for states seeking 1115 waivers and for all demonstrations CMS needs to provide additional guidance on how the budget neutrality process works and what submissions are required to show budget neutrality.

Outstanding Questions

What cost-effectiveness methodology applies to the Medicaid State Plan premium assistance option?

How will states that are conducting premium assistance demonstrations under 1115 authority, show they have met their cost-effectiveness/budget neutrality requirements over the course of the demonstration?

What provisions around cost sharing may be waived under an 1115 premium assistance demonstration?

What provisions regarding wrap around services may be waived under an 1115 premium assistance demonstration?

How do the Risk Adjustment, Reinsurance, and Risk Corridors apply for qualified health plans that enroll individuals through Medicaid premium assistance?

Recommendations

The following actions would help to ameliorate some of the federal barriers to implementing Medicaid expansion premium assistance options.

- Allow states to mandate enrollment into a Medicaid State Plan premium assistance option for the individual market as they can for premium assistance in the group market.
- Streamline and make more transparent the 1115 application and approval process and the budget neutrality and cost-effectiveness requirements.
- Allow states to review 1115 premium assistance demonstrations for the full demonstration period of 5 years, instead of limited to a coverage period through 2016. Innovation waivers will be available beginning in 2017, however, states will have to invest significant resources into the analysis and development of such waivers.
- Allow for states to use monthly required contributions or premiums for individuals at all income levels, including those with incomes below 150% of FPL.
- Allow states to use the qualified health plans standard cost sharing limited to 5% of income maximum out of pocket as an alternative to CMS allowable cost sharing under premium assistance demonstrations.

- Clarify the provisions that may be waived and those that may not. The granting of waivers is inconsistent at best. One state may receive a waiver of a certain provision and another state may be denied a waiver on the same provision.
- Allow states to be exempt from the requirement to provide wrap around services for EPSDT and non-emergency transportation.
- Clarify that wrap around payments to federally-qualified health centers are not required under a premium assistance option, as qualified health plans are already required to pay at least this rate.
- Clarify reporting expectations for qualified health plans covering Medicaid participants under premium assistance options.
- Clarify the policy around Risk Adjustment, Reinsurance, and Risk Corridors for qualified enrolling individuals through Medicaid premium assistance.
- Provide detail on how cost-effectiveness will be determined through a Medicaid State Plan option and how states will be required to demonstrate ongoing cost-effectiveness under an 1115 premium assistance demonstration.

The Honorable Michael Burgess

1. **In your testimony, you cite reduced provider reimbursement rates as a reason behind the decreasing number of primary care providers willing to accept Medicaid patients.**

   How can the federal government ensure provider rates are set at levels that encourage provider buy-in?

   States have been forced to make the difficult decision to reduce provider reimbursement rates as there are few alternative models under the current regulatory structure available which can provide such short-term and immediate cost-savings. The ACA maintenance of effort (MOE) requires states to maintain eligibility levels. Additionally, there are not many optional benefits to cut. States must also be cautious to ensure that reductions in covered benefits do not lead to shifting care to more expensive settings. For example, cuts in primary care can lead to increased visits to the emergency department.

   States need better tools to manage costs. Any federal efforts to set rates must consider financing and should not be an unfunded mandate placed on states. Strategies designed to better manage care and in turn generate cost savings through improved coordination of care, increased efficiencies and reduction in duplication of services are difficult and lengthy to implement. Specifically, the State Plan Amendment and waiver review process for such program changes are onerous and delay states' ability to realize savings. By reducing the length of time required for these review processes, states would be better positioned to implement innovative management strategies likely to generate cost-savings. This would reduce states' tendency to utilize provider rate cuts as the first go-to strategy for cost-containment.

2. **As one of the major architects of Indiana's Medicaid 1115 Waiver program, "Healthy Indiana", you helped the state implement a consumer-driven approach to Medicaid reform, enabling Medicaid beneficiaries to get a high-deductible health plan and a health savings account.**

   How did this consumer-driven approach to Medicaid affect patient access to providers?

   The state legislation mandates that providers be paid at Medicare rates. One of the goals of requiring these rates (which are higher than those paid to providers for traditional Medicaid enrollees) is to ensure adequate provider network access for HIP members. HIP networks are assessed by State staff on a quarterly basis to ensure primary and specialist adequacy meets standards. If a provider is not available in network within program allowed distances (30 miles for primary and 60 miles for specialists), members are allowed to visit out-of-network providers. This ensures members receive needed care. During the first year of HIP MCOs worked diligently to build networks and continue these efforts on an ongoing basis. No significant gaps in network adequacy exist currently.

   Additionally, outcomes data indicates enrollees are appropriately accessing and utilizing services. Unlike traditional Medicaid, HIP decreases inappropriate ER usage. HIP enrollees pay copayments for inappropriate (non-emergent) ER use. During a 12 month enrollment period, HIP enrollees on average showed a 14.8% decline in non-emergent ER use and increased their physician office visits by 25%, demonstrating that the consumer-driven structure of the plan does not discourage participants from seeking needed care. HIP helps members understand the importance of where and when they seek health care services. Use of care among new and established HIP members over a 6 month time period demonstrates high growth in preventive care and primary care services, and a decrease in non-emergent use of the ER. Data indicates 90% of established enrollees utilize primary care.

   Indiana has received confirmation of the greater access to much needed care provided by the HIP program for uninsured, low income Hoosiers from the managed care organizations for HIP, health care providers, and professional associations representing health care providers.

   For example, the CEO of MDwise, one of the managed care organizations for HIP, reported that the company's market research shows very high member satisfaction with HIP, and 83% of MDwise's HIP members received care as soon as they thought they needed it. In addition, MDwise reported that 76% of its HIP members take medications and are compliant with medication regimens and 96% of members are being treated for a chronic condition: thus, showing that these individuals are getting much needed access to care as compared to before they were enrolled in HIP. Lastly, MDwise informed Indiana that it has received numerous member stories regarding HIP members' access to care that they had not received before enrolling in the program.

3. **Nearly 10% of Medicaid beneficiaries have third-party coverage, in addition to their Medicaid coverage. In these circumstances, the third party payer is required to pay prior to Medicaid, as Medicaid, by statue, is the "payor of last resort." The Deficit Reduction Act of 2005 worked to ensure Medicaid is the payer of last resort by requiring states to amend their Medicaid programs with certain provisions.**
    a. **Are you aware of what challenges states continue to face in recovering third-party payments?**
    b. **What impediments prevent third-party payers from following through on their payments?**

States face a number of challenges with regards to recovering third party payments. These challenges come in the form of administrative and enforcement complexities for the state Medicaid agency, providers, and third party payers.

Medicaid Agency
In order to be in compliance with state and federal laws, Medicaid agencies are required to perform a number of functions that are complex and difficult to enforce. First, agencies must collect information on any third party payers. While other state agencies can provide verification mechanisms (i.e. the Bureau of Motor Vehicles for accident compensation or a Department of Child Services to see if a parent has received health coverage for a child), Medicaid applicants and beneficiaries may not be forthcoming with information about third party payers – especially if they believe that admission of such coverage may jeopardize their eligibility for Medicaid. The state makes efforts to locate member third party liability (TPL) coverage and providers also provide this information at times. However, there is no guarantee that TPL information will be found prior to claims payment.

Once the Medicaid Agency has managed to collect information about these third party payers, they must also capture and process information regarding the third party payer coverage. This coverage may be complex and highly varied from person to person. Before the state Medicaid agency decides to pursue payment from a third party, it should verify that the services or items for which it is requesting payment are also covered by the Medicaid State Plan. If the services are not covered by the Medicaid State Plan, the third party payer is not obligated to provide the Medicaid agency with compensation.

Even when the services or items are covered by the Medicaid State Plan, payment collection can be difficult, as there is rarely any penalty for non-compliant third party payers. In an effort to address this issue, Kentucky has begun to seek implementation of monetary fines and penalties, license suspension, and/or revocation; and the state has classified non-compliance as an unfair trade practice.

Providers

Providers have a set period of time within which they must submit their claims; and many may delay claim submission. When a payment is recovered from a provider, it may not be within the filing deadline, and it would be too late to file a new claim.

Third Party Payers

It is the objective of the third party payers to retain as much of their income as possible, so third party payers impose a number of barriers for Medicaid agencies that would seek to recover funding. Some of these barriers are as basic as refusing to acknowledge that the organization meets the definition of a "third party" as outlined in the Deficit Reduction Act (DRA) legislation. If the organization recognizes that it is in fact a third party payer, it may use HIPAA's privacy focus as an excuse to deny requests for sharing membership files. This denial poses a challenge to Medicaid agencies in spite of a letter from CMS to Patrick Ryan, Illinois Medicaid TPL Director dated July 8, 2009 in which CMS clarified that this sort of data sharing is permissible under HIPAA. Third party payers also resist sharing information with third parties acting on behalf of the state Medicaid agency, such as contractors or managed care entities, in spite of the fact that these parties are supposed to be considered an extension of the state Medicaid agency.

Even when third party payers do acknowledge their beneficiaries and the entity tasked with funding recovery, it can still be difficult for Medicaid agencies to recover all of the funds they should. Information-sharing from third party to Medicaid agency may be incomplete, and service coverage may be sparse, so identifying matches between service provided and service covered by the third party payer may be difficult. In addition, payers may confuse, delay, or halt the recovery process by misusing Prior Authorization denials, requesting additional information, or by simply refusing to respond to recovery requests.

4. **How does the recent increased use of managed care in Medicaid influence third-party liability issues?**

The increased use of managed care has presented state Medicaid agencies with a series of options on how they would like to designate the responsibility of reimbursement recovery from third party payers. While some states have opted to exclude beneficiaries with third party payers from managed care, other states have allowed enrollment with managed care, in which the state may either retain the TPL responsibilities or designate the Managed Care Organization as responsible for recovering compensation from third party payers. In the latter, the state would adjust the capitation payment to recognize other funding sources for provider reimbursement.

Regardless of whether funding recovery is subsequently handled by the state Medicaid agency or the Managed Care Organization, there are some unique challenges to coordinating that funding recovery. For example, in a commercial market, third party coverage may change and claims may be sent to the wrong carrier or contain outdated or incorrect information (i.e. old

group numbers or policy numbers). Third party payers may also fail to provide sufficient information to the claims processor regarding the beneficiary. This means that the recovery efforts may require more extensive research and processing time, which can create a significant administrative burden for the entity attempting to recover funding.

Managed care influences TPL differently state to state. In some states if the recipient has other coverage they cannot be on a Managed Care plan so that the State can recover any TPL savings on the Fee for Service (FFS) recipients. For example, Massachusetts structures their TPL program in this manner today.

In most states where MCO recipients can have other coverage, MCOs are required to perform TPL functions. There may be a lack of incentive for the MCOs to identify TPL and recover as it may reduce their claims and ultimately affect future capitation rate setting. Additionally, many MCOs have a parent company that also has a FFS population. These MCOs may choose not to recover from within their own corporation as they should.

Additionally, in states where Medicaid MCOs have been delegated authority to perform their own TPL identification and recovery, they run into roadblocks collecting from other payers. TPL providers do not recognize the right of the Medicaid MCOs to collect. They reference DRA language which gives the states the right of recovery and not the MCO. As a result, CMS has recently posted guidance on their website empowering MCOs, stating that they are to be recognized as an agent of the state Medicaid agency; some states, for example Ohio and Colorado, have made compatible statutory updates.

5. **The dramatic expansion of Medicaid under ACA exacerbates the administration complexity of determining eligibility and tracking enrollees. How would this additional complexity influence the ability of states to ensure third-parties pay what they are responsible for?**

Expansion of Medicaid under the ACA may have two very different impacts on a state's ability to ensure third parties pay what they are responsible for: 1) the increased caseload and increased variety of coverage options may make it even more difficult to track beneficiary coverage; and 2) the increased coordination between the federal and state governments, particularly in the area of technology and information-sharing may help states to identify possible third party payers that they might not have identified otherwise. The identification of these third party payers will only be helpful, however, if states are able to translate that information into increased service and item cost recovery.

In order to improve third party payments, federal and state governments will likely need to coordinate to send a clear and consistent message to third parties, addressing the common excuses for avoiding or denying payment. Failure to address these excuses while proceeding with a Medicaid expansion will only lead to expanded failure to recover funding from third party payers, and Medicaid will continue to, in practice, serve as the payer of first resort.

The Honorable Bill Cassidy

1. **In your testimony you highlight the fact that current Medicaid regulations "disempower individuals from taking responsibility for their health" and that within the Medicaid program "there are no incentives for states to achieve quality outcomes." These two areas must be addressed in order to achieve better health outcomes and responsible state and federal healthcare spending.**

   The concept of patient activation and the robust science behind it is rooted in the notion of empowering individuals. By definition, activated patients effectively manage their own health to the degree that they are competent to do so. Once a provider understands what an individual is and is not capable of, the provider can identify behavior change opportunities that are realistic and achievable. Through tailored support and education, patients become more successful managers of their health and healthcare. This approach has proven to reduce emergency room visits, hospital admits and readmission, increase medication adherence and improve chronic condition management.

   A limited number of Medicaid programs are utilizing the Patient Activation Measure survey in order to improve allocation of resources and provide real patient-centered care-to treat the individual, not simply their symptoms. Organizations using PAM have demonstrated improved outcomes and cost savings of $300 to $3,700 per patient per year depending on the program. Cost savings are driven by fewer ER visits and hospital admits.

   Do you agree that in order to substantially improve outcomes and lower healthcare spending, patients must be engaged in managing their own health? Should federal Medicaid regulations facilitate the incorporation of patient activation measurement in state's Medicaid programs?

   Medicaid beneficiaries must be engaged in managing their own health; an essential component of Medicaid programs should be to improve health outcomes and lower health care spending. There are different ways to incentivize Medicaid beneficiaries to be more proactive in their health care decision making. States I have worked with have used high-deductible health plans with financial responsibility along with incentives to waive such financial responsibility with the completion of certain healthy behaviors, such as obtaining preventative services or participating in a weight loss or smoking cessation program. Other measures that can be taken to encourage beneficiaries to become more engaged in managing their care and making better health care decisions are education, coaching, and involving beneficiaries in the management of their care or, otherwise, making them an integral part of their health care team. However, the member must have "skin in the game," and a vested interest and incentive to improving their health.

   The Patient Activation Measurement (PAM), a survey that measures how "activated" or involved a patient is with their care, could be a useful tool for health care providers to utilize in understanding where their patients fall on the "activation" or involvement scale. This better understanding could assist health care providers in knowing how much encouragement or

coaching patients might need to become more "activated" or involved in their health care decisions and management and in tailoring the patients' care to better meet their needs.

While I do believe the PAM survey could be beneficial, the current federal Medicaid regulations do not call for States to implement any type of patient survey similar to the PAM survey, and States would need to evaluate how it could be implemented within their programs.

In sum, we need to do better than simply paying Medicaid beneficiaries' claims. In order to bend the cost curve and improve health outcomes, we need to employ multiple strategies, and such strategies cannot exclude incentivizing beneficiaries to be directly involved with and responsible for their health care decisions and disease management. The current facade of Medicaid is outdated and must change in order to include the up-to-date knowledge we have gained from the private market and studies regarding the benefits of beneficiary accountability and involvement in their health care decisions.

The Honorable Gus Bilirakis

1. **Can you talk about your work with states and working with CMS on obtaining an 1115 waiver? Florida took almost two years to get an 1115 Medicaid waiver for a state wide managed care plan. What have other states tried through the waiver process? How was interacting with CMS during this process, and how long did it take for CMS to approve the waiver?**

The timing, process, and resulting waived provisions for states going through an 1115 waiver process varies greatly and is inconsistent across different states and 1115 demonstration applications. Some States have seen their waivers go through in a matter of weeks, or months, whereas other States may take years to receive responses, if there is a response. Another concern is the demonstration periods. More recently, in the case of waiver extensions, CMS is granting 1-year waiver, as opposed to the maximum 3 year waiver periods. While they indicate this is due to wanting to understand the impact of the ACA, waiver applications represent a significant effort for States and having to develop and negotiate the applications within a year is a large undertaking. The short periods also do not allow for relevant data to be collected to inform CMS of the waiver's impact.

States can also be faced with the challenge of CMS' shifting position on policy issues during the waiver approval process. For example, Louisiana submitted a 1915(c) waiver request in May 2008 for an Adult Residential Care (Assisted Living) Waiver. The waiver included a provision to convert empty nursing home stock into new residential settings as has been done with CMS approval in many states. The state responded to a CMS Request for Additional Information, and upon submission was given the impression that the only outstanding issue was migration of the waiver application to a new version. In the time that elapsed while the state migrated to the new version, CMS's position changed and the state was informed verbally that the waiver would not be approved as the conversion option would not meet the new CMS definition of a home

and community based setting. While the state argued that the proposal met all the published guidelines at the time, CMS formally denied the waiver in August 2011, over three years past the original submission.

Many states have noted slow progress in negotiations with CMS including consistent back and forth in questions, clarifications and requests for revisions. It is not unheard of for waiver negotiations to take upwards of a year or more. However, some states do experience a more streamlined approval process with CMS, and approvals for 1115 demonstrations can be granted quickly. For example, in 2010 Louisiana received approval in approximately 30 days for an 1115 waiver to provide primary and behavioral health care benefits to uninsured adults in the greater New Orleans region which was put together to serve as a bridge from the expiration of a post-Katrina federal primary care grant.

2. **The recent Oregon Medicaid study published in the New England Journal of Medicine seemed to show that individuals on Medicaid did not have better health outcomes than individuals without health insurance. Have you seen the study and what are your thoughts on it?**

Despite the growing investment of states in their Medicaid programs, this study in the New England Journal of Medicine "showed that Medicaid coverage generated no significant improvements in measured physical health outcomes."[7] Medicaid coverage alone does not guarantee improved care or outcomes. This is a key issue for states to consider as they contemplate Medicaid expansion.

The focus of Medicaid reform must be on rethinking how care is delivered and ensuring access and quality outcomes. Providing a Medicaid card to new recipients, without fundamental restructuring of the program will only increase taxpayer spending without delivering results. Medicaid must be transformed to focus on access, outcomes and quality. This requires a realignment of incentives for states, providers, and recipients; for maximum effect all health system actors must have common goals. Federal policy should support this realignment and provide states with the tools to implement innovative strategies such as shared savings models, provider bonuses, financial incentive, and bundled payments.

[7] Baicker,K., Taubman, S., Allen, H., Bernstein, M., Gruber, J., Newhouse, J., Schneider, E., Wright, B., Zaslavsky, A., & Finkelstein, A . (2013). The Oregon Experiment – Effects of Medicaid on Clinical Outcomes. *New England Journal of Medicine, 368,* 1712-22. Retrieved online: http://www.nejm.org/doi/full/10.1056/NEJMsa1212321#t=abstract

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORN
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

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Minority (202) 225–3641

July 3, 2013

Dr. Joseph W. Thompson
Surgeon General, State of Arkansas
Director, Arkansas Center for Health Improvement
1401 Capitol Avenue, Suite 300, Victory Building
Little Rock, AR 72201

Dear Dr. Thompson:

Thank you for appearing before the Subcommittee on Health on Wednesday, June 12, 2013, t testify at the hearing entitled "The Need for Medicaid Reform: A State Perspective."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remain: open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing i bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close business on Friday, July 19, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

SURGEON GENERAL, STATE OF ARKANSAS
JOSEPH W. THOMPSON, MD, MPH

July 19, 2013

Sydne Harwick
Legislative Clerk
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Ms. Harwick:

Please find enclosed my responses to the questions for the record regarding my testimony before the U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health hearing on Wednesday, June 12, 2013, entitled "The Need for Medicaid Reform: A State Perspective."

Thank you for the opportunity to testify on this important issue. Please feel free to contact me if additional information is needed.

Best regards,

Joseph W. Thompson, MD, MPH
Surgeon General, State of Arkansas
Director, Arkansas Center for Health Improvement

cc: Governor Mike Beebe, State of Arkansas
Arkansas Congressional Delegation
Arkansas House of Representatives, Speaker of the House
Arkansas Senate, President Pro Tempore

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Arkansas Surgeon General Joe Thompson's response to questions related to appearance before the Subcommittee on Health of the US House of Representatives-Committee on Energy and Commerce (June 12, 2013 – "The Need for Medicaid Reform: A State Perspective")

1. **Your state has reached a preliminary agreement with the U.S. Department of Health and Human Services (HHS) to use Medicaid dollars to pay for private coverage sold on the insurance marketplaces that are being created by the ACA, correct?**

   The state has reached an agreement with the Secretary of the U.S. Department of Health and Human Services (DHHS) conceptually regarding Arkansas's planned use of Medicaid dollars for premium assistance to purchase Health Insurance Marketplace (HIM) qualified health plan coverage for those who would have otherwise been eligible for Medicaid expansion under the Patient Protection and Affordable Care Act (PPACA). This concept has been authorized legislatively by the state via the Health Care Independence Act of 2013,[1] also commonly known as the "private option." The state is currently pursuing an 1115 waiver with DHHS to implement the private option.

2. **Do you believe your state has enough providers to support coverage of additional beneficiaries?**

   Like many other states, Arkansas faces primary and specialty care workforce shortages. The greater issue in Arkansas is the maldistribution of its health care workforce, with urban areas having potentially excess supply and rural areas having critical shortages. Unlike many other states, Arkansas has taken a comprehensive approach to health care system transformation. Rather than pursue coverage expansion for Arkansans in isolation, the state simultaneously engaged in initiatives beginning in 2010 to develop a strategic plan to address workforce issues, optimize the use of health information technology, and transition from a volume-based to an outcome-based payment system using a public-private collaborative approach. Removing the financial barrier to coverage for uninsured Arkansans—some of whom reside in counties where the uninsured rate is near 40 percent—is not an immediate solution to workforce issues. However, providing a paying source for providers is a first step toward stimulating business growth in health care services and should be accompanied by incentives that improve patients' health care seeking behavior.

   a. **Do you believe that, had Arkansas chose to undergo a standard Medicaid expansion under the ACA, there would have been enough providers to support such an expansion?**

      Under a traditional Medicaid expansion as contemplated by PPACA, Arkansas would likely not have had enough participating providers to meet demand from an additional 250,000 adult eligibles. Eligibility for Arkansas's Medicaid program is among the most restrictive in the nation for adults. While the state's Medicaid program maintains a network of providers who are responsive to the demands of the current Medicaid population—largely comprised of children and the aged, blind and disabled—the state would have had significant difficulty

[1] Acts 1497 and 1498 of 2013

building a network to meet the demand of the newly covered population. Building a sufficient network would have required robust recruitment inclusive of increased reimbursement rates approaching that offered in the private insurance market.

b. How does your state's plan insure access to a sufficient number of providers?

In the short term, capacity constraints particularly in rural areas may delay services for non-acute needs (e.g., preventive screening). However, the use of private qualified health plans' provider networks and leveraging the HIM network adequacy requirements will help to mitigate provider access issues. Longer term workforce goals as outlined in the state's health workforce strategic plan—team-based care, optimal use of heath information technology, and financing arrangements that will promote patient-centered medical homes, including the use of physician extenders in remote locations—are also underway.

3. Last year CBO estimated that private insurance plans cost nearly 50 percent more than Medicaid. In Arkansas' own actuarial analysis, it was found that the difference in provider rates between the private market and Medicaid is less than 25%. The report also indicated that there may be actual cost-savings associated with the Medicaid proposal.

a. What evidence is there that placing Medicaid beneficiaries into the private insurance marketplace will achieve cost-savings?

Analysis released from the Arkansas Department of Human Services (DHS) earlier this year shows the estimated financial impact of the private option. The estimates point to several differences in the Arkansas market for which the CBO estimates were unable to account by using national averages for Medicaid costs and national estimates of rate differences between Medicaid and private carriers. As noted, Arkansas analysis showed that the average difference in Arkansas was less than half of that estimated nationwide. Beginning with this Arkansas-specific baseline, the analysis projected a 5 percent reduction in private provider reimbursement rates due to the introduction of 250,000 individuals into the market, generating deflationary price pressure on commercial carrier contracts with providers. Competitive pressure from qualified health plan management and transparent pricing in the Marketplace is estimated to reduce premiums by an additional 5 percent, a reduction that would be shared by premiums for all individuals (e.g., above and below 138% FPL) across the Marketplace, not just plans in which private option eligibles can enroll. Extracting medically frail populations from eligibility for the private option is estimated to further reduce Marketplace premiums. All of these factors—combined with a displaced need to increase provider reimbursement under a traditional expansion—results in an impact that could drive the incremental costs of the private option to zero, or even produce cost savings, depending on thriving competition and strategic qualified health plan management.

b. Will the "actuarial soundness" certification regulations which apply to Medicaid managed care plans also apply to the exchange plans offered to Medicaid beneficiaries?

Actuarial soundness requirements that are applicable to all qualified health plans offered through the HIM will apply to the plans from which private option eligibles will be able to choose.

c. How will the state address the vast difference in provider rates that will likely occur between Medicaid provider rates and qualified health plan provider rates?

While private insurer provider rates are greater than those currently provided by Medicaid, the differences in those rates in Arkansas do not appear to be as "vast" as they are in the majority of other states. A traditional Medicaid expansion would have required an increase in provider rates to meet access requirements. A coverage expansion via the private option is expected to produce deflationary pressure on private market rates given the volume of new patients with a paying source and will reduce uncompensated care costs, which is now reflected in an approximate 8 percent hidden surcharge in premiums.

4. In a recent memo to states from HHS, Secretary Sebelius stated "beneficiaries must remain Medicaid beneficiaries and continue to be entitled to all [Medicaid] benefits and cost-sharing protections." It seems HHS is actually eliminating the benefits the state hoped to achieve through the private insurance market and thus make the state Exchange look more like Medicaid.

a. How will the private plans offered to Medicaid beneficiaries in the Exchange compare to Medicaid, in terms of cost-sharing and benefits provided?

Medicaid cost sharing requirements will be satisfied by all silver level qualified health plans offered to individuals eligible for the private option. Required Medicaid benefits not already covered by qualified health plans—non-emergency transportation, oral and vision care for 19- and 20-year olds—will be "wrapped" for beneficiaries, provided by fee-for-service Medicaid.

b. Will Medicaid continue to provide wrap-around services for those services that are not covered in the standard set of benefits?

Yes, fee-for-service Medicaid will provide those services to beneficiaries.

c. Will these wrap-around benefits include the cost-sharing portion of the plans?

Private option beneficiaries between 100-138 percent of federal poverty level (FPL) and subsidy-eligible beneficiaries between 139-150 percent FPL will be subject to cost-sharing that complies with Medicaid requirements. Private option eligible beneficiaries under 100 percent of FPL will have no-cost sharing in the first year of the program.

d. Under the ACA, the federal government established new provisions to stabilize the cost of insuring beneficiaries through the Exchange: reinsurance, risk corridors, and risk adjustment. Will the Medicaid population enrolled in Exchange health plans be included in these programs?

i. If YES - how will these additional costs be distributed to other beneficiaries within the Exchange?

ii. If NO- will these provisions be applicable in just the Medicaid pool? If so, how will costs be distributed among Medicaid beneficiaries?

The risk adjustment, reinsurance, and risk corridor programs will apply to the qualified health plans offered to private option eligible, which are also plans in which subsidy-eligible individuals will be enrolled. The risk pools will not differ; costs will be distributed no differently than they are for other beneficiaries in the HIM.

e. What flexibilities does Arkansas require from HHS to provide true consumer driven, market-based insurance?

Flexibility pursued via the proposed 1115 waiver process currently under public comment prior to state submission includes the following requests:

Use for Waiver	Reason for Waiver Request	Waiver Authority
To enable the State to apply the 5% cap on cost-sharing on an annual, rather than quarterly, basis.	This waiver authority will allow the State to align with how carriers will apply the annual cost-sharing limit for commercial coverage in the individual market.	§ 1902(a)(14)
To permit the State to limit reimbursement for federally qualified health centers (FQHC) and rural health centers (RHC) to the amount the FQHC/RHC negotiated with the QHP carrier, rather than the amount established under the prospective payment system.	This waiver authority will allow the State to limit its financial exposure and align reimbursement to FQHCs/RHCs for Private Option beneficiaries with QHPs' contracted rates.	§ 1902(a)(15)
To permit the State to provide coverage through different delivery systems for different populations of Medicaid beneficiaries. Specifically, to permit the State to provide coverage for Private Option eligible Medicaid beneficiaries through QHPs offered in the individual market. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.	This waiver authority will allow the State to test using premium assistance to provide coverage for QHPs offered in the individual market through the Marketplace or a subset of Medicaid beneficiaries.	§ 1902(a)(17)
To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Private Option beneficiary's QHP.	This waiver authority will allow the State to require that Private Option eligible beneficiaries receive coverage through the Demonstration, and not through the State Plan. This waiver authority will also allow the state to align the network available to Private Option beneficiaries with the network offered to QHP enrollees who are not Medicaid beneficiaries.	§ 1902(a)(23)
To permit the State to limit a Private Option beneficiary to receiving coverage for drugs on the formulary of the Private Option beneficiary's QHP.	This waiver authority will allow the State to align the prescription drug benefit for Private Option beneficiaries with the prescription drug benefit offered to QHP enrollees who are not Medicaid beneficiaries.	§ 1902(a)(54)
To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.	This waiver authority will allow the State to align prior authorization standards for Private Option beneficiaries with standards in the commercial market.	§ 1902(a)(54)

5. **Nearly 10% of Medicaid beneficiaries have third-party coverage, in addition to their Medicaid coverage. In these circumstances, the third party payer is required to pay prior to Medicaid, as Medicaid, by statute, is the "payor of last resort". The Deficit Reduction Act of 2005 worked to ensure Medicaid is the payer of last resort by requiring states to amend their Medicaid programs with certain provisions.**

   a. Are you aware of what challenges states continue to face in recovering third-party payments?

   Yes

   b. What impediments prevent third-party payers from following through on their payments?

   I am aware that states, including Arkansas, face challenges when applicants fail to realize that they may have other coverage or do not disclose that they have other coverage in fear that they may be disqualified. Because low-income individuals have constant shifts in employment and family situations, their access to coverage other than Medicaid is dynamic. Even where an applicant may fail to disclose the availability of other coverage, Medicaid's access to enrollment data to cross-check that availability is sometimes lacking due to concerns from third parties—and even other state or federal entities—about releasing information to Medicaid. States also face a litany of challenges related to third parties not responding to filed claims or not processing claims in a timely manner. Regarding pharmacy benefit managers (PBMs), many states face challenges related to PBMs' claims that they lack the authority to reimburse Medicaid directly.

   I am also aware that payers face technical challenges with processing Medicaid and Medicaid managed care claims and that, in response, many states have looked to alternative methods of processing those claims. Also, many states lack an enforcement mechanism to incentivize third parties from following through on their payments.

6. **How does the recent increased use of managed care in Medicaid influence third-party liability issues?**

   Unlike many other states, managed care has never been a delivery model Arkansas has used for its Medicaid program. Therefore, we have no first-hand knowledge of how the increased use of managed care may or may not influence third-party liability.

7. **The dramatic expansion of Medicaid under ACA exacerbates the administration complexity of determining eligibility and tracking enrollees. How would this additional complexity influence the ability of states to ensure third-parties pay what they are responsible for?**

   The ACA provides resources to states to improve eligibility and enrollment systems and, for some states, actually makes eligibility determination less burdensome by eliminating asset tests. In Arkansas, the private option leverages the protections guaranteed by the HIM and the efficiencies provided by the private market to better ensure that beneficiaries and the state are getting a product that improves access and quality.

The Honorable Gus Bilirakis

1. **Can you talk about your work with states and working with CMS on obtaining an 1115 waiver? Florida took almost two years to get an 1115 Medicaid waiver for a state wide managed care plan. What have other states tried through the waiver process? How was interacting with CMS during this process, and how long did it take for CMS to approve the waiver?**

   Arkansas's experience with the US DHHS thus far has been a cordial and collaborative one. DHHS has provided a streamlined template for the waiver application and has been available and responsive to the state's questions and concerns throughout the process. Beginning two weeks after the private option was authorized, state officials began meeting with DHHS officials—both from CMS and the Center for Consumer Information and Insurance Oversight (CCIIO)—on a regular basis to work through the waiver process. We anticipate filing the waiver in early August and expect approval in time for HIM open enrollment. Other states have proposed a variety of 1115 waivers, ranging from block grants to targeted demonstrations for family planning services or delivery models for developmentally disabled populations, but Arkansas's proposed waiver to use premium assistance to purchase private coverage through the Marketplace will be the first of its kind.

2. **The recent Oregon Medicaid study published in the New England Journal of Medicine seemed to show that individuals on Medicaid did not have better health outcomes than individuals without health insurance. Have you seen the study and what are your thoughts on it?**

   This was a short-term but powerful study that had the expected short term results with regard to chronic disease. Chronic diseases develop over time and will require long term efforts and observation to gauge the effectiveness of Medicaid coverage. What is encouraging from the report is the significant increased use of preventive care, screening services and prescription drugs. This would portend more effective management and avoidance of future chronic disease. Overall, results exemplify the need to further study the effects of increased coverage using different delivery models, inclusive of Medicaid. The study's findings on health outcomes in Medicaid—though touted by many as proof that Medicaid is a flawed delivery model on the whole—suffer from significant limitations to jump to such a conclusion. Our health care system is no doubt in need of quality improvement, but this need is not unique to Medicaid. Dissolving the Medicaid program is not a rational solution to poor health outcomes in our health care system; neither is simply providing individuals with financial access to coverage and sending them on their way. A more comprehensive strategy is necessary, one that has a multi-payer approach, ensures adequate access to a quality workforce, and incentivizes providers to deliver more cost-effective, quality care and consumers to seek care in an appropriate manner.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

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July 3, 2013

Mr. Anthony E. Keck
Director
South Carolina Department of Health and
Human Services
P.O. Box 8206
Columbia, SC 29202-8206

Dear Mr. Keck:

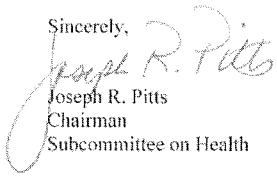
Thank you for appearing before the Subcommittee on Health on Wednesday, June 12, 2013, to testify at the hearing entitled "The Need for Medicaid Reform: A State Perspective."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Friday, July 19, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

South Carolina Department of
Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

July 31, 2013

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
U.S. House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Chairman Pitts:

Thank you for allowing me the opportunity to present to the House Committee on Energy and Commerce's Subcommittee on Health June 12, 2013, regarding the need for Medicaid reform. It was an honor to share my perspective with the members, and gain some perspective on the issues important to them.

Attached are my responses to the additional questions posed by members. If you or any members have questions regarding these, please contact me.

Thank you for your service in the U.S. House, and your commitment to exploring ways to reform our states' Medicaid programs. If I can ever be of assistance, please let me know.

Sincerely,

Anthony E. Keck

AEK/kl

Enclosure

Office of the Director
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Responses to Follow-up Questions from House Energy and Commerce Hearing

Director Tony Keck, South Carolina Department of Health and Human Services

The Honorable Joseph R. Pitts

1) **Most states have implemented Medicaid managed care to some degree, but there remain certain areas of the program that do not have much managed care penetration, such as long-term care and behavioral health. Obviously, there are valid concerns about these especially vulnerable populations, but as Medicaid costs continue to balloon, do you see a need for more managed care in these areas? If so, what kind of rules, if any, should the Congress or the Administration give states with regard to Medicaid managed long-term care and/or behavioral health? Are there particular state programs that serve as an effective model for how to implement managed care in these areas of Medicaid?**

   The term "managed care" can be applied to a broad spectrum of delivery and financing mechanisms used in Medicaid. These include Primary Care Case Management (PCCM) programs which overlay patient care management expectations and care management payments on a traditional Fee-For-Service (FFS) primary care system as well as capitation payment to private health plans to accept full financial risk for certain Medicaid populations.

   There is clear evidence in South Carolina Medicaid and nationally that these managed care mechanisms generally produce better quality at lower overall cost than unmanaged FFS. Yet FFS continues as the default preference for the Centers for Medicare and Medicaid Services (CMS). In fact, individuals and population groups most in need of comprehensive care management – such as individuals living with disabilities and foster children – are often excluded from mandatory enrollment in managed care without a waiver.

   Instead of requiring that states obtain waiver authority Congress should implement legislation that requires all individuals to be enrolled in some form of managed care as the default, and that mutually agreed upon and nationally validated outcome measures for access, quality and cost control are identified, measured and reported on a regular basis.

2) **Much news has been made in recent months about using Medicaid dollars to enroll individuals in private coverage through the state exchanges. What federal barriers exists for states to exercise this option, and what unanswered questions do states have with regard to premium assistance?**

   There seems to be a fundamental misunderstanding of recent efforts by several states to provide "private coverage" in lieu of Medicaid expansion:

   A. States already use private health plans to manage millions of current Medicaid beneficiaries in FFS and both PCCM and capitated Medicaid managed care. This is not new.

   B. States involved in "private coverage" negotiations are planning to cover the same population and number of covered lives as would otherwise be covered under the Affordable Care Act Medicaid expansion.

   C. Typical Medicaid premium assistance combines contributions from employers, the individual and the state to achieve cost effectiveness. In the states currently negotiating these "private

coverage" arrangements, employers do not appear to be eligible to contribute and beneficiary cost sharing – especially under 100% FPL – appears to be limited.

D. States that currently pay private health plan premiums to manage Medicaid lives operate similar to self-insurers where premiums are set to reflect the service utilization of the covered populations – not of the general population. Current models being negotiated with CMS that propose to pay the health insurance exchanges/marketplaces a market-based premium forgoes the advantage of self-insuring and puts Medicaid in the position of being a premium "price-taker" on the open market. In fact, where medically frail populations are being carved out of the exchange/marketplace and placed in traditional Medicaid, states will end up not only managing and paying for the most costly individuals, but will also pay excessive premiums on the exchange/marketplace for the remaining Medicaid expansion beneficiaries that are healthy, low-utilizers of services. This arrangement actually subsidizes exchanges/marketplaces that may struggle with adverse selection and low enrollment by guaranteeing a base of healthy (and profitable) Medicaid beneficiaries. If and how the OMB will certify that these arrangements are cost neutral is unclear.

The Honorable Michael Burgess

1) **The Medicaid statue 1903(m)(2)(iii) requires that state payments to managed care entities be made on an actuarially sound basis. In 2009, the Government Accountability Office (GAO) was asked to investigate CMS's oversight of the state's compliance in meeting the statutory requirement. The GAO found that CMS has been inconsistent in reviewing states' rate setting for compliance with the Medicaid managed care actuarial soundness requirements, which specify that rates must be developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries.**

   a. **Can you explain how your states analyzes, interprets and calculates payments made to managed care entities on an actuarially sound basis?**

   b. **What methods are used to determine if rates paid to managed care entities are actuarially sound?**

   c. **What methods are used to confirm the accuracy of data used in computing actuarial soundness? Are the plans consulted to confirm accuracy of the data?**

The South Carolina Department of Health and Human Services (SCDHHS) contracts with an actuarial consulting firm, Milliman, Inc., to provide the actuarial certification required under 42 CFR 438.6(c) regarding actuarially sound capitation rates. The actuaries involved in the capitation rate development and rate certification are Members of the American Academy of Actuaries and meet the qualification standards established for rendering the certification. The actuaries have extensive experience in Medicaid managed care programs.

CMS regulations govern the development and approval of capitation rates paid by state Medicaid agencies to Medicaid Managed Care Organizations (MCOs) under full-risk contracts, including:

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- Code of Federal Regulations, 42 CFR 438.6(c)
- The CMS rate setting checklist, also known as "Appendix A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-Risk Capitated Contracts Rate setting"

These regulations require capitation rates to be actuarially sound and that states obtain an actuarial certification from a qualified actuary. CMS does not have set criteria to determine actuarial soundness of capitation rates and relies on qualified actuaries to certify to the soundness of the rates in an actuarial certification. However, CMS uses a checklist to assist the regional offices in reviewing the materials prepared and submitted by the states and their consulting actuaries in support of their proposed Medicaid managed care capitation rates. The checklist is also used to document the capitation rate methodology and assumptions used in developing the capitation rates. The checklist was issued in draft form in July 2003. CMS has begun a review process of the checklist and is anticipated to issue an updated checklist.

In 2005, the American Academy of Actuaries published a nonbinding Practice Note to be used as guidance to actuaries certifying Medicaid capitation rates. The goals of the Practice Note were to:

- Provide guidance to the actuary when certifying rates or rate ranges as meeting the requirements of 42 CFR 438.6(c) for capitated Medicaid managed care programs, and
- Provide examples of responses to certain situations and issues.

However, practice notes do not have the same standing as an Actuarial Standard of Practice (ASOP) in determining what constitutes generally accepted actuarial principles and practices. ASOPs are considered part of an actuary's professional code of conduct and have the highest standing. In contrast, practice notes are not a definitive statement as to what constitutes generally accepted practice.

Currently, no ASOP applies specifically to actuarial work performed to comply with CMS requirements for rate certification. However, several ASOPs apply to certain components of a Medicaid managed care capitation rate development methodology. For example, ASOP No.23 on Data Quality addresses the binding guidance to an actuary surrounding the topic of data. The American Academy of Actuaries Actuarial Standards Board has approved the development of an ASOP that specifically addresses the actuarial certifications for Medicaid managed care capitation rate development under 42 CFR 438.6(c). It is anticipated that the ASOP will be final by the end of calendar year 2014.

The Practice Note includes the following definition of actuarial soundness related to Medicaid managed care capitation rates:

"Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation payments, including expected reinsurance and governmental stop loss cash flows, governmental risk adjustment cash flows and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, state-mandated assessments and taxes and the cost of capital."

In other words, Medicaid managed care capitation rates are actuarially sound if they provide the participating plans an opportunity to cover their projected expenses and generate a modest profit if they are operated in an efficient manner.

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For the Medicaid managed care rate setting and certification process in South Carolina, the contracted actuaries work closely with SCDHHS and the managed care plans to assure complete and accurate information is utilized in the rate setting process. The following provides a general outline of the rate setting process:

- Collection of historical utilization and cost experience for the managed care population: The State has developed and maintained an encounter data reporting process for the managed care health plans. The encounter data represents the claim experience incurred by the managed care plans. The encounter data is monitored on a quarterly basis for completeness and accuracy. The state's contracted actuaries use the encounter data in the capitation rate setting process. The managed care plans are given an opportunity to review the encounter data used in the rate calculation.

- Adjust historical data for trend and policy and program changes: The historical data is trended forward to reflect medical inflation. The data is further adjusted to reflect policy and program changes that have been implemented in the Medicaid managed care program since the historical data period.

- Adjust for health plan administration: The historical data is further adjusted to reflect the cost of health plan administration services.

- Documentation: The capitation rate setting process, including assumptions, are outlined in a report along with an actuarial certification.

- Communication of results to the state and the contracted health plans: The actuaries present the capitation rate development process to the state Department of Health and Human Services and the contracted health plans. This allows for a review of the development of the capitation rates by interested parties, who typically employ outside actuaries of their own to comment on the Department's calculation.

- Monitoring of health plan financial results: The actuaries regularly review the financial results of the contracted health plans.

The state's contracted actuaries provide on-going support to SCDHHS in the rate approval process. The state's contracted actuaries participate in follow-up telephone conversations with CMS to address any questions related to the rate certification.

2) **In your testimony you highlight the false illusion that health insurance equals access, and therefore leads to health. As the Affordable Care Act further extends health insurance coverage to millions of more Americans, your point becomes even more valuable. However, there are specific issues within Medicaid that create a disincentive for physicians to accept patients with Medicaid coverage.**

   The federal government has attempted to manage Medicaid expenditures through maintenance of effort requirements and by focusing on combating fraud and abuse.

   a. **How has the federal maintenance of effort requirements affected state Medicaid rates?**

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Most states must maintain balanced budgets. In times of economic downturn or when circumstances may require a state to increase spending or investment in certain programs or sectors, states must either draw on reserves, cut state spending across the board or in select programs, or raise new revenues through taxes, fees or revenue maximization schemes.

State Medicaid programs' major cost drivers are eligibility limits, beneficiary enrollment rates, provider enrollment, benefit design, service utilization and service reimbursements. Total spending may be managed up or down by manipulating each of these drivers.

MOE requirements on states – including those not expanding – generally do not allow states to reduce eligibility limits or implement changes that would restrict or reduce beneficiary enrollment rates for a set period of time. This leaves the other drivers as the only options to manage overall spending, however:

- Many benefits are mandatory, and optional services which may be reduced (such as home and community based services) are in-fact more cost effective than mandatory services;
- CMS is applying increased scrutiny to most benefit or service-level reductions or restrictions and is in fact requiring states to actually expand services without regard to state or federal budget considerations (such as recently requiring South Carolina to make adult incontinence supplies available in the state plan rather than as a waiver-only service);
- Service utilization management programs (such as prior authorization) take significant time to implement and have in many cases already reached their maximum effectiveness where they are implemented;
- Medicaid FFS must generally continue to enroll all willing providers regardless of their quality and cost effectiveness.

Given the MOE and the other constraints listed above, reducing reimbursement rates provides the largest opportunity and quickest means to manage substantial state shortfalls; and both expansion states and non-expansion states have consistently cut Medicaid provider reimbursement rates over the past several years. Recent studies clearly show that relative reimbursement rates are directly tied to the likelihood of accepting Medicaid patients, and these reductions undoubtedly have had an effect on access. Fortunately, because South Carolina has not generally made eligibility or benefit commitments it cannot keep, our reimbursement rates remain competitive and we have among the highest rates of physician Medicaid participation in the country.

3) **Nearly 10% of Medicaid beneficiaries have third-party coverage, in addition to their Medicaid coverage. In these circumstances, the third party payer is required to pay prior to Medicaid, as Medicaid, by statute, is the "payor of last resort". The Deficit Reduction Act of 2005 (DRA) requiring states to amend their Medicaid programs with certain provisions to ensure that Medicaid is the payor of last resort.**

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a. **Are you aware of what challenges states continue to face in recovering third –party payments?**

South Carolina continues to encounter challenges in collecting from third party carriers. The most common reasons that third party carriers will not pay or will fail to properly process claims include: requiring additional information; carriers using numerous locations for claims processing; requiring a National Provider Identifier (NPI) to process claims even though Medicaid is not a provider and therefore does not have an NPI; invalid prescriber last name; basis of cost; claims previously processed; duplicate claims; timely filing not following DRA. Pay and chase requirements make recovery more difficult and are less successful than cost avoidance.

Verifying TPL policies has become challenging for various reasons including customer service representatives who fear that obtaining coverage information violates HIPPA. Verification can also be difficult when Medicaid's information does not must match the private insurers records exactly.

TPL recoveries have also been impacted by Supreme Court rulings (*Ahlborn* and *Wos v. E.M.A.*) and state legislative changes that limit recovery.

b. **What impediments prevent third party payers from following through on their payments?**

SC Medicaid's paper invoicing is an issue for third party carriers. Electronic billing could expedite claims payment.

In casualty cases, the lack of the prioritization of Medicaid claims or the allocation of settlement proceeds to medical damages negatively impacts recoveries.

4) **How does the increased use of managed care influence TPL issues?**

The Medicaid agency has included a TPL recovery factor in the capitation rate to account for TPL coordination of benefits.

5) **The dramatic expansion of Medicaid under ACA exacerbates the administration complexity of determining eligibility and tracking enrollees. How would this additional complexity influence the ability of states to ensure third-parties pay what they are responsible for?**

It is imperative that new enrollee information be shared with TPL once eligibility is determined so that verification can begin in order to start the cost avoidance process. If TPL has to depend on post-payment recoveries, Medicaid will experience increased problems with third party reimbursement as we continue to pay and chase.

<u>The Honorable Cathy McMorris Rodgers</u>

1) **For many states, innovation and reforms in their respective Medicaid programs translate into not only improved quality of care but substantial monetary savings. Section 1115 is intended to allow states to test these innovations. Yet, as we know from experience, CMS's implementation of the**

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1115 waiver process has been slow. Are there ways that the waiver process can be updated to improve the approval process? For example, if there are demonstration models that CMS has previously approved through the waiver process and another state would like to adopt that model, should the state have to go through the entire application process to obtain approval for a model that already has been approved?

South Carolina does not currently operate Section 1115 waivers. However, based on experience in Louisiana as well as conversations with my colleagues, it is clear that 1115 waivers are granted less on the needs of a particular state and more so on the policy objectives of the federal administration in place at the time.

The limitation of 1115 waivers is that in complex system improvement, the best solution is rarely evident at the outset of the effort. In many cases the root causes of a problem or set of problems cannot even be sufficiently defined, much less best-practice solutions be devised, without significant expenditure of effort and resources.

For this reason, a preferable, albeit more partnership-based approach, would be to view demonstrations not as pilots of fully-formulated and unchanging solutions, but instead as a series of well-formulated and strategic rapid-cycle performance improvement efforts based on mutually negotiated and measurable population health outcomes. While uncertainty regarding the exact solutions that will eventually be implemented increases under this model, certainty regarding the goals and the progress towards those goals would increase.

Short of this transformational shift in approach, the suggestion that waivers (1115 or otherwise) that have been approved should be, for instance, "conditionally approved" for use in other states is a generally a good one. While the nature of 1115 waivers as demonstrations/pilots might suggest that other states could receive conditional approval only once the demonstration has been renewed in the pilot state, other waivers, including common home and community based waivers, etc., which are less experimental in nature, should receive immediate conditional approval in other states. One potential unintended consequence is that CMS would greatly slow down or restrict innovative waivers in one state if it meant that the same waiver would quickly become available for other states.

<u>The Honorable Gus Bilirakis</u>

1) **Can you talk about your work with states and working with CMS on obtaining an 1115 waiver? Florida took almost two years to get an 1115 Medicaid waiver for a state wide managed care plan. What have other states tried through the waiver process? How was interacting with CMS during this process, and how long did it take for CMS to approve the waiver?**

   South Carolina does not currently operate Section 1115 waivers. However, based on experience in Louisiana, one relatively large waiver to improve access to primary care services for a previously uninsured population in the greater New Orleans area took approximately 30 days to grant, while a relatively small waiver related to assisted living dragged on for three years until it was eventually denied. A third effort was in the informal, but often relied upon, pre-application stage for approximately a year until it was eventually determined that approval in a formal application process would not occur. This occurred under both the Bush and Obama administrations.

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2) **The recent Oregon Medicaid study published in the New England Journal of Medicine seemed to show that individuals on Medicaid did not have better health outcomes than individuals without health insurance. Have you seen the study and what are your thoughts on it?**

Yes, I have reviewed this study as well as another study published in the New England Journal of Medicine "Mortality and Access to Care among Adults after State Medicaid Expansions" also co-authored by Katherine Baicker, Ph.D. I am also familiar with a third study recently published in Health Affairs by Kindig and Chen titled "Even as Mortality Fell in most US Counties, Female Mortality Nonetheless Rose in 42.8 Percent of Counties from 1992 to 2006". All three of these studies provide insight and support to a body of evidence related to the Social Determinants of Health model.

As both a policy maker as well as an executive responsible for implementing reimbursement and financing strategies that lead to better health, I do believe that insurance is one method of promoting better health, but not the only method nor always the most cost effective or efficient depending on the covered population.

For example, what properly constructed insurance (health, life, home, auto, etc.) does do well is protect individuals from catastrophic financial loss by spreading the very high costs of rare events across a large population. The Oregon study findings indicate that the increased coverage provided to the expansion population did indeed provide protection from catastrophic financial losses. It can even be inferred that the lower levels of depression found in the expansion population could be attributed to the protective effect of coverage on their financial status. The finding that there was no additional increase in the use of medication for depression, despite the observed decrease in depression, may bolster this argument.

Several questions not addressed in this article, although Dr. Baicker has referenced them during interviews on the subject, are what is the value of that economic protective effect to each individual and society, how much should be paid to achieve it, is health insurance the best way to do it, and importantly, are there alternative uses of the money elsewhere which produce more value – such as the protective effect of extending unemployment benefits beyond their current level, or reducing the burden of child care or higher education tuition on low-income families?

As far as improvements on physical health, the data is less clear in the Oregon study. Utilization of services increased but measures of health outcomes generally did not. And while the Mortality and Access study showed significant reductions in mortality in expansion states versus non-expansion states *as a group* there was no significant reduction in mortality in two (Maine and Arizona) of the three individual states studied, and in fact, the authors identified as a limitation that the overall results were driven by the positive results in the largest state (New York).

Further confusing the picture as to the benefits of health insurance are the findings of Kindig and Chen in their study of factors associated with mortality in all 3,140 counties in the United States. They conclude that none of the medical care factors examined in the study, including the county specific rates of primary care providers or preventable hospitalizations, nor the percentage of uninsured, predicted changes in mortality.

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Does this suggest insurance does not promote health? No. But the results are consistent with Social Determinants of Health model accepted broadly within the public health community, which suggests that approximately 20% of overall health is driven by health services and 80% is driven by factors such as income, education, race, personal behavior, social supports, environment and genetics.

In order for insurance to make a difference in health, it first has to ensure good access to health services, and this is increasingly becoming problematic, especially in Medicaid as reimbursement leads physicians to drop out of the program. This is well documented.

Once access is gained, the services must be effective. A recent CDC Morbidity and Mortality Weekly Review examined hypertension in the United States and reported that over half of American adults with hypertension had out-of-control hypertension, and that of these individuals 85 percent had health insurance and 89 percent identified having a regular source of care. Overall, insurance only reduced the probability of being out-of-control from approximately 70 percent (uninsured) to approximately 50 percent (insured).

Why don't insurance and a regular source of care result in better outcomes? There is certainly substantial research that a large amount of ineffectual care is being delivered by a poorly functioning health system. But more importantly, the good care that is being delivered is often short circuited by overwhelming barriers confronting patients related to low education, race, lack of family and community supports, etc.

If a patient leaves a physician's office and doesn't fill a prescription for lack of understanding of its importance or transportation to the pharmacy; or fills the prescription but doesn't take it properly again for lack of understanding or support from family members to remember to take it; or takes the medication but continues to eat poorly and not exercise; then much of the time and money spent on the physician visit as well as the prescription is wasted.

The ability of insurance to improve health – Medicaid or otherwise – is critically dependent on the ability to overcome these social barriers. Yet our excessive spending per capita on health insurance and health services continues to crowd out spending and investment on the very things – job and wage growth, education, community building and smart infrastructure – that drive health the most.

Our current publicly financed health care system has two major flaws. First it fails to find the people most in need of our services. Most health care providers and insurers passively wait for individuals to access care. If an individual presents and needs services, they are delivered and paid for. And in our FFS system, even if an individual presents and *doesn't* need services, they still receive them (though not as many) and they are paid for. But the people that are most in need of services are walking around undiagnosed, shut-in their home, or sleeping under a bridge. These patients are difficult. They drive provider quality and patient satisfaction scores down. They may disturb the other (better paying) patients in waiting rooms. So the system doesn't work very hard to find these individuals. We've lost all sense of the mission of public health in the United States to reach those in most need and even our public health clinics act like physician offices. Flooding the health care system with more money and more patients simply reinforces the tendency for the system to take the path of least resistance and highest profitability.

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Once we do get those hard-to-find, difficult-to-treat patients, our system tends to treat them like everyone else. A physician on the six-minute primary care visit hamster wheel does not have the time, nor the training or system support, to slow down for the one in seven or eight patients with significant social barriers that will diminish or eliminate the effectiveness of the physician visit. *In most cases the clinician doesn't even know that they should slow down.*

South Carolina Medicaid is identifying priority populations most in need – our community hotspots – and investing in the systems and supports that will make their medical treatment as effective and sustainable as possible. This includes our Birth Outcomes Initiative which has already reduced harmful early elective deliveries; our Community Health Worker program to help improve treatment plan adherence by bridging the cultural gaps between individuals and the health system; our aggressive push to open more convenient after hour access points such as CVS Minute Clinics; and our most recent state-wide effort just getting underway to significantly lower the cost and improve the clinical outcomes of 10,000 uninsured, chronically ill, high utilizers of emergency department services through focused case management, social interventions and community partnerships.

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