

EXAMINING LEGISLATION TO IMPROVE MEDICARE AND MEDICAID

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FOURTEENTH CONGRESS FIRST SESSION

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EXAMINING LEGISLATION TO IMPROVE MEDICARE AND MEDICAID

TUESDAY, NOVEMBER 3, 2015

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

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2322 Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Shimkus, Blackburn, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Collins, Green, Castor, Sarbanes, Schrader, Kennedy, and Pallone (ex officio).

Also present: Representative Loeb sack.

Staff present: Clay Alspach; Chief Counsel, Health; Rebecca Card, Assistant Press Secretary; Karen Christian, General Counsel; Graham Pittman, Legislative Clerk; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment and the Economy; Heidi Stirrup, Policy Coordinator, Health; Josh Trent, Professional Staff Member, Health; Christine Brennan, Democratic Press Secretary; Jeff Carroll, Democratic Staff Director; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Rachel Pryor, Democratic Health Policy Advisor; Samantha Satchell, Democratic Policy Analyst; and Arielle Woronoff, Democratic Health Counsel.

Mr. PITTS. OK. I will ask our guests to please take their seats, and the subcommittee will come to order. The Chair will recognize himself for an opening statement.

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

Today's hearing will examine five bipartisan legislative bills designed to make commonsense improvements to the Medicare and Medicaid programs.

First, the committee is happy to have with us one of our own colleagues, Representative Lynn Jenkins from Kansas. Representative Jenkins will be testifying on our first panel about a bill she is sponsoring, H.R. 2878.

This bill would simply prohibit Medicare contractors from enforcing supervision requirements for outpatient therapeutic services and critical access in small rural hospitals for another year.

The Senate companion to this bill was approved by the Senate Finance Committee in June, so we are pleased to be able to review this bill today.

On our second panel, we will hear from representatives of the Government Accountability Office, GAO, and the Medicaid and CHIP Payment and Access Commission, MACPAC.

GAO and MACPAC will help us in our review of four bipartisan bills to improve Medicaid. The first Medicaid bill is an updated version of H.R. 1362, the Medicaid REPORTS Act, by Vice Chairman Guthrie.

This bill seeks to address GAO and MACPAC findings that the Centers for Medicare and Medicaid Services, CMS, does not collect accurate and complete data from all States on the various sources of funds to finance the non-Federal share.

This bill requires States to submit a report at least once a year on sources of funds used to finance the non-Federal share of expenditures in the Medicaid program.

This issue is important policy because State financing approaches affect Medicaid payment methodologies and payment amounts, which may affect enrollees' access to services.

The next Medicaid bill is H.R. 2151, sponsored by our colleague, Representative Chris Collins, the Improving Oversight and Accountability in Medicaid Non-DSH Supplemental Payments Act, would improve the calculation, oversight, and accountability of non-DSH supplemental payments under the Medicaid program.

This is important because GAO founds gaps in Federal oversight of high-risk supplemental payments including a lack of information on the providers receiving them, inaccurate payment calculation method and a lack of assurances the payments were used for Medicaid purposes.

In 2014, MACPAC recommended that the HHS collect, and make publically available, provider-label non-DSH supplemental payment data in a standard format that enables analysis.

Thirdly, the updated version of H.R. 1361, Medicaid Home Improvement Act, sponsored by Representative Guthrie, would establish a Federal cap on the home equity allowance consistent with the current Federal default of \$552,000.

This bill would preserve existing beneficiary protections but help protect taxpayers by updating the limit of allowable equity interest a beneficiary can have in their home. This is a commonsense step to prevent cost shifting from the private to the public sector.

And finally, the Quality Care for Moms and Babies Act, sponsored by Representatives Engel and Stivers, seeks to improve the quality, health outcomes, and value of maternity care under the Medicaid and CHIP programs by developing maternity care quality measures.

This bill would authorize the appropriations of \$16 million for HHS to identify and publish quality measures for maternal and infant health.

Together, these five bills continue the commitment that this Congress has to strengthen the Medicare and Medicaid programs to help sustain these important safety net programs for those most relying on them.

I want to thank all of our witnesses for agreeing to testify today, and I yield back and now recognize the ranking member of the subcommittee, Mr. Green, 5 minutes for his opening statement.

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

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The subcommittee will come to order.

The chairman will recognize himself for an opening statement.

Today's hearing will examine five bipartisan legislative bills designed to make common-sense improvements to the Medicare and Medicaid programs.

First, the committee is happy to have with us one of our own colleagues, Representative Lynn Jenkins from Kansas. Representative Jenkins will be testifying on our first panel about a bill she is sponsoring, H.R. 2878. This bill would simply prohibit Medicare contractors from enforcing supervision requirements for outpatient therapeutic services in critical access and small rural hospitals for another year. The Senate companion to this bill was approved by the Senate Finance Committee in June, so we are pleased to be able to review the bill today.

For our second panel, we will hear from representatives of the Government Accountability Office (GAO) and the Medicaid and CHIP Payment and Access Commission (MACPAC). GAO and MACPAC will help us in our review of four bipartisan bills to improve Medicaid.

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Thirdly, the updated version of H.R. 1361, Medicaid HOME Improvement Act—sponsored by Rep. Guthrie—would establish a Federal cap on the home equity allowance consistent with the current Federal default of \$552,000. This bill would preserve existing beneficiary protections, but help protect taxpayers by updating the limit of allowable equity interest a beneficiary can have in their home. This is a common-sense step to prevent cost-shifting from the private to the public sector.

Finally, the Quality Care for Moms and Babies Act, sponsored Reps. Engel (NY) and Stivers (OH) seeks to improve the quality, health outcomes, and value of maternity care under the Medicaid and CHIP programs by developing maternity care quality measures. This bill would authorize the appropriation of \$16 million for HHS to identify and publish quality measures for maternal and infant health.

Together these five bills continue the commitment this Congress has to strengthen the Medicare and Medicaid programs to help sustain these important safety net programs for those most relying on them.

I want to thank our witnesses for agreeing to testify today. I will yield to anyone on my side seeking time.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, and welcome our colleague from Kansas. Thank you for being here today.

We are here to examine five legislative proposals. One impacts the Medicare Part B program and the others affect the Medicaid program. As we know, the Medicaid program has served as a critical safety net for the American public since its creation on 1965, 50 years ago this year.

Today, over 70 million low-income Americans rely on Medicaid for comprehensive affordable health care. Medicaid covers more than one in three children, pays for nearly half of all births and accounts for more than 40 percent of the Nation's total cost for long-term care.

One in seven Medicare beneficiaries is also a Medicaid beneficiary—dual eligible. The Quality Care for Moms and Babies Act, the discussion and draft put forth by Reps. Engel and Stivers, will improve health outcomes for women and children who depend on Medicaid.

This legislation will authorize funding for HHS to develop quality measures for maternal and infant health and award grants related to care quality and I support this important legislation.

I am concerned about the other legislation we are considering, such as the Medicaid REPORTS Act and proposals requiring additional auditing on States that are overly burdensome, proscriptive, and likely intended to chip away at the Medicaid program.

Additional transparency on Medicaid payments is a goal we all share. My priority is always including ensuring Medicaid beneficiaries have access to the care that they need by supporting providers that serve beneficiaries who otherwise have nowhere else to go for the necessary care.

However, these bills as structured will not achieve our goal of fully understanding Medicaid payments and whether these payments are adequate to guarantee equal access for beneficiaries within the Medicaid program.

My State of Texas uses supplemental and Medicaid DSH payments in a unique way. These sources of funding are an incredible and important revenue stream for hospitals and providers that serve a large portion of Medicaid beneficiaries and the uninsured.

For example, in Texas supplemental payments are used for DSRIP and I want to make sure we maintain the flexibility so CMS and States can deliver each Medicaid program the best way for its unique patient base.

Providers in a Medicaid program must be paid a fair rate. Given the complexities and the 56 distinct Medicaid programs, there is a nuanced way to address these issues.

The question you need to ask is its full payment that a provider receives for treating a Medicaid enrollee fair and sufficient to ensure equal access.

Unfortunately, legislation like Medicaid REPORTS Act, H.R. 2125, won't get us the information we need to see the full picture and it may actually put more burdens on the States. They are not in line with the actions CMS has taken to improve in the area and I look forward to learning more about this complex issue.

Reforms done for the right reasons and nuance in an intelligence way can truly improve how CMS ensures that payments to Medicaid providers are sufficient and enforce equal access to Medicaid beneficiaries.

Such proposals should be a priority for our committee and I look forward to a comprehensive discussion on ways we can improve transparency, strengthen coverage and expand access to providers and increase the quality of health care.

[The prepared statement of Mr. Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN

Good morning and thank you all for being here today. We are here to examine five legislative proposals. One impacts the Medicare Part B program and the others affect the Medicaid program.

As we know, the Medicaid program has served as a critical safety net for the American public since its creation in 1965, 50 years ago this year.

Today, over 70 million low-income Americans rely on Medicaid for comprehensive, affordable health insurance.

It is a lifeline for millions of children, pregnant women, and people with disabilities, seniors, and low-income adults.

Medicaid covers more than 1 in 3 children, pays for nearly half of all births, and accounts for more than 40 percent of the Nation's total costs for long-term care.

One in 7 Medicare beneficiaries is also a Medicaid beneficiary.

The Quality Care for Moms and Babies Act, a discussion draft put forth by Representatives Eliot Engel and Steve Stivers, would improve health outcomes for the women and children who depend on Medicaid.

This bipartisan legislation builds on the Pediatric Quality Measures Program, which is the only program targeting quality performance measurement reporting in the Medicaid and CHIP programs.

Remarkably, it does not currently include a maternal and infant quality core set.

This legislation will authorize funding for HHS to develop quality measures for maternal and infant health, and award grants related to care quality. I support this important legislation.

I am concerned about other legislation we are considering, such as the Medicaid REPORTS Act and proposals requiring additional auditing on States that are overly burdensome, prescriptive, and likely intended to further chip away at the Medicaid program.

Additional transparency on Medicaid payments is a goal we all share.

My priorities have always included ensuring Medicaid beneficiaries have access to the care that they need by supporting providers that serve beneficiaries, who would otherwise have nowhere else to go for necessary care.

However, the way these bills are structured will not achieve our goal of a full understanding of Medicaid payments, and whether those payments are adequate to guarantee equal access for beneficiaries within the Medicaid program.

My State of Texas uses supplemental and Medicaid DSH payments in unique way.

These sources of funding are an incredibly important revenue stream for hospitals and providers that serve a large portion of Medicaid beneficiaries and the uninsured.

For example, in Texas, supplemental payments are used for the DISRIP ("dis-rip"), and I want to be sure we maintain that flexibility so CMS and States can deliver each Medicaid program in the best way for each unique patient base.

Providers in the Medicaid program must be paid fair rate.

Given the complexities and the 56 distinct Medicaid programs, there is a nuanced way to address these issues.

The question we need to be asking is, "is the full payment that a provider receives for treating a Medicaid enrollee fair and sufficient to ensure equal access?"

Unfortunately, legislation like the Medicaid REPORTS Act and H.R. 2125 won't get us the information we need to see the full picture and may actually put more burdens on States.

And, they are not in line with actions CMS has taken to improve in this area.

I look forward to learning more about this complex issue.

Reforms done for the right reasons, in a nuanced and intelligent way, can truly improve how CMS ensures that payments to Medicaid providers are sufficient and enforce equal access for Medicaid beneficiaries.

Such proposals should be a priority for this committee, and I look forward to a comprehensive discussion on ways to improve transparency, strengthen coverage, expand access to providers, and increase the quality of care.

Thank you, Mr. Chairman.

Mr. GREEN. And Mr. Chairman, I will yield the remainder of my time to my colleague from Iowa, Dave Loebsack.

Mr. LOEBSACK. I thank Mr. Green for yielding.

I also want to thank my colleague, Congresswoman Jenkins, for testifying here today on our bill. I am happy to be the lead Democratic cosponsor of H.R. 2878.

It has been a pleasure to work with her on this issue. As a native Kansan, she truly understands the needs of rural Americans and I thank her for her bipartisan work on the bill.

Basically, what 2878 would do is suspend the physician direct supervision requirement for outpatient therapeutic services furnished at critical access hospitals and small rural hospitals until January of 2016.

I often visit critical access hospitals in my district. There are many, given that I represent rural Iowa, and the number-one concern I have heard about recently was this direct supervision issue.

In 2009, CMS issued a rule that mandated direct supervision for all outpatient therapeutic services at these hospitals.

In response to concerns over the implementation of this policy they delay the enforcement through 2013, which was extended by Congress to 2014.

Direct supervision requires that a physician is immediately available when the service is provided. This is difficult in many of these rural settings.

Many outpatient services such as continued chemotherapy, administration of IV fluids or drawing of blood can be safely administered under general supervision, a fact that CMS itself recognized in its delay of the policy.

Further, small rural hospitals often face staffing and workforce shortages that make direct supervision of these services incredibly difficult.

There are a lot of challenges facing our rural hospitals, as you know all too well, Congresswoman Jenkins. This legislation, I think, would go some distance to remedying at least one of those issues facing them and I thank you for introducing this legislation. I am happy to be a part of it, and I yield back.

Thank you.

Mr. PITTS. Chair thanks the gentleman and now recognizes the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. GUTHRIE. Thank you, Mr. Chairman, and I appreciate my classmate from the 2008 class coming in, being here with us this morning, Ms. Jenkins.

But thank you, and I appreciate you holding this hearing on the number of important bills. Today, the committee is examining two bills that I introduced—H.R. 1361, the Medicaid Home Improvement Act, and H.R. 1362, the Medicaid REPORTS Act.

These are both good Government bills that help strengthen the Medicaid program and protect valuable taxpayer dollars. H.R. 1361, the Medicaid Home Improvement Act, caps the maximum al-

lowable equity for beneficiaries to qualify for long-term care under Medicaid.

Currently, in some States those with home equities—not home values but home equities—above \$828,000 can qualify for Medicaid assistance. My bill reindexes the maximum threshold of \$500,000, adjusted for inflation.

With an average home sale in the United States at \$221,000, the current limits allow those not truly in need to access Medicaid dollars, draining Federal and State dollars.

H.R. 1362, the Medicaid REPORTS Act, requires States to submit an annual report that identifies the sources and amounts of funds used by the State to finance the non-Federal share of Medicaid.

With the growing burden the Medicaid program is placing on the Federal budget and those of each of our States, it is important that we know how States are coming up with the dollars necessary to meet their Medicaid match.

Again, Mr. Chairman, I appreciate you holding this hearing to examine these and other important issues and I look forward to talking more with our witnesses and yield back the balance of my time.

Anybody seeking time? I yield back.

Mr. PITTS. Chair thanks the gentleman.

As usual, all written opening statements of the committee will be made part of the record and we will proceed to our first panel.

On our first panel today we have the Honorable Lynn Jenkins, Second District of Kansas, and we thank you for coming to talk about your legislation.

You may proceed.

STATEMENT OF HON. LYNN JENKINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Ms. JENKINS. Chairman Pitts, Ranking Member Green, honorable members of the committee, thank you for holding this hearing and inviting me to speak on H.R. 2878, a critical piece of legislation.

The bill would delay Medicare's physician direct supervision requirement for outpatient therapeutic services in critical access and small rural hospitals until 2016.

In January of 2014, the Centers for Medicaid and Medicare Services began enforcing a requirement that physicians must supervise outpatient therapy at critical access hospitals and other small rural hospitals.

CMS' decision meant that routine outpatient procedures such as drawing blood or undergoing active therapy would have to be directly supervised by a physician.

This decision by CMS would have put a severe strain on providers, particularly those in rural areas, while providing no quality improvements for the patients they serve.

Most of these outpatient procedures are relatively simple, are very safe and would not benefit from a Federal mandate that that physician always be in the room, and as a practical matter in rural hospitals across Kansas such a requirement is simply not feasible.

I was proud to introduce legislation last Congress that delayed this Medicare direct supervision requirement through 2014 and it was signed into law with bipartisan support.

It has been widely recognized as an effective tool to improve care in rural hospitals and keep the regulatory burden in check.

Unfortunately, rural hospitals are once again staring down the threat of this Federal mandate from CMS. The existing law delayed enforcement action from CMS has expired.

Accordingly, I have now reintroduced similar legislation this Congress, further delaying enforcement until 2016. It is about this legislation, H.R. 2878, which this committee has graciously invited me to speak today.

When I think about the healthcare needs facing my district, there is nothing more challenging than ensuring access to quality and accessible rural health care.

Rural America is struggling and the 84 critical access hospital in Kansas are the lifeblood of our rural communities.

The presence of facilities such as a critical access hospital in a community could be the deciding factor in whether or not the next generations of children decide to raise their family in their home town or perhaps whether or not a business decides to locate there.

Easy access to emergency care can be a life and death situation and we cannot threaten the existence of these facilities by piling on the regulatory burden from Washington.

Earlier this year I invited the CEO of Holton Community Hospital to testify about this issue before the Ways and Means Committee's Subcommittee on Health.

Holton Community Hospital happens to be responsible for serving my hometown, Holton, a community of just over 3,000 Kansans.

She explained in great detail that direct supervision would be extremely burdensome, costly and is simply unrealistic at a hospital serving rural America. The result of enforcing this mandate would be to severely limit the type of services rural healthcare hospitals could offer and it would threaten their financial stability at a complicated and uncertain time in our Nation's healthcare system.

H.R. 2878 will correct this problem. It will do so by reinstating the moratorium on enforcement of this unnecessary regulation. It has broad bipartisan support in Congress and the support of key stakeholders including the American Hospital Association, the National Rural Health Association and the Kansas Hospital Association.

As a small town girl, I feel strongly that folks in rural communities deserve access to quality health care. I can't emphasize enough that rural hospitals—rural communities in Kansas and across the country depend on access hospitals like critical access hospitals which are directly threatened by CMS' action.

I hope the Members from both parties can come together once again to ensure high quality and timely care is available to you no matter where you live in America. Companion legislation was introduced by Senators Thune, Moran and Jon Tester.

It has passed the Senate back in September. I also want to thank my lead cosponsor on the legislation, Congressman Dave Loebsack and for all his hard work and advocacy on the issue as well.

I urge my colleagues to support the legislation and move it forward in a timely fashion.

Thank you all for allowing me to join you today.

[The statement of Ms. Jenkins follows:]

LYNN JENKINS, CPA
2ND DISTRICT, KANSAS
VICE CHAIR
HOUSE REPUBLICAN CONFERENCE
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Statement of the Honorable Lynn Jenkins
Before the House Committee on Energy and Commerce Subcommittee on the Health
Examining Legislation to Improve Medicare and Medicaid

Chairman Pitts, Ranking Member Green,

Thank you for holding this hearing and inviting me to speak on H.R. 2878, a critical piece of legislation that I have sponsored. The bill would delay Medicare's physician "direct supervision" requirement, for outpatient therapeutic services in critical access and small rural hospitals, until 2016.

In January of 2014, the Centers for Medicaid and Medicare Services began enforcing a requirement that physicians must supervise outpatient therapy at Critical Access Hospitals and other small, rural hospitals. CMS's decision meant that routine outpatient procedures, such as drawing blood or undergoing active therapy, would have to be directly supervised by a physician. This decision by CMS would have put a severe strain on providers, particularly those in rural areas, while providing no quality improvements for the patients they serve.

Most of these outpatient procedures are relatively simple, are very safe, and would not benefit from a federal mandate that a physician always be in the room. And, as a practical matter, in rural hospitals across America, such a requirement is simply not feasible.

I was proud to introduce legislation last Congress that delayed this Medicare "direct supervision" requirement through 2014, and it was signed into law with bipartisan support. It has been widely recognized as an effective tool to improve care in rural hospitals, and keep the regulatory burden in check.

Unfortunately, rural hospitals are once again staring down the threat of this federal mandate from CMS. The existing law delaying enforcement action from CMS has expired. Accordingly, I have now re-introduced similar legislation this Congress, further delaying enforcement until 2016. It is about this legislation, H.R. 2878, which this committee has graciously invited me to speak about today.

When I think about the healthcare needs facing my district, there is nothing more challenging than ensuring access to quality and accessible rural healthcare. Rural America is struggling and

the 84 Critical Access Hospitals in Kansas are the lifeblood of our rural communities. The presence of a facility such as a Critical Access Hospital in a community could be the deciding factor in whether or not the next generations of children decide to raise their family in their hometown, or perhaps whether or not a business decides to locate there. Easy access to emergency care can be a life and death situation and we cannot threaten the existence of these facilities by piling on the regulatory burden from Washington.

Earlier this year, I invited Carrie Saia, CEO of Holton Community Hospital, to testify about this issue before the Ways and Means Committee's Subcommittee on Health. Holton Community Hospital happens to be responsible for serving my hometown, Holton, a community of just over 3,000 Kansans. She explained in great detail that direct supervision would be extremely burdensome, costly, and is simply unrealistic at a hospital serving rural America. The result of enforcing this mandate would be to severely limit the type of services rural hospitals could offer, and it would threaten their financial stability at a complicated and uncertain time in our nation's healthcare system.

H.R. 2878 will correct this problem. It will do so by reinstating the moratorium on enforcement of this unnecessary regulation. It has broad bipartisan support in Congress, and the support of key stakeholders, including the American Hospital Association, the National Rural Health Association, and the Kansas Hospital Association.

As a small town girl, I feel strongly that folks in rural communities deserve access to quality health care. I cannot emphasize enough that rural communities in Kansas, and across the country, depend on Critical Access Hospitals, which are directly threatened by CMS's actions. I hope that Members from both parties can once again come together to ensure that high-quality, timely care is available no matter where you live in America.

Companion legislation introduced by Senators John Thune, Jerry Moran, and Jon Tester was passed by the Senate this September. I urge my colleagues to support this legislation, and move it forward in a timely fashion. Thank you very much for the invitation to speak.

Mr. PITTS. Chair thanks the gentlelady. Really appreciate you taking time out of your busy schedule to come and present testimony to us today.

As usual, we will not have any questions for our Members presenting testimony. So we will excuse the gentlelady with our thanks and call our second panel to the witness table. And while they are setting up the table I would like to submit the following document for UC request for the record. It is a statement from the American College of Obstetricians and Gynecologists.

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

Without objection, so ordered. I will introduce our second panel in the order they will testify. First, Ms. Katherine Iritani, director of Health Care, Government Accountability Office, and then Ms. Anne Schwartz, Ph.D., executive director, Medicaid and CHIP Payment and Access Commission.

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

So with that, Ms. Iritani, you are recognized for 5 minutes.

STATEMENTS OF KATHERINE M. IRITANI, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, AND ANNE L. SCHWARTZ, PH.D., EXECUTIVE DIRECTOR, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

STATEMENT OF KATHERINE M. IRITANI

Ms. IRITANI. Chairman Pitts, Ranking Member Green and members of the subcommittee, thank you for this opportunity to be here today as you consider ways to strengthen the jointly financed Federal and State Medicaid program, now the largest healthcare program in the Nation by enrollment.

My testimony today will cover a body of GAO work from recent years on two complex topics—Federal oversight of certain large payments States often make known as supplemental payments and how States finance the non-Federal share of their programs.

Supplemental payments are above and beyond regular payment rates for services and States have considerable flexibility for making them. States can distribute them to only a small number of providers, often hospitals.

Congress and CMS have taken important steps to enhance Medicaid program integrity through better oversight of these payments. We believe there are opportunities for even more improvements.

Our recent work on certain Medicaid supplemental payments that States often make has shown that better Federal information is needed to understand and oversee them.

The payments have been growing in size and now total over \$20 billion a year and can amount to tens or hundreds of millions of dollars a year to a single provider.

CMS and others need better information to understand who States are paying, how much they are paying and how such payments relate to services provided to Medicaid beneficiaries.

Many States have made supplemental payments that greatly exceed the provider's cost of providing Medicaid care. In 2012, we found that 39 States had made supplemental payments to over 500

hospitals that resulted in total Medicaid payments exceeding the hospitals' costs of providing Medicaid care by \$2.7 billion.

Payments are not limited to costs under Medicaid but payments that greatly exceed costs may not be economical and efficient as required by law.

Now, let me turn to our work on State financing, which has concluded that better information on State sources of funds to finance Medicaid is also needed. States are allowed within certain limits to seek funds from providers and local governments to fund Medicaid payments.

States can, for example, tax providers or seek intergovernmental fund transfers from local governments to help finance the non-Federal share.

We have found that States are increasingly depending on local governments and providers for financing, which can ultimately shift Medicaid costs not only to providers and local governments but to the Federal Government.

On the basis of our National survey of State Medicaid programs, in 2012 about \$46 billion or 26 percent of the non-Federal share of Medicaid was financed with funds from providers and local governments, a 21 percent increase from 2008.

Taxes on healthcare providers almost doubled in size during that time from \$9.7 to \$18.7 billion. Such taxes are subject to certain restrictions, for example, to ensure that taxes are broad based and uniform.

Cost shifts to the Federal Government can occur through financing arrangements that concentrate financing of the payments on those providers who receive the payments.

For example, a State can increase payments for Medicaid providers such as hospitals, impose a tax on those providers for the non-Federal share and draw down Federal matching funds for the payments.

CMS and other stakeholders are not well positioned to assess payments States make to individual institutional providers. Federal data on certain supplemental payments States often make is not complete, reliable, uniform or accessible.

CMS has important initiatives underway but CMS has reported that legislation is needed to compel States to report such payments uniformly and to subject them to audit.

CMS also lacks good data on State financing sources. Such data are needed to ensure financing is appropriate and to understand how payments affect beneficiary access to care.

In conclusion, a needed step towards strengthening the Medicaid program is to make payments and financing more transparent.

For this large and growing program, CMS and others need to know who States are paying and in what amounts and right now CMS lacks sufficient data to know this.

We have suggested that Congress consider requiring CMS to require States to report and audit these payments. We have also recommended that CMS develop a strategy for improving information on State sources of funds for Medicaid.

In view of growing costs and enrollments, such transparency can help ensure the program is efficiency and effectively meeting the

promise of providing medical assistance to our Nation's low-income populations.

Mr. Chairman, this concludes my testimony. I am happy to answer any questions.

[The statement of Ms. Iritani follows:]



United States Government Accountability Office

Testimony

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

For Release on Delivery
Expected at 10:15 a.m. ET
Tuesday, November 3, 2015

MEDICAID

Improving Transparency and Accountability of Supplemental Payments and State Financing Methods

Statement of Katherine M. Iritani
Director, Health Care

GAO Highlights

Highlights of GAO-16-195T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicaid is an over \$500 billion dollar jointly financed program for which the federal government matches state Medicaid expenditures. Within certain limits, states can make supplemental payments to providers in addition to their regular claims-based payments and receive federal matching funds. These payments have grown in the past decade. To finance the nonfederal share of Medicaid payments, states can use funds from local governments and providers, within federal parameters. CMS is responsible for overseeing state programs and ensuring that state payments are consistent with Medicaid payment principles—including that they are economical and efficient, and appropriately financed.

States may have incentives to make excessive supplemental payments to certain providers who finance the nonfederal share of the payment. GAO has a body of work from 2004 to 2015 raising concerns with Medicaid supplemental payments and financing methods. Congress and CMS have taken actions to improve accountability for these payments, and GAO has made further suggestions for Congress and CMS.

This statement highlights key issues and opportunities for improving transparency and oversight from GAO's work related to (1) certain supplemental payments states make to providers, and (2) states' financing of the non-federal share of Medicaid. This testimony is based on GAO reports from 2004 to 2015 on state Medicaid financing and supplemental payments, and selected updates from CMS on the status of prior recommendations.

View GAO-16-195T. For more information, contact Katherine M. Irtani at (202) 512-7114 or irtani@gao.gov.

November 3, 2015

MEDICAID

Improving Transparency and Accountability of Supplemental Payments and State Financing Methods

What GAO Found

GAO has found that complete and reliable data are lacking on the tens of billions in Medicaid supplemental payments states often make, hindering transparency and oversight. In a November 2012 report, GAO found that Congress and the Centers for Medicare & Medicaid Services (CMS) have acted to improve transparency and accountability for one type of Medicaid supplemental payment known as disproportionate share hospital (DSH) payments, made for uncompensated care costs experienced by hospitals serving low-income and Medicaid patients. Since 2010, DSH payments are required to be reported to CMS and are subject to independent audits that assess their appropriateness. States also make other supplemental payments—referred to here as non-DSH payments—to hospitals and other providers that, for example, serve high-cost Medicaid beneficiaries. Gaps in oversight remained for non-DSH supplemental payments, which as of 2011 exceeded DSH in amounts paid. For example, GAO reported that 39 states made non-DSH supplemental payments to 505 hospitals that, along with regular Medicaid payments, exceeded those hospitals' total costs of providing Medicaid care by about \$2.7 billion. Medicaid payments are not limited to a provider's costs for services, but GAO concluded in an April 2015 report that payments that greatly exceed costs raise questions about whether they are economical and efficient as required by law, and the extent to which they are ultimately used for Medicaid services. CMS lacks data on supplemental payments made to individual providers. Per federal internal control standards, agencies should have reliable information for decision making and reporting, and reasonable assurance that agency objectives, such as compliance with laws, are being met. In 2012, CMS officials said legislation was needed to implement non-DSH reporting and auditing requirements, and GAO suggested that Congress consider requiring CMS to provide guidance on permissible methods for calculating non-DSH payments and require state reports and audits.

GAO found in a July 2014 report that states are increasingly relying on providers and local governments to finance Medicaid and data needed for oversight are lacking. About \$46 billion or 26 percent of the nonfederal share was financed with funds from providers and local governments in 2012—an increase from 21 percent in 2008. GAO found that states' financing arrangements can effectively shift costs from states to the federal government. In one state, a \$220 million payment increase for nursing facilities funded by a \$115 million tax on nursing facilities yielded a net payment increase to the facilities of \$105 million. The state obtained \$110 million in federal matching funds for the payments. GAO found that CMS generally does not require or otherwise collect data from states on sources of funds to finance Medicaid, nor ensure that the data it does collect are accurate and complete. GAO identified, for example, incomplete reporting of provider taxes. As a result, CMS cannot fully assess the appropriateness of states' financing or the extent to which the increased reliance on providers and local governments serves to provide fiscal relief to states or improve access. Per federal internal control standards, agencies should collect accurate and complete data for monitoring. GAO recommended in 2014 that CMS improve the data states report on Medicaid financing. The agency disagreed, stating its efforts were adequate. GAO maintains its recommendation is valid.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

I am pleased to be here today as you discuss legislative proposals related to Medicaid financing and certain payments states often make, known as supplemental payments. The size, growth, and diversity of Medicaid create significant challenges for administration and oversight. Medicaid is the nation's largest health program as measured by enrollment and the second largest health program, after Medicare, as measured by expenditures. Medicaid is administered by states, overseen by the Centers for Medicare & Medicaid Services (CMS), and financed jointly by the federal government and states based on a statutory formula. It is a significant component of federal and state budgets, with estimated outlays of \$529 billion in fiscal year 2015, of which \$320 billion was expected to be financed by the federal government and \$209 billion by the states.¹ By 2020, Medicaid expenditures are projected to total \$725 billion, with federal expenditures alone totaling \$436 billion.

States generally finance their share of Medicaid—often called the nonfederal or state share—by using state general funds appropriated by state legislatures. However, states can, within certain federal parameters, use other sources of funds to finance Medicaid, such as taxes on health care providers and funds from local government providers or local governments on behalf of providers.² States' financing of the nonfederal share is subject to federal limits and requirements. For example, states must use state funds to finance at least 40 percent of the nonfederal share of total Medicaid expenditures each year. This limit is applied in the aggregate; that is, across each state's entire Medicaid program, and not for individual payments. In addition to flexibility in determining sources of funds to use to finance their nonfederal share, states have flexibility, within broad federal requirements, in designing and operating their Medicaid programs, including setting payment rates for providers. Many states make supplemental payments—payments above regular claims-based payments for Medicaid services—to certain providers, mainly

¹Centers for Medicare & Medicaid Services, Office of the Actuary, *2014 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2015).

²For purposes of this statement, sources of funds are the means (e.g., taxes) by which funds are supplied by entities (e.g., providers) to the state to be used to finance the nonfederal share of Medicaid; we do not use the term sources to refer to the entities themselves.

hospitals. The federal government shares in the costs of these payments. Supplemental payments are a significant component of Medicaid spending, totaling at least \$43 billion in fiscal year 2011, up from \$32 billion in fiscal year 2010 and at least \$23 billion in fiscal year 2006. These amounts were likely understated because reporting of supplemental payments was incomplete.³

As the agency overseeing Medicaid at the federal level, CMS is responsible for providing guidance to states on federal Medicaid requirements and for overseeing state programs, including ensuring that state Medicaid payments are appropriately financed and consistent with Medicaid payment principles. For example, Medicaid payments generally must be for Medicaid covered items and services, and consistent with efficiency, economy, and quality of care.

We have reported over many years on a number of challenges facing Medicaid and have a significant body of work on states' supplemental payments to providers and financing of the non-federal share. Both Congress and CMS have taken significant steps to improve transparency and accountability in these areas. We believe there are opportunities for additional improvements that are important in view of both the significant spending for supplemental payments and the integrity of the program. My testimony today will cover our work related to the supplemental payments states often make to certain institutional providers, and to states' financing of the nonfederal share of the Medicaid program. My remarks focus on key issues related to:

1. certain supplemental payments states make to providers, and opportunities for improved oversight and transparency, and
2. states' financing of the non-federal share of Medicaid, and opportunities for improved oversight and transparency.

My remarks are based on multiple reports and testimonies we have produced on these topics since 2004, including our recent report on key issues facing the Medicaid program; our reports on opportunities to reduce fragmentation, duplication and overlap in federal programs; and

³See GAO, *Medicaid: States Reported Billions More in Supplemental Payments in Recent Years*, GAO-12-694 (Washington, D.C.: July 20, 2012), and *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, GAO-13-48 (Washington, D.C.: Nov. 26, 2012).

our most recent high-risk update.⁴ My remarks on supplemental payments states make to providers are based in large part on findings from our November 2012 report, which examined how information from newly required reporting facilitated CMS's oversight of certain types of supplemental payments, and the extent to which similar information existed to facilitate CMS's oversight of other types of supplemental payments.⁵ For that report, we reviewed audits and reports, analyzed data on supplemental payments, and interviewed CMS officials. My remarks on states' financing of the non-federal share of Medicaid are based in large part on findings from our July 2014 report, which examined the extent to which states have relied on funds from health care providers and local governments to finance the nonfederal share of Medicaid; the extent to which states have changed their reliance on health care providers and local governments to help finance the nonfederal share of Medicaid in recent years and the implications, if any, of these changes; and the extent to which CMS collects data to oversee states' use of various sources of funds.⁶ For that report, we administered a questionnaire to all state Medicaid agencies, examined effects of financing changes in a nongeneralizable sample of three states selected in part based on Medicaid spending and geographic diversity, and interviewed CMS officials. The reports cited provide further details on our scope and methodology. My remarks also draw on information we obtained from CMS between March 2015 and June 2015 about the status of our prior recommendations in these areas, as well as current CMS efforts related to Medicaid.⁷

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards

⁴See GAO, *Medicaid: Key Issues Facing the Program*, GAO-15-677 (Washington, D.C.: July 30, 2015), *2015 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*, GAO-15-404SP (Washington, D.C.: April 14, 2015), and *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: February 11, 2015). See Related GAO Products at the end of this statement for additional reports on these topics.

⁵See GAO-13-48.

⁶See GAO, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection*, GAO-14-627 (Washington, D.C.: July 29, 2014).

⁷See appendix I for related GAO recommendations and matters for congressional consideration.

require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicaid is an open-ended entitlement; states are generally obligated to pay for covered services provided to eligible individuals, and the federal government is obligated to pay its share of a state's expenditures under a federally approved state Medicaid plan. The federal share of each state's Medicaid expenditures is based on a statutory formula known as the Federal Medical Assistance Percentage (FMAP).⁸ Some states design their Medicaid programs to have local governments contribute to the programs' costs, for example, through intergovernmental transfers of funds from government-owned or -operated providers to the state Medicaid program. States may, subject to certain requirements, also receive funds to finance Medicaid payments from health care providers, for example, through provider taxes—taxes levied on providers such as hospitals or nursing facilities. Under federal law, provider taxes must be broad-based, must be uniformly imposed, and must not hold providers harmless; that is, they must not provide a direct or indirect guarantee that providers will receive all or a portion of tax payments back. Taxes that are at or below 6 percent of the individual provider's net patient service revenues are considered not to have provided an indirect guarantee that providers will receive their tax payments back.

In addition to flexibility in determining sources of funds they use to finance their nonfederal share, states have flexibility, within broad federal requirements, in designing and operating their Medicaid programs, including determining which services to cover and setting payment rates for providers. In general, federal law provides for federal matching funds for state Medicaid payments for covered services provided to eligible beneficiaries up to a ceiling or limit, often called the upper payment limit (UPL). The UPL is based on what Medicare would pay for the same services. States often make two general types of Medicaid supplemental payments:

⁸The FMAP is based on a formula established by law under which the federal share of a state's Medicaid expenditures for services generally may range from 50 to 83 percent. States with lower per capita income receive a higher FMAP for services.

-
- First, under federal Medicaid law, states are required to make disproportionate share hospital (DSH) payments to certain hospitals. These payments are designed to help offset these hospitals' uncompensated care costs for serving Medicaid and uninsured low-income patients. States' Medicaid payment rates are not required to cover the full costs of providing care to Medicaid beneficiaries, and many providers also provide care to low-income patients without any insurance or ability to pay. Under federal law, DSH payments are capped at a facility-specific level and state level.
 - Second, many states also make another type of Medicaid supplemental payment, referred to here as non-DSH supplemental payments, to hospitals and other providers who, for example, serve high-cost Medicaid beneficiaries. Unlike DSH payments, non-DSH supplemental payments are not required under federal law, do not have a specified statutory or regulatory purpose, and are not subject to firm dollar limits at the facility or state level. Unlike regular Medicaid payments, which are paid on the basis of covered Medicaid services provided to Medicaid beneficiaries through an automated claims process, non-DSH supplemental payments are not necessarily made on the basis of claims for specific services to particular patients and can amount to tens or hundreds of millions of dollars to a single provider, annually. States can generally make non-DSH payments up to the UPL. Typically, state Medicaid payment rates are lower than what the Medicare program would pay, and so many states make supplemental payments under the UPL. Non-DSH supplemental payments, like regular Medicaid payments, must be consistent with Medicaid payment principles. Under federal law, to receive federal matching funds, payments generally must (1) be made for covered Medicaid items and services, (2) be consistent with economy, efficiency, and quality of care, and (3) not exceed the UPL. Supplemental payments may also be made under Medicaid

demonstrations, but may not be subject to these requirements, depending on the terms of the demonstration.⁹

Historically, DSH payments exceeded Medicaid non-DSH payments. In recent years the opposite has occurred, and non-DSH payments have exceeded DSH payments. In fiscal year 2011, Medicaid non-DSH payments totaled nearly \$26 billion compared to over \$17 billion for DSH payments.

**Complete and
Reliable Data on
Non-DSH
Supplemental
Payments are
Lacking, Hindering
Transparency and
Oversight**

For about two decades, we have raised concerns about supplemental payments and the adequacy of federal oversight. We have designated Medicaid a high-risk program due in part to these concerns. For example, in a February 2004 report, we found that over the years some states had made relatively large non-DSH supplemental payments to relatively small numbers of government-owned providers, and that these providers were then sometimes required to return these payments to the states, resulting in an inappropriate increase in federal matching funds. We also found that some states had used widely varying and inaccurate methods for estimating their non-DSH payment amounts, which may inflate the amount of non-DSH supplemental payments.¹⁰ CMS is responsible for ensuring that state Medicaid payments are consistent with federal requirements, including that payments are consistent with economy and efficiency and are for Medicaid-covered services. To do so, it is important

⁹Under section 1115 of the Social Security Act, states may apply to and receive approval from CMS for a demonstration that allows states to deviate from their traditional Medicaid program. Spending authorities under the demonstrations provide states with the ability to claim federal Medicaid funds for new types of expenditures, including the costs of making additional payments to providers. These supplemental payments are governed by the terms and conditions of the individual demonstrations. Our work prior to 2013 did not generally refer to demonstration supplemental payments as non-DSH payments. Our work in 2014 and 2015 refers to demonstration supplemental payments as a type of non-DSH supplemental payment. CMS, when reporting states' non-DSH supplemental payment expenditures, includes both supplemental payments made under a state Medicaid plan and demonstration supplemental payments.

¹⁰See GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228 (Washington, D.C.: February 13, 2004). In this report, we recommended CMS issue guidance on permissible methods for estimating non-DSH payment amounts. CMS concurred with our recommendation, and has taken some steps to improve oversight of these payments, but has not specified uniform methods for calculating non-DSH supplemental payment amounts.

for CMS to have relevant, reliable, and timely information for management decision making and external reporting purposes.¹¹

In recent years, our work examining these payments has identified several instances of payments that further raise concerns about whether Medicaid payments that greatly exceeded costs are economical and efficient. For example, as reported in November 2012, we found that 39 states had made non-DSH supplemental payments to 505 hospitals that, along with their regular Medicaid payments, exceeded those hospitals' total costs of providing Medicaid care by \$2.7 billion.¹² In some cases, payments greatly exceeded costs; for example, one hospital received almost \$320 million in non-DSH payments and \$331 million in regular Medicaid payments, which exceeded the \$410 million in costs reported for the hospital for providing Medicaid services by about \$241 million.

As we reported in April 2015, our more recent analysis of average daily payment amounts—which reflect both regular payments and non-DSH supplemental payments—identified hospitals for which Medicaid payments received exceeded their Medicaid costs, and we also found a few cases where states made payments to local government hospitals that exceeded the hospitals' total operating costs.¹³ CMS's oversight mechanisms had not identified large overpayments to two hospitals in one state that resulted from non-DSH supplemental payments until we identified them. CMS began reviewing the appropriateness of the two hospitals' payments during the course of our review. As we concluded in our 2012 and 2015 reports, although Medicaid payments are not required to be limited to a provider's costs of delivering Medicaid services, payments that greatly exceed these costs raise questions, including whether they are consistent with economy and efficiency, whether they

¹¹According to federal internal control standards, agencies are responsible for determining through monitoring that relevant, reliable, and timely information is available for management decision making and external reporting purposes. In addition, agencies are responsible for continually examining and improving internal controls to provide reasonable assurance that the objectives of the agency, such as compliance with applicable laws and regulations, are being achieved. See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

¹²See GAO-13-48.

¹³See GAO, *Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, GAO-15-322 (Washington, D.C.: April 10, 2015).

contribute to beneficiaries' access to quality care, and the extent to which they are ultimately used for Medicaid purposes. However, CMS lacks data at the federal level on non-DSH supplemental payments, and the payments are not subject to audit.¹⁴

Based on our findings, we have identified opportunities to improve the oversight, transparency, and accountability of non-DSH supplemental payments to providers, in particular through improved reporting, auditing, and guidance. Since 2010, states have been required by federal law to submit annual facility-specific reports and annual independent certified audits on DSH payments.¹⁵ In connection with the independent audit requirement, standard methods were established for calculating DSH payment amounts.¹⁶ However, similar requirements for reporting, annual independent audits, and guidance on acceptable methods for calculating non-DSH supplemental payments are not in place for non-DSH payments. As we reported in November 2012, we found that the newly implemented annual reporting and audits for DSH payments improved CMS oversight—and we concluded that better reporting and audits of non-DSH supplemental payments could improve CMS's oversight of these payments as well.

As our work has shown, states' non-DSH supplemental payments can be complex and challenging to assess. Hospital-specific information can be helpful to CMS and others for understanding, at the provider level, the relationship of supplemental payments to both regular Medicaid payments and Medicaid costs. For example, reporting of non-DSH payments that states make to individual hospitals and other providers relative to the providers' Medicaid costs could improve the transparency of these payments. In addition, audits could improve accountability by providing information on how these payments are calculated and the extent to which payments to individual providers are consistent with the Medicaid payment principles of economy and efficiency.¹⁷ Absent complete and

¹⁴See GAO-15-322 and GAO-13-48.

¹⁵These requirements were mandated by statute. In 2008, CMS issued a final rule to implement the 2003 DSH audit and report requirements. The first sets of DSH audits and reports, covering payments made in 2005 through 2007, were submitted to CMS in December 2010. See GAO-13-48.

¹⁶See GAO-12-694 and GAO-13-48.

¹⁷See GAO-13-48.

reliable provider-specific data on the non-DSH supplemental payments individual providers receive, CMS may not identify potentially excessive payments to providers, and the federal government could be paying states hundreds of millions—or billions—of dollars more than what is appropriate.¹⁸

CMS has taken some steps to improve oversight of these payments, but has not established facility-specific reporting requirements, required annual independent audits of states' non-DSH payments, or specified uniform methods for calculating non-DSH supplemental payment amounts. Steps CMS has taken include issuing a state Medicaid Director letter in 2013 to obtain more information on non-DSH supplemental payments and awarding a contract in May 2014 to review Medicaid supplemental payment information, the outcomes of which were not yet known as of July 2015.¹⁹ CMS said in 2012 that legislation was necessary for them to implement reporting and auditing requirements for DSH payments, and that legislation would be needed for the agency to implement similar requirements for non-DSH supplemental payments. Consequently, we have suggested that Congress consider requiring CMS to take steps to improve the transparency and accountability of non-DSH supplemental payments, including requirements similar to those in place for DSH.

¹⁸As we reported in April 2015, we found that CMS oversight of provider supplemental payments is limited because the agency does not require states to report provider-specific data on these payments, nor does it have a policy and standard process for determining whether Medicaid payments to individual providers are economical and efficient. We recommended that CMS improve its oversight by taking steps to ensure that states report accurate, provider-specific payment data, and by developing a policy and process for reviewing payments to individual providers to determine whether they are economical and efficient, and HHS concurred with our recommendations.

¹⁹The contract will develop options for improving oversight of payments to support CMS's Medicaid program integrity and oversight efforts. As of July 2015, the contract study was ongoing. According to CMS officials, CMS plans to develop an appropriate action plan as necessary when the results of the contract study are available.

States are Increasingly Relying on Providers and Local Governments to Finance Medicaid, and Data Needed for Oversight is Lacking

Our work has found that states are increasingly relying on providers and local governments to finance Medicaid, and has also pointed to the need for better data and improved oversight to ensure that Medicaid payments are financed consistent with federal requirements, to understand financing trends, and to ensure federal matching funds are used efficiently. Further, our work has shown that state flexibility to seek contributions from local governments or impose taxes on health care providers to finance Medicaid may create incentives for states to overpay providers in order to reduce states' financial obligations. Such financing arrangements can have the effect of shifting costs of Medicaid from states to the federal government. Benefits to providers, which may be financing a large share of any new payments, and to the beneficiaries whom they may serve, may be less apparent. CMS is responsible for ensuring that state Medicaid payments made under financing arrangements are consistent with Medicaid payment principles, including that they are economical and efficient, and that the federal government and states share in the financing of the Medicaid program as established by law. To oversee the Medicaid program, it is important for CMS to have accurate and complete information on the amount of funds supplied by health care providers and local governments to states to finance the nonfederal share of Medicaid.²⁰

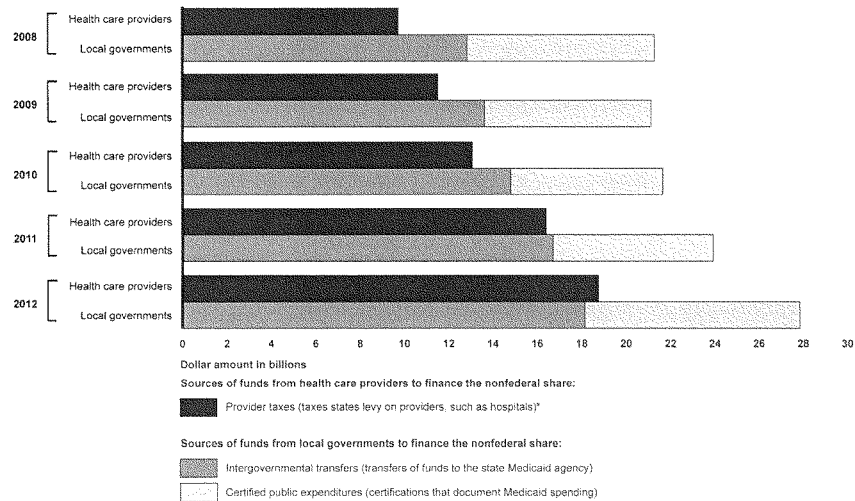
As we reported in July 2014, our survey of all state Medicaid programs found that states are increasingly relying on providers and local governments to help fund Medicaid. For example, in state fiscal year 2012, funds from providers and local governments accounted for 26 percent (or over \$46 billion) of the approximately \$180 billion in the total nonfederal share of Medicaid payments that year—an increase from 21 percent (\$31 billion) in state fiscal year 2008.²¹ (See fig. 1.) These sources were used to fund Medicaid supplemental payments—both DSH and non-DSH—to a greater extent than other types of payments, and we found this reliance was growing. For Medicaid DSH and non-DSH

²⁰According to federal internal control standards, federal agencies should collect accurate and complete data to monitor programs they oversee. See GAO/AIMD-00-21.3.1.

²¹We found that the percentage and amount of funds from health care providers and local governments that states used to finance the nonfederal share of Medicaid payments varied significantly among states in state fiscal year 2012. For example, in the 48 states that reported using funds from health care providers and local governments, the percentage of funds from providers and local governments ranged from less than 1 percent in South Dakota and Virginia to 53 percent in Missouri. See GAO-14-627.

supplemental payments, the percentage of the nonfederal share financed with funds from providers and local governments increased from 57 percent (or \$8.1 billion) in state fiscal year 2008 to 70 percent (or \$13.6 billion) in state fiscal year 2012. Several states relied on health care providers and local governments for the entire nonfederal share of supplemental payments in 2012.

Figure 1: Amount of the Nonfederal Share of Medicaid Payments from Health Care Providers and Local Governments, State Fiscal Years 2008 through 2012



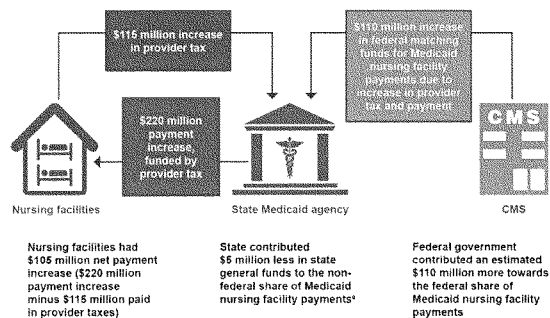
Source: GAO. | GAO-16-195T

*For this graphic, we use the term provider tax to refer to health care provider taxes, fees, or assessments. The amounts of provider taxes reported include provider donations. Provider donations totaled \$17 million in 2008, \$16 million in 2009, \$78 million in 2010, \$69 million in 2011, and \$72 million in 2012.

Our reports have illustrated how this increased reliance on non-state sources of funds can shift costs from states to the federal government, changing the nature of the federal-state partnership. For example, in our July 2014 report, our analysis of arrangements involving financing of the nonfederal share of Medicaid payments with funds from provider taxes or local governments in three selected states illustrated how Medicaid costs can be shifted from the state to the federal government and, to a lesser extent, to health care providers and local governments.²² The use of funds from providers and local governments is, as previously described, allowable under federal rules, but it can also have implications for federal costs. By increasing providers' Medicaid payments, and requiring providers receiving the payments to supply all or most of the nonfederal share, we found that states claimed an increase in federal matching funds without a commensurate increase in state general funds. For example, in our 2014 report, we found that in one state a \$220 million payment increase for nursing facilities in 2012 (which was funded by a tax on nursing facilities) resulted in an estimated \$110 million increase in federal matching funds; no increase in state general funds; and a net payment increase to the facilities, after paying the taxes, of \$105 million. (See fig. 2.)

²²See GAO-14-627.

Figure 2: Example of How One State's Use of Non-State Sources to Fund Medicaid Payments to Nursing Facilities Shifted Medicaid Costs to the Federal Government in State Fiscal Year 2012



Source: GAO. | GAO-16-195T

Note: This figure illustrates the estimated effect of a new provider tax and increased Medicaid payments on the state and federal share of total regular Medicaid payments to nursing facilities and on net Medicaid payments to nursing facilities in one state in state fiscal year 2012. For the analysis, we compared actual payments in that year to what payments would have been without the provider tax and increased Medicaid payments to nursing facilities.

*The state used state general funds to finance most of the nonfederal share of Medicaid, but we estimated that the provider tax resulted in the state needing to use \$5 million less in state general funds to finance its share of Medicaid.

As we found in our 2014 report, due to data limitations, CMS is not well-positioned to either identify states' Medicaid financing sources or assess their impact. Apart from data on provider taxes, CMS generally does not require (or otherwise collect) information from states on the funds they use to finance Medicaid, nor ensure that the data that it does collect are accurate and complete.²³ The lack of transparency in states' sources of funds and financing arrangements hinders CMS's and federal policymakers' efforts to oversee Medicaid. Further, it is difficult to

²³We reported in July 2014, for example, that when we compared the provider tax data reported to CMS in 2012 with state responses to our questionnaire, we found evidence of incomplete reporting. Specifically, 6 of the 47 states that reported in the questionnaire that they had at least one health care provider tax or provider donation in effect that year did not report a tax or donation to CMS in 2012.

determine whether a state's increased reliance on funds from providers and local governments primarily serves to (1) provide fiscal relief to the state by increasing federal funding, or (2) increase payments to providers that in turn help improve beneficiary access.

CMS has recognized the need for better data from states on how they finance their share of Medicaid and has taken steps to collect some data, but additional steps are needed. We recommended in July 2014 that CMS take steps to ensure that states report accurate and complete information on all sources of funds used to finance the nonfederal share of Medicaid, and offered suggestions for doing so. The Department of Health and Human Services (HHS) did not concur with our recommendation, stating that its current efforts were adequate; however, HHS acknowledged that additional data were needed to ensure that states comply with federal requirements regarding how much local governments may contribute to the nonfederal share, and stated that it would examine efforts to improve data collection for oversight.²⁴ As of June 2015, HHS reported that its position continued to be that no further action is needed. Given states' increased reliance on non-state sources to fund the nonfederal share of Medicaid, which can result in costs shifting to the federal government, we continue to believe that improved data are needed to improve transparency and oversight, such as to understand how increased federal costs may affect beneficiaries and the providers who serve them.

In conclusion, the flexibility states have in how they pay providers and finance the nonfederal share has enabled states to make excessive payments to certain providers and allowed states to shift costs to the federal government. While Congress and CMS have taken important

²⁴In commenting on a draft of our July 2014 report, HHS acknowledged that it does not have adequate data on state financing methods for overseeing compliance with a certain federal requirement related to the nonfederal share—the 60 percent limit on contributions from local governments to finance the nonfederal share—and stated that it will examine efforts to improve data collection toward this end. HHS also stated that it is working to identify needs for improvement in current payment and financing review processes. However, HHS did not concur with two options we suggested in our recommendation for short- and long-term ways of improving agency data collection. Specifically, HHS disagreed with suggestions that facility-specific data are needed for oversight, and that an enhanced Medicaid claims data system the agency is developing—called the Transformed Medicaid Statistical Information System (T-MSIS)—may be an appropriate means for collecting financing data. HHS stated that it believed that its current financing reviews are sufficiently reviewing provider-level data. See GAO-14-627.

steps to improve the integrity of the Medicaid program through improved oversight of some Medicaid supplemental payments and financing arrangements, Congress and CMS need better information and more tools to understand who receives non-DSH supplemental payments and in what amounts, to ensure they are economical and efficient as required by law, and to determine the extent to which they are ultimately used for Medicaid purposes.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you might have at this time.

**GAO Contacts and
Staff
Acknowledgments**

If you or your staff have any questions about this testimony, please contact Katherine M. Iritani at (202) 512-7114. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Tim Bushfield, Assistant Director; Robin Burke; Sandra George; Jessica Morris; Laurie Pachter; Said Sariohghalam; and Emily Wilson.

Appendix I: GAO's Matters for Congressional Consideration and Agency Recommendations

The following table lists matters for congressional consideration regarding actions to improve the transparency of and accountability for the Medicaid non-disproportionate share hospital (DSH) supplemental payments states make to providers. It also includes recommendations we have made to the Department of Health and Human Services (HHS) regarding actions to improve data and oversight of the sources of funds states use to finance the nonfederal share of Medicaid.

Table 1: GAO's Related Matters for Congressional Consideration, Agency Recommendations, and Status

GAO Report	Matters for Congressional Consideration and Agency Recommendations	Status
Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed. GAO-13-48, November 26, 2012	<p>Congress should consider requiring the Centers for Medicare & Medicaid Services (CMS) to</p> <ol style="list-style-type: none"> 1. improve state reporting of non-disproportionate share hospital (DSH) supplemental payments, including requiring annual reporting of payments made to individual facilities and other information that the agency determines is necessary to oversee non-DSH supplemental payments; 2. clarify permissible methods for calculating non-DSH supplemental payments; and 3. require states to submit an annual independent certified audit verifying state compliance with permissible methods for calculating non-DSH supplemental payments. 	As of October 2015, Congress had not implemented this matter for its consideration.
Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection. GAO-14-627, July 29, 2014	<p>CMS should develop a data collection strategy that ensures that states report accurate and complete data on all sources of funds used to finance the nonfederal share of Medicaid payments. There are short- and long-term possibilities for pursuing the data collection strategy, including</p> <ol style="list-style-type: none"> 1. in the short-term, as part of its ongoing initiative to annually collect data on Medicaid payments made to hospitals, nursing facilities, and other institutional providers, CMS could collect accurate and complete facility-specific data on the sources of funds used to finance the nonfederal share of the Medicaid payments; and 2. in the long-term, as part of its ongoing initiative to develop an enhanced Medicaid claims data system (T-MSIS), CMS could ensure that T-MSIS will be capable of capturing information on all sources of funds used to finance the nonfederal share of Medicaid payments, and, once the system becomes operational, ensure that states report this information for supplemental Medicaid payments and other high-risk Medicaid payments 	In commenting on a draft of our report, the Department of Health and Human Services (HHS) did not concur with our recommendation, stating that its current efforts were adequate. However, HHS acknowledged that additional data were needed to ensure that states comply with federal requirements regarding how much local governments may contribute to the nonfederal share, and stated that it would examine efforts to improve data collection for oversight. As of June 2015, HHS reported that no further action was needed.

Source: GAO | GAO-16-195T

Related GAO Products

Medicaid: Key Issues Facing the Program. GAO-15-677. Washington, D.C.: July 30, 2015.

2015 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits. GAO-15-404SP. Washington, D.C.: April 14, 2015.

Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy. GAO-15-322. Washington, D.C.: April 10, 2015.

Medicaid Financing: Questionnaire Data on States' Methods for Financing Medicaid Payments from 2008 through 2012. GAO-15-227SP. Washington, D.C.: March 13, 2015, an e-supplement to GAO-14-627.

High-Risk Series: An Update. GAO-15-290. Washington, D.C.: February 11, 2015.

Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection. GAO-14-627. Washington, D.C.: July 29, 2014.

Medicaid: Completed and Preliminary Work Indicate that Transparency around State Financing Methods and Payments to Providers Is Still Needed for Oversight. GAO-14-817T. Washington, D.C.: July 29, 2014.

2013 Annual Report: Actions Needed to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits. GAO-13-279SP. Washington, D.C.: April 9, 2013.

Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed. GAO-13-48. Washington, D.C.: November 26, 2012.

Medicaid: States Reported Billions More in Supplemental Payments in Recent Years. GAO-12-694. Washington, D.C.: July 20, 2012.

Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs is Warranted. GAO-10-69. Washington, D.C.: November 20, 2009.

Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments. GAO-08-614. Washington, D.C.: May 30, 2008.

Related GAO Products

Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency.
GAO-07-214. Washington, D.C.: March 30, 2007.

Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed. GAO-04-228. Washington, D.C.: February 13, 2004.

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Mr. PITTS. Chair thanks the gentlelady and now recognizes Ms. Schwartz, 5 minutes for her opening statement.

STATEMENT OF ANNE L. SCHWARTZ

Ms. SCHWARTZ. Good morning, Chairman Pitts, Ranking Member Green, and members of the Subcommittee on Health.

I am Anne Schwartz, executive director of MACPAC, the Medicaid and CHIP Payment and Access Commission.

As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary of HHS, and the States on issues affecting these programs.

Its members, led by Chair Diane Rowland and Vice Chair Marsha Gold, are appointed by GAO, and the insights I will share this morning reflect the consensus views of the Commission itself anchored in a body of analytic work conducted over the past 5 years. And we appreciate the opportunity to share our views this morning.

My comments today will focus on reporting of provider-level data on non-DSH supplemental payments and contributions to the non-Federal share, the subject of two bills being considered by the subcommittee—H.R. 2151 and H.R. 1362.

The Commission shares the objective of transparency reflected in these two bills. There are several compelling reasons that providers' specific data should be reported. First, these data are necessary for assessing whether State payments and rates are consistent with Federal statute.

While States have considerable flexibility in setting rates and payment methods, Section 1902(a)(30)(a) of the Social Security Act requires that Medicaid payments be consistent with efficiency, economy, quality and access and that they safeguard against unnecessary utilization.

But information on the base Medicaid payments that providers receive—that is the per-case or per-diem payment associated with the delivery of specific services to specific Medicaid beneficiaries—provides only a partial picture of how much Medicaid is paying a given provider.

To assess payment fully, policy makers need to know the amount of Medicaid payment that providers receive including both claims-based and supplemental payments less the amount that providers contribute towards the non-Federal share of Medicaid expenditures.

The level of payment can be considered the most basic measure of economy and is essential to an assessment of patient efficiency. A measure of value compares what is being spent—economy—to what is obtained—quality, access, use of specific services.

Typically, an analysis of whether a healthcare payment is economical includes comparison to the cost to provide a given service and comparison to what other payers pay for a comparable service in a given geographic area.

Other healthcare payers including Medicare commonly conduct such assessments. In Medicaid, however, Federal policy makers and program administrators do not have complete data to make

such assessments and therefore to ensure that payments are consistent with the delivery of quality necessary care to beneficiaries.

The second reason for collecting provider-level data is that Medicaid spending for supplemental payments is substantial and growing.

In fiscal year 2014, States reported making \$24.2 billion in non-DSH supplemental payments to hospitals, more than 20 percent of total Medicaid fee for service payments to hospitals nationally and more than 50 percent in some States.

The amount of funds raised through providers and local government contributions is also significant and increasing.

As such, the Federal Government has a reasonable expectation of having complete payment and financing data that permit it to understand and oversee States' use of Medicaid funds.

In light of these concerns, in March 2014 MACPAC recommended that the Secretary of HHS collect and report data on non-DSH supplemental payments at the provider level and just last week in deliberations on a report on disproportionate share hospital payments that is due to Congress on February 1st, the Commission voted unanimously on a recommendation focused on reporting of data for both payments and the non-Federal share.

Specifically, MACPAC recommends that the Secretary collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them.

In addition, the Commission recommends that the Secretary collect and report data on the sources of non-Federal share necessary to determine net Medicaid payment at the provider level.

Efforts to fully understand provider payment levels are more relevant now than at any time in the program's history. Use of supplemental payments is growing, particularly to hospitals through Section 1115 expenditure authority.

In addition, interest in payment reforms that incentivize greater value in the delivery of health services is also growing. Even so, lack of solid data on net payments makes it extremely difficult to assess the effectiveness of these efforts.

MACPAC shares this subcommittee's interest in ensuring that taxpayer dollars are spent appropriately on delivery quality necessary care and preventing and reducing fraud, waste and abuse.

Provider-level data on supplemental payments and contributions to the non-Federal share would provide greater transparency and facilitate Medicaid payment analysis including assessments of Medicaid payment adequacy and analysis of the relationship between payment and desired program objectives.

Again, thank you for this opportunity to share MACPAC's work with the subcommittee and I am happy to answer any questions.

[The statement of Ms. Schwartz follows:]



Advising Congress on
Medicaid and CHIP Policy

**Statement of
Anne L. Schwartz, Ph.D., Executive Director**

**Medicaid and CHIP
Payment and Access Commission**

**Before the
Subcommittee on Health
House Committee on Energy and Commerce**

November 3, 2015

Summary

In our testimony today, we focus on reporting of provider-level data on supplemental payments and contributions to the non-federal share, the subject of two of bills being considered by the Subcommittee: H.R. 2151 and H.R. 1362. The Commission shares the objective of transparency reflected in the bills before the Subcommittee today.

There are several compelling reasons that such data should be reported at the provider level. First, such data are necessary for assessing whether state payment methods and rates are consistent with federal statute. While states have considerable flexibility in setting rates and methods, Section 1902 (a)(30)(A) of the Social Security Act requires that Medicaid payments be consistent with efficiency, economy, quality, and access and that they safeguard against unnecessary utilization. But information on the base Medicaid payments that providers receive – that is the per case or per diem payment associated with delivery of specific services to specific Medicaid beneficiaries – provides only a partial picture of how much Medicaid is paying a given provider. To assess payment fully, policymakers need to know the amount of Medicaid payment that providers receive, including both claims-based and supplemental payments, less the amount that providers contribute toward the non-federal share of Medicaid expenditures.

Second, Medicaid spending for supplemental payments is substantial. In fiscal year 2014, states reported making \$24.2 billion in non-disproportionate share hospital (DSH) supplemental payments, more than 20 percent of total Medicaid fee-for-service payments to hospitals nationally and more than 50 percent in some states. The amount of funds raised through providers and local government contributions is also significant and increasing. As such, the federal government has a reasonable expectation of having complete payment and financing data that permit it to understand and oversee states' use of Medicaid funds.

In light of these concerns, MACPAC recommended, in its March 2014 report to Congress, that the Secretary of the U.S. Department of Health and Human Services (HHS) collect and report data on non-DSH supplemental payments at the provider level. And just last week, in deliberations on a congressionally mandated report on DSH payments that will be transmitted to Congress on February 1, the Commission voted unanimously on a recommendation focused on reporting of data for both payments and the non-federal share. Specifically, MACPAC recommends that the Secretary of HHS collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Commission recommends that the Secretary collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.

Efforts to fully understand provider payment levels is more relevant now than at any time in the program's history. Use of supplemental payments is growing, particularly to hospitals through Section 1115 expenditure authority. In addition, interest in payment reforms that incentivize greater value in the delivery of health services is also growing. Even so, lack of solid data on net payments makes it extremely difficult to assess the effectiveness of these efforts.





Advising Congress on
Medicaid and CHIP Policy

Statement of Anne L. Schwartz, Ph.D., Executive Director
Medicaid and CHIP Payment and Access Commission

Good morning Chairman Pitts, Ranking Member Green, and Members of the Subcommittee on Health. I am Anne Schwartz, executive director of MACPAC, the Medicaid and CHIP Payment and Access Commission. As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS) and the states on issues affecting these programs. Its members, led by Chair Diane Rowland and Vice Chair Marsha Gold, are appointed by the U.S. Government Accountability Office (GAO). The insights I will share this morning reflect the consensus views of the Commission itself, anchored in a body of analytic work conducted over the past five years. We appreciate the opportunity to share MACPAC's views with the Subcommittee.

My testimony today will focus on reporting of provider-level data on supplemental payments and contributions to the non-federal share, the subject of two of bills being considered by the Subcommittee: H.R. 2151 which seeks to improve oversight and accountability in Medicaid non-disproportionate share hospital (DSH) supplemental payments, and H.R. 1362 which requires states to report the sources and amounts used by states to finance the non-federal share of Medicaid.

Over the past five years, the Commission, using data reported to the Centers for Medicare & Medicaid Services (CMS) as well as those collected from individual states, has devoted considerable analytic resources to these two

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related topics and has made recommendations concerning both. The Commission shares the objective of transparency reflected in the bills before the Subcommittee today.

Specifically, in its March 2014 report to Congress, MACPAC recommended that the Secretary collect and report data on non-DSH supplemental payments at the institutional level. And just last week, in deliberations on a congressionally mandated report on DSH payments that will be transmitted to Congress on February 1, the Commission voted unanimously on a recommendation focused on reporting of data for both payments and the non-federal share. Specifically, MACPAC recommends that the Secretary of HHS collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Commission recommends that the Secretary collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.

Below we describe the Commission's rationale for these recommendations and also comment on different approaches to collecting needed data. In addition we provide some brief comments on the proposed Quality Care for Moms and Babies Act.

Rationale for Recommendations

In the Commission's view, there are several compelling reasons that data on supplemental payments and contributions to the non-federal share of Medicaid spending should be reported at the provider level. First, such data are necessary for assessing whether state payment methods and rates are consistent with federal statute. While states have considerable flexibility in setting rates and methods, Section 1902 (a)(30)(A) of the Social



Security Act requires that Medicaid payments be consistent with efficiency, economy, quality, and access and that they safeguard against unnecessary utilization. But information on the base Medicaid payments that hospitals receive – that is the per case or per diem payment associated with delivery of specific services to specific Medicaid beneficiaries – provides only a partial picture of how much Medicaid is paying a given provider. To assess payment fully, policymakers need to know the amount of Medicaid payment that providers receive, including both claims-based and supplemental payments, less the amount that providers contribute toward the non-federal share of Medicaid expenditures.

Because data on supplemental payments and provider contributions to the non-federal Medicaid share (whether in the form of health care related taxes or other mechanisms such as intergovernmental transfers) are not reported to the federal government at the provider level, it is not possible to fully analyze the relationship of payment to program objectives. Moreover, given the variety of methods and payment levels used across states, there is value in assessing payment through a consistent lens.

Other health care payers, including Medicare, commonly conduct assessments of payment adequacy and compare payment levels across providers and geographic areas. The level of payment, or payment rate, can be considered the most basic measure of economy and is essential to an assessment of payment efficiency, a measure of value that compares what is spent (economy) to what is obtained (quality, access, utilization). Typically, an analysis of whether a health care payment is economical includes comparison to the cost to provide a given service and comparison to what other payers (for example, other states, Medicare, commercial insurance) pay for a comparable service in a given geographic area. In Medicaid, however, federal policymakers and program administrators do not have the complete data to make such assessments and therefore to ensure that payments are consistent with delivery of quality, necessary care to beneficiaries.

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Second, Medicaid spending for supplemental payments is substantial. In fiscal year 2014, states reported making \$24.2 billion in non-DSH supplemental payments. Such payments account for more than 20 percent of total Medicaid fee-for-service payments to hospitals nationally and more than 50 percent in some states. The amount of funds raised through providers and local government contributions is also significant and increasing. GAO reported that in 2012, about two-thirds of DSH payments, and three quarters of non-DSH supplemental payments, were financed by non-state sources of funding. Eight states used non-state funds to finance more than 90 percent of their DSH payments. Because providers often supply the non-federal share of Medicaid payments, the net payment that they receive may be less than payment data indicate. As such, the federal government has a reasonable expectation of having complete payment and financing data that permit it to understand and oversee states' use of Medicaid funds.

The task of ensuring that payments are set to incentivize value is more relevant now than at any time in the program's history. Use of supplemental payments is growing, particularly to hospitals through Section 1115 expenditure authority. In 2014, 44 percent of the \$24.2 billion in non-DSH supplemental payments was made through Section 1115 expenditure authority, including delivery system reform incentive program (DSRIP) payments and uncompensated care pools. Although DSRIP payments are not made for Medicaid services directly, they do represent large payments to hospitals that should be considered in analyses of Medicaid payments.

In addition, interest in payment reforms that incentivize greater value in the delivery of health services is also growing. Even so, lack of solid data on net payments makes it extremely difficult to assess the effectiveness of these efforts.

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Data Collection Issues

The bills before the Subcommittee today map out specific strategies for data collection. H.R. 2151 requires both annual reporting of non-DSH supplemental payments and an annual independent certified audit of such payments. H.R. 1362 requires that states submit an annual report on the sources and amounts associated with the non-federal share of Medicaid spending. In its recommendations, MACPAC has not spelled out the mode of data collection, rather calling on the Secretary of HHS to develop the appropriate methods. In doing so, the Secretary must balance the interest in collecting specific information from all states in a timely manner against the burden this task would create for state and federal program administrators as well as providers serving Medicaid beneficiaries. In the Commission's view, it makes sense to build upon existing data collection efforts to the extent possible. Below we describe different approaches to data collection and their strengths and limitations.

Currently, most provider-level payment data are reported through the Medicaid Statistical Information System (MSIS). While MSIS appears to be capable of receiving and reporting supplemental payment data, our analysis finds that most states do not currently report them. The specifications for the next iteration of MSIS (known as the Transformed Medicaid Statistical Information System or T-MSIS) also include fields for the collection of supplemental payments, although it is not clear whether or to what extent these elements will be required.

CMS currently collects some supplemental payment data as part of its oversight activities. Beginning in 2014, CMS began requiring states to submit annual non-DSH supplemental data for certain providers. These data are being collected by CMS regional offices and are meant to allow the agency to assure compliance with federal statute and upper payment limit (UPL) regulations, and may provide an improved understanding of total Medicaid

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payments at the provider level. A solicitation for contractor support issued by CMS in 2014 indicated the agency's interest in compiling a database of DSH and non-DSH supplemental payment data, analyzing payments at state and provider-specific levels, and assessing the utility of data from the T-MSIS for oversight and analysis of DSH payments and state UPL submissions. However, data now being collected are not required to be submitted in a standardized format, nor are they publicly available.

CMS also collects non-DSH supplemental payment data through its DSH audit reports, but these data only include about half of U.S. hospitals. While audit requirements could be expanded to include all hospitals that receive Medicaid payments, the burden on states and hospitals of conducting such audits should be carefully weighed against other alternatives. In addition, reliance on audits alone raises concerns about timeliness, particularly given that the most current DSH audit data are five years old. Given the rapid evolution of the health care system and frequent changes in state Medicaid payment policy, submission of complete payment data on a more timely basis is desirable.

With regard to the non-federal share of Medicaid spending, MACPAC is unaware of any consistent and complete source of data on the sources and amounts of such payments. In response to the GAO, CMS has expressed concerns about the feasibility and desirability of collecting facility-level data on the non-federal share and whether such data could be collected through T-MSIS. CMS does require states to answer a series of questions related to non-federal financing as part of the previously mentioned annual UPL demonstrations. States are asked to provide, for any payment funded by via intergovernmental transfers or certified public expenditures, a complete list of the names of entities transferring or certifying funds and the amounts. Most of the questions, however, require general, rather than provider-specific, responses.



Regardless of the method of data collection, the ability to link different sources of data for the same providers is useful, especially for analyses of payments such as DSH that support services to Medicaid enrollees as well as individuals without insurance. CMS recently required that Medicaid DSH audit data include Medicare provider identification numbers which help link these data to Medicare cost reports. We are also interested in the ability to link Medicaid data to other sources, such as the community benefit report provided to the Internal Revenue Service. Thus, we urge that any data collection efforts that result from the bills also allow policymakers to link to other relevant data.

Improving Quality of Care for Mothers and Infants

The Commission supports efforts to improve the quality of care for children and adults in Medicaid and CHIP and has shared its support for data improvements and the development of core measures in its comments on HHS reports to Congress. Broader use of nationally recognized, evidence-based measures is important to help identify those program characteristics and policies that have the greatest impact on quality of care received by Medicaid and CHIP enrollees. In addition, quality measurement is a necessary component of payment and delivery reforms intended to improve the efficiency of Medicaid payments. Development and broader use of core measures is desirable because the proliferation of different measures can make it difficult to compare quality outcomes and adds administrative complexity for providers.

With Medicaid now covering almost half of all births in the United States, the program plays a key role in reducing preterm births and improving care and outcomes for mothers and their children. State Medicaid programs are working with federal and private sector partners to reduce non-medically indicated inductions and elective cesarean sections before 39 weeks of gestation, which are associated with adverse outcomes. In addition, state-



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based perinatal health quality collaboratives are providing feedback to providers, implementing new policies to limit the circumstances under which elective deliveries care take place, and changing delivery scheduling processes. Such efforts have been effective in significantly reducing early elective deliveries and changing rates of admission to neonatal intensive care units.

The legislation before the Subcommittee would add measures focused on maternal and infant health to the existing set of core quality measures, and provide resources to develop and expand collaborative activities such as those described above. MACPAC supports expanding use of core measures in state quality improvement efforts and in particular, those measures that can be calculated by states using existing data. In addition, the Commission has previously noted that needed investments in quality measurement are small compared to total Medicaid spending, but are important for ensuring that taxpayers' investments in the program result in the delivery of high quality care to beneficiaries.

Conclusion

MACPAC shares this Subcommittee's interest in ensuring that taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing and reducing fraud, waste, and abuse. Making provider-level data on supplemental payments and contributions to the non-federal share of Medicaid funds would provide greater transparency and facilitate Medicaid payment analysis, including assessments of Medicaid payment efficiency and analysis of the relationship between payment and desired outcomes.



Mr. PITTS. The Chair thanks the gentlelady, thanks both of the witnesses for your testimony. I will begin the questioning and recognize myself 5 minutes for that purpose.

This is for both of you. We will start with you, Ms. Iritani. What data does CMS currently collect about the sources of the non-Federal share Medicaid funding?

Ms. IRITANI. CMS collects some data on the sources of funds on a case-by-case basis. When States submit a new request for approval for a State plan, CMS asks several questions about the sources of funds.

It is not very accessible—this data—and it is not in a uniform manner. CMS also collects some data on provider taxes. But CMS acknowledges that the data are unreliable and incomplete.

Mr. PITTS. Anything to add, Ms. Schwartz? Let me ask you, what additional data do you think they need and how will having this data improve CMS' ability to oversee States' financing of Medicaid? Both of you.

Ms. IRITANI. Additional data that CMS needs includes data on all sources of funds used to finance the Medicaid program. Currently, CMS does not collect this data.

In order to understand net payments to providers, as Ms. Schwartz has discussed the need for understanding, we need to understand whether or not the financing of payments is being concentrated on certain providers that also receive payments and in order to understand this we need to collect complete data on how States finance the non-Federal share of payments.

Mr. PITTS. Ms. Schwartz, do you want to add anything?

Ms. SCHWARTZ. Just to add that our primary concern in conducting this analysis is to get provider-specific data on their contributions to the non-Federal share, which would allow us then to net those contributions out from the total payments that they are receiving Medicaid to get a true picture of what they are being paid.

Mr. PITTS. OK.

Now, Ms. Iritani, in your written testimony you indicate that HHS acknowledged that additional data was needed to ensure that States comply with Federal requirements regarding how much local governments may contribute to non-Federal share.

But despite this, HHS has said that no further action is needed. Can you explain these seemingly contradictory statements, explain why GAO believes that additional data is necessary to properly oversee the program?

Ms. IRITANI. Yes. We made a recommendation to CMS that they collect—develop a strategy for collecting better information and I think CMS disagreed because they did not believe that information on the sources of Medicaid financing was needed on a payment specific basis.

They collect information in the aggregate but they don't collect information that would enable us to ascertain how much individual providers are collecting, as Ms. Schwartz discussed a need for.

Mr. PITTS. Now, what does the required reporting and auditing of DSH payments tell us about the utility of requiring similar reporting and auditing for non-DSH supplemental payments?

Ms. IRITANI. The DSH payments are subject to complete reporting of both the financing of the payments and this—the information for non-DSH payments is lacking.

And I am sorry, could you repeat the question?

Mr. PITTS. Yes. What does the required reporting and auditing of DSH payments tell us about the utility of requiring similar reporting and auditing for non-DSH supplemental payments?

Ms. IRITANI. Right. So the required reporting and auditing of DSH payments has been very important for understanding who the payments are going to and at what levels and the non-DSH payments are currently not subject to similar requirements.

Mr. PITTS. OK.

Ms. IRITANI. We have suggested that non-DSH payments really need to be comparable to the DSH payments in terms of the extent of the reporting.

Currently, one cannot tell with the non-DSH payments the net payments that providers are actually receiving because you cannot tell on a provider-specific basis what a provider is actually contributing to the financing of a particular payment.

So the financing of a payment could be, for example, 100 percent concentrated on the providers who receive the payments. Therefore, you know, the net payments that the providers receive is actually much lower.

Mr. PITTS. My time is expired. The Chair recognizes the ranking member of the subcommittee, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman, and I would like to ask the panel to provide information on how Medicaid payments work. I think Medicaid payments are so complicated. Even as I was a State legislator in Texas, it was tough.

I know that we would appreciate a little more information about how this actually works. Ms. Schwartz, given that the issue of rate setting is so complicated, explain how States set these rates and what types of payments are provided to providers and what is recorded to CMS.

Ms. SCHWARTZ. Yes. Setting payment rates and methodologies is one of the parts of the Medicaid program that varies the most.

States pay hospitals in very different ways. Some of them use a system similar to the prospective payment system in Medicare where they make a per-case payment at the diagnosis level for a number of different services that are provided in the hospital.

Some States still pay hospitals per diem. The range is all over the place in both how they pay, the special adjusters they have for that, and the actual payment rate. We have collected some of this information from MACPAC, and it is a rather unwieldy spreadsheet that gives you a sense of the complexity of those payments.

One of the things that MACPAC is most interested in is trying to get a sense of how payments can be used to leverage proper, appropriate, greater value care, and as part of that we need to be able to know both the methods and the payment rates and to be able to net out these additional payments.

So it is quite complex with considerable State flexibility reflecting historical practices and the local markets.

Mr. GREEN. OK. Ms. Iritani, my understanding is it is very hard to gather Medicaid data and indeed to compare Medicaid data,

given the time lag on availability of that data and how different all these programs are from one another.

Is that a problem that you encounter regularly in your work at the GAO?

Ms. IRITANI. Regular payment data is available to us. But the supplemental payments that States often make are not reported in the claims data that go to the CMS.

So States really have all the data that shows who those payments are going to, and so that is part of the transparency that we believe is needed, is more data at the Federal level on who supplemental payments are going to and for what purposes, and in what amounts.

Mr. GREEN. Ms. Schwartz, I thought your point about linking other sources of data to better understand a full picture of the payments was interesting.

Can you expand on that recommendation?

Ms. SCHWARTZ. Well, as Ms. Iritani says, claims are available and are reported up to the Federal level. So we know on a per-case or per-diem level what hospitals are making.

Supplemental payments are not paid associated with claims and what is reported by the States to the Federal level is the aggregate amount across all institutions in a particular class and we can't associate that big chunk of dollars that is being reported to the particular institutions that receive them.

States, clearly, know this information because they are making the payments. But States also have many different data systems and approaches to making those payments and so you can't just go out and ask every State to report this information and get the right answer.

So that is the desire to have the Secretary specify a method by which those data would be reported so that they could be consistently reported and available to analyze both at the national level and across States.

Mr. GREEN. OK. Ms. Iritani, both you and Ms. Schwartz mentioned that CMS is actually taking quite a number of steps on the issue and I am glad the administration is taking those steps in recent years to shed light on.

I know there has been a GAO recommendation through administrations on both sides of the aisle. Can you talk about CMS work on nonsupplemental payments in recent years?

Wasn't that work based in part on longstanding GAO recommendations and isn't it true that CMS hasn't even finished rolling out the new actions on the supplemental payments?

Ms. IRITANI. Yes. CMS has taken some significant steps, we would agree, to try to improve the transparency and accountability of supplemental payments.

Recently, CMS has, for example, had initiatives to try to require States to submit reports that would provide information on the financing and payments for supplemental payments.

This information is more than what they have had before. It is extensive. CMS has provided that information to a contractor to assess how they can use it to improve oversight, for example.

CMS also has a initiative known as T-MSIS, Transform Medicaid Information System reforms to try to collect better information on claims. That would include supplemental payments.

Mr. GREEN. OK.

Thank you, Mr. Chairman. I yield back.

Mr. PITTS. Chair thanks the gentleman.

I recognize the vice chair of subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman, and my questions to Ms. Iritani will be directed at you, and I know you have talked about some of the things I am going to ask you about but I would like to give you a chance to elaborate with—through the question I am going to move forward.

So in your testimony you point out that States generally use general revenue funds for their Medicaid share but you point out that States can use other financing options, specifically that States are increasingly relying on providers and local governments to finance their Medicaid share.

Can you discuss some of the ways States are financing their Medicaid share? It is not just general revenue?

Ms. IRITANI. What we have reported on, apart from the general revenues, which is the majority of how States finance Medicaid, is the growing reliance on taxes on healthcare providers, for example, to help finance the non-Federal share of payments. Intergovernmental transfers, which can be used between units of Government to—

Mr. GUTHRIE. Can you give an example of one—an example?

Ms. IRITANI. So, for example, a local government may operate a hospital and an intergovernmental fund transfer might be a transfer from the local government to the State that it is in to provide the non-Federal share of a payment that is going to the provider.

And another method is known as certified public expenditures, which is basically certifying that an expenditure was made for Medicaid. That can also be used as a non-Federal share.

Mr. GUTHRIE. OK. And I think every member of this committee wants to ensure that vulnerable beneficiaries are protected and receive the Medicaid benefits, which are eligible.

But I know many of us also want to ensure that Federal Medicaid policy doesn't unnecessarily crowd out private sector's role.

Medicaid long-term care is the largest chunk of Medicaid spending and represents one of the biggest challenges to the program's sustainability over the long term.

My bill, H.R. 1361, the Medicaid Home Improvement Act, seeks to address the concerns of GAO in this area and requires States to submit an annual report identifying the sources and amounts of funds used to—as the Medicaid report items are—use funds to finance their non-Federal share of Medicaid.

Can you talk about how that will be beneficial as we move forward?

Ms. IRITANI. Yes. Currently CMS does not collect data on the sources of funds that States use for Medicaid and there are several reasons why we believe that information is needed.

One is just to enforce Medicaid requirements on limits that are set on the extent that States can rely on providers and local governments.

There is a limit that States cannot exceed. It is called the 60/40 rule that States can only obtain a certain proportion of funds from local governments and providers.

The other is just to understand net payments that providers actually receive. Without having better data on the extent that payments are being financed by the providers who receive the payments, we can't really understand net payments to providers.

Mr. GUTHRIE. OK. Also a bill I have today is the Medicaid Home Act that changes the equity requirement to \$500,000 plus—I mean, plus inflation.

Can you talk about if this policy were adopted how individuals could access the equity interest in their home through a variety of legal means such as reverse mortgages, home equity loan or other financial vehicles?

Ms. IRITANI. I am not prepared to answer that question but I would be happy to get information for you—for a question for the record.

Mr. GUTHRIE. OK. All right.

And can you talk about there is an exception under current law which my bill does not change which allows an individual with any level of home equity to qualify for Medicaid if an individual spouse, child under 21 or child that is considered blind or disabled also live in the home? Are you familiar with that provision?

Is that—maybe, Ms. Schwartz, you have a—checking in on that—do you have a—

Ms. SCHWARTZ. Yes, that is correct.

Mr. GUTHRIE. That is correct. OK.

And given that—there are few seconds here—given the aging of the Baby Boomers and the growth of long-term care, have MACPAC or GAO conducted any analysis about the challenges unrestrained growth in this part of the program imposes on Federal and State budgets?

For example, CBO estimates that Federal spending alone on Medicaid long-term care will be \$77 billion this year. So is GAO or MACPAC looking at the long-term care and ensuing Baby Boomer arrival, not just at retirement but also older in life so that more demands on long-term care?

Ms. IRITANI. We have several engagements underway around long-term care and Medicaid.

Mr. GUTHRIE. Thanks.

Ms. SCHWARTZ. Yes, and MACPAC is engaged in a long-term work plan on analyzing spending trends and different aspects of the Medicaid program, and we are just beginning that work, and since long-term care is such a significant part of the program, it will be included as part of that area of work.

Mr. GUTHRIE. Thank you. My time is expired and I yield back.

Mr. PITTS. Chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I want to follow up on my colleague's discussion of long-term care.

Dr. Schwartz, I would like to discuss how the proposed Medicaid Home Improvement Act would affect beneficiary eligibility for long-term care services.

As you know, the Medicaid program is the backbone of our country's long-term care system. Sadly, even with Medicaid as the safety net, the majority of Americans lack the options or resources to sufficiently plan for future long-term care needs.

And, you know, my questions relate to, obviously, to the spend down provision, which I think is a terrible way to pay for long-term care—actually shameful, in my opinion.

The last thing I want to do is to take someone's home to pay for their long-term care. Could you briefly describe the purpose of the home equity exemption?

Ms. SCHWARTZ. I think there are two purposes. One is to allow living family members to remain in the home while the beneficiary is in an institution and the other is to—there is the limit that exists on there to ensure that the Government is seeing a contribution of assets to their care. So that is the purpose of the act.

Mr. PALLONE. Thank you.

And States are allowed the option of maintaining a higher home equity threshold. What is the purpose of allowing States to choose between different equity allowances?

I know for New Jersey, you know, in our State it is much higher. We have chosen the option of the higher equity.

Ms. SCHWARTZ. Well, I am not an expert in this area and it is not an area where MACPAC has done any significant work.

But in general, States exercise flexibility in definitions within the program to reflect local circumstances in their communities and I do believe New York and New Jersey are two of the States that have allowed a higher exemption, presumably reflecting the higher market value of real estate in those areas.

Mr. PALLONE. I mean, that is absolutely the case. I mean, it is not unusual at all for, you know, a person of average income, you know, to be living in a home that is worth \$800,000, which I think would qualify in New Jersey under the higher—because New Jersey has opted for the higher equity but I think wouldn't qualify if this bill became law because they wouldn't allow States to have a higher threshold.

Would you expect the Medicaid Home Improvement Act to have different effects in different States because it wouldn't allow this higher threshold?

Ms. SCHWARTZ. Well, certainly, to the extent that States have a higher threshold now, that would affect those States more than those who have a threshold similar to what is in the bill.

Mr. PALLONE. Thank you.

I mean, my concern, Mr. Chairman, you know, I find this proposed piece of legislation to be very concerning with regard to this home equity threshold and not allowing States to raise the threshold.

I mean, our country, we know, has still not implemented a thoughtful, comprehensive approach to long-term care, yet this bill would only serve to restrict eligibility to long-term services and

supports, and I would—you know, I can't stress enough that in States like New Jersey where real estate—you know, you have this much higher ability—it costs a lot more, essentially, to have a home in New Jersey. And, I mean, the last thing I would want to see is people to have to sell their home because the threshold is reduced.

Let me ask you, Dr. Schwartz, I understand that Medicaid and CHIP have experience in quality performance measures through the Pediatric Quality Measures Program and this program was established in 2009 with the goal of improving the quality of care delivered to our Nation's pediatric patients.

Could you briefly describe the Pediatric Quality Measures Program and the effect it has had in advancing pediatric care for Medicaid patients? I think you have a minute.

Ms. SCHWARTZ. Sure.

The core set of measures, as you mentioned, was developed in 2009, and all States are reporting at least two of the measures.

The median is 14 measures, and they are things like the share of kids between the ages of 3 and 17 with an outpatient visit to a primary care practitioner, the share of children up to the age of 2 who are up to date on their vaccines, the share of births at low birth weight.

These are areas that are agreed have a clinical definition as being meaningful for the purposes of high quality care.

MACPAC has commented on the importance of improving the number of States reporting those measures, and increasing the number of measures, and also strengthening the capacity of CMS to calculate those measures for States from claims data to the extent that it is possible.

Mr. PALLONE. Do you have any suggestions for improvement? I know my time is almost up but if you had to mention one or two.

Ms. SCHWARTZ. To the extent that data from claims that States submit up to CMS that those data can be used and that require no additional data collection on the part of the States, that would be a really valuable way to get more information on the performance of different States in providing quality pediatric care.

Mr. PALLONE. Thank you.

Thank you, Mr. Chairman.

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. And welcome back, it is good to see you. This question would be for both of you as I begin. Many of us are familiar with the Disproportionate Share Hospitals, or DSH, supplemental payments. However, can you please explain what non-DSH supplemental payments are, who they go to and what purpose they serve? Ms. Iritani, why don't you start?

Ms. IRITANI. Yes, the non-DSH payments are a type of supplemental payments that States often make under the upper payment limit that is established under Medicaid or under Medicaid demonstrations. The purposes are largely unknown, which is part of why we believe there is a need for more reporting so we can understand who these payments are going to and for what purposes.

Mr. SHIMKUS. Ms. Schwartz, do you want to comment on it?

Ms. SCHWARTZ. Sure. I can just say that the non-DSH supplemental payments are calculated by a State looking across a class of providers—say, public hospitals, nonprofit hospitals—looking at the total payments under fee-for-service that are paid, and then the difference between that payment amount and what would have been paid under Medicare principles, which is generally more. So the difference there is the amount that the State can make in non-DSH supplemental payments, and it uses those funds presumably to target different types of hospitals.

But again, as Ms. Iritani said, that is one of the reasons we would like to be able to get the provider-specific data to see the relationship between the specific payments and which hospitals are receiving them.

Mr. SHIMKUS. So in the question previously, Ms. Iritani, you talked about—we were talking about general funds payment and I think you did raise the issues of taxes. So some States use provider taxes to finance the non-Federal share of Medicaid cost which has been used to shift cost to the Federal Government. Can you kind of talk through that?

Ms. IRITANI. Yes, so to the extent that financing of large payments is concentrated on the same providers receiving those payments, there can be a cost shift. For example, when we looked at this issue in a recent report, we looked at certain new arrangements that States put in place where they increased provider payments but they at the same time imposed a tax on those providers, the same providers, to pay for the non-Federal share.

And so then they drew down the Federal matching for those payments, and in the end the Federal Government paid much more, hundreds more, or tens of millions for those new payments. The providers who received the payments funded the non-Federal share and the State ended up not having to pay more for those payments.

Mr. SHIMKUS. Ms. Schwartz, do you want to comment? No. That is fine.

And last for Ms. Iritani, GAO has had longstanding recommendation for CMS to require additional reporting and auditing of non-DSH supplemental payments. Why don't you think CMS has implemented those recommendations?

Ms. IRITANI. CMS has agreed with our findings, but with regard to that particular recommendation they said that they would need to be required to do so; that because of the effect on States that they would need legislation to be ordered and to be able to do that.

Mr. SHIMKUS. OK, very good. I yield back my time. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. I now recognize the gentle lady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Great. And that is where I want to pick up. So CMS says that they do not have the authority to go out and collect all of the data from States on their supplemental payments. Do you agree with that, that legislation is needed?

Ms. IRITANI. We defer to CMS on that. We believe that in the past when CMS has tried to require States to report information that States didn't necessarily want to report or want to report at the level that CMS needed it, CMS needed legislation.

Ms. CASTOR. Ms. Schwartz, do you agree with that?

Ms. SCHWARTZ. CMS is collecting information from States to demonstrate compliance with the upper payment limit regulations. And for the purposes that MACPAC is interested in, the payments on provider-specific data on the non-DSH supplemental payments from those regulations might be sufficient. We don't have any access to those data. CMS does not share a lot of details.

We do know that they have been talking about a regulation on supplemental payments, so it does seem that there is activity going on and that as part of its oversight activity it does have the ability to collect the payment information. I believe an audit is another level in which I think it is probably fair to say that they would need legislation to conduct an audit as they had to do the additional—

Ms. CASTOR. And it certainly would give them the leverage to say to States we need it to be accessible and we need it to be uniform, because these supplemental payments go to all 50 States, correct? So oftentimes I imagine the data comes back in different forms. What impact now has Medicaid expansion in some States and not in others had on supplemental payments?

Ms. SCHWARTZ. I am not sure that we have done the analysis of the supplemental payments of expansion versus nonexpansion States, and it is something we could do. In any case, it would still be at the aggregate State level and not give you a picture of what is happening to individual providers.

Ms. CASTOR. How about with the expansion of the 1115 waivers and supplemental payments? Has the trend towards States having those Medicaid waivers changed the format of supplemental payments at all?

Ms. SCHWARTZ. Many of those waivers have allowed States to continue making supplemental payments, and so we do know that those payments under the 1115 waivers are increasing.

Ms. CASTOR. So, and in the Medicaid managed care rules that were proposed recently, did those rules propose any type of standardized reporting for supplemental payments through the waivers or—

Ms. SCHWARTZ. I am not sure if the rules specifically mention that, but in general supplemental payments are not permitted under managed care because in managed care the plan is making a payment to the institution, not the State.

Ms. CASTOR. So it is more applicable to the 1115 waivers to States than in managed care rules for sure.

Ms. SCHWARTZ. That is my understanding.

Ms. CASTOR. OK. In one example, I wonder if GAO has looked at States that have taken supplemental payments and done things with them that really are outside the bounds of the intent of the Medicaid laws. Do you know of any cases where States have said, OK, we are going to provide, use supplemental payments, that revenue, and pay providers that don't serve the Medicaid population?

Ms. IRITANI. Years ago in prior reports, we have looked at how excessive supplemental payments were used by States and did find that the payment revenues could be used for non-Medicaid purposes. And in more recent years, we have just been looking at the level of the supplemental payments and how that they relate to costs of the providers for providing Medicaid and that is where we

have found that many States are making payments that are much—

Ms. CASTOR. In Florida we had that crop up where the State went in and said, here, we are going to take some of the supplemental payments and give it to some providers that were not serving the Medicaid population. And that is a real worry in my home county that has a half-cent sales tax that they use as an intergovernmental transfer and to bring down their Medicaid match.

So I think this is a very good idea for us to standardize the reporting from States and get all the data so we can ensure the funds are being spent accordingly. Thank you, and I yield back.

Mr. PITTS. The Chair thanks the gentle lady. I now recognize the gentleman from Missouri, Mr. Long, 5 minutes for questions.

Mr. LONG. Thank you, Mr. Chairman. And Ms. Iritani, what factors prompted CMS to require audits and reporting of the DSH payments?

Ms. IRITANI. CMS identified concerns with States making excessive payments over the limits, and Congress had required them to also establish reporting and auditing requirements. And some of our work also found concerns with excessive payments and also requirements on providers to return the non-Federal share to the State, so effectively reducing the net payments that some providers received. So CMS did, and now requires DSH payments, Disproportionate Share payments to be reported on a facility-specific basis and subject to audit.

Mr. LONG. OK. These overpayments, were they an anomaly, or do you know what percentage they found, find or think are overpaid?

Ms. IRITANI. Well, what I can say is the original, the very first DSH audits found that the majority of States, I believe it was 41, had overpaid at least one hospital. And one of our reports reported on the findings of the DSH audits, and 41 States had paid over 500 hospitals \$2.7 billion on the non-DSH side, but they also reported on significant noncompliance on the DSH side in terms of—

Mr. LONG. Significant. Do you have any idea what percentage when you said significant?

Ms. IRITANI. So the DSH payments, payments that were in excess of the hospitals' uncompensated care and/or not calculated with acceptable data and methods, 41 States made DSH payments that exceeded the hospitals'—

Mr. LONG. Yes, but that doesn't tell me what percentage.

Ms. IRITANI. So 24 percent of the hospitals were found to have received DSH payments that were noncompliant.

Mr. LONG. Twenty-four percent across the board.

Ms. IRITANI. Twenty-four percent of hospitals.

Mr. LONG. OK. OK, thank you. And Dr. Schwartz, on Thursday, MACPAC Commissioners recommended that the Secretary of HHS should collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, they said the Secretary should collect and report data on the sources of non-Federal share necessary to determine net Medicaid payments at the provider level.

As I have been told, HHS said legislation was necessary to implement reporting and auditing requirements for DSH payments and

that legislation would be needed to implement similar requirements for non-DSH supplemental payments. So why did MACPAC target its recommendations to the Secretary?

Ms. SCHWARTZ. Sure. We have not asked for nor received a review from CMS of our recommendations, so I don't know what CMS will say about our specific recommendation. MACPAC's recommendation was for reporting of payment information, which—we know from what CMS already is asking of States in the UPL payment demonstrations that it is already asking for similar types of information, and that is why we believe that the Secretary had the authority to do this.

Auditing is a different step, and auditing is a much more intense activity as seen in the DSH audits and that is not what MACPAC was asking for. MACPAC was asking for collecting and reporting payment data, and so we believe that the Secretary has the authority to do that.

Mr. LONG. OK, thank you. With that I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Oregon, Mr. Schrader, 5 minutes for questions.

Mr. SCHRADER. Thank you, Mr. Chairman. I guess for GAO, have you evaluated what the cost-benefit might be in changing from reporting classes of overpayments versus going to the individual providers?

Ms. IRITANI. We have not evaluated the cost-benefit, but we would note that this is required on the DSH side. And non-DSH payments are now higher in amounts than DSH payments, but the non-DSH payments are not subject to reporting and auditing as with DSH.

Mr. SCHRADER. Has there been any consideration of just increasing the Medicaid payments as opposed to going with the DSH and non-DSH supplemental payments that we have got?

Ms. IRITANI. Well, ideally, Medicaid payments would be sufficient to ensure access in a local area comparable to what others outside of Medicaid would be receiving.

Mr. SCHRADER. Like everyone in this committee and Congress fully realizes, Medicaid payments are not sufficient and as a matter of fact are so low that many providers can't accept Medicaid patients. We have the same problem with Medicare. I think a lot of folks need to be aware that that is a very, very low reimbursement rate compared to the private insurance market.

Ms. IRITANI. Yes, our work has found that Medicaid payment rates are lower generally for certain services than private.

Mr. SCHRADER. Has there been any move to just fund Medicaid to the various States and providers based on outcomes? There has been a lot of talk in health care recently about outcomes, quality based health care.

Ms. IRITANI. What I can say is that I think that there are some demonstrations that are trying to incentivize outcomes by making payments for that.

Mr. SCHRADER. MACPAC have any comments on that?

Ms. SCHWARTZ. I think there is a lot of activity at the State level to try and link payment to outcomes through different approaches such as health homes, bundling of payments, different approaches. We don't know very much yet about the outcomes and whether

they have affected outcomes. That is something we would be very interested to know.

And it is also very difficult to conduct that research because you have to be able to control for everything else that is going on in the health system and in the patients' lives to be able to attribute the outcomes to specific actions on the part of the beneficiary and the provider.

Mr. SCHRADER. Well that is interesting and that is always true whether it is an education bill or anything we do. But we are doing that right now in Medicare. We are trying to get at that in Medicare. We are doing that under the Affordable Care Act. So I don't think it is impossible, and certainly there could be risk based reimbursement to accommodate the types of socioeconomic factors that people have.

And I would argue respectfully that rather than us trying to micromanage all the States and the different providers, it would be a heck of a lot easier for us, particularly non-doctors, although I guess I am a veterinarian but I wouldn't want to be the guy in charge of your healthcare, that we go to an outcome based reimbursement system where we could easily judge whether or not the people are staying healthier, staying out of the hospitals, getting that quality based healthcare.

That should really be what we are about, then our task here would be pretty easy. We would just be able to have a common set of outcomes, and your job would be a little bit easier and we could see whether or not things are doing well or not.

Another question. In the REPORTS bill why do we have the 40/60 rule? Why is that significant? What is the goal of having that rule?

Ms. IRITANI. I can't speak to the legislative history around that rule, but I think that the concept generally is that States should share in the non-Federal share of the financing that——

Mr. SCHRADER. Well, why do we specify it can't be more than 40 or more than 60? What is the point of that? Who cares? Why do we care? I am the Federal Government. As long as someone is paying their fair share, why do I care?

Ms. IRITANI. Well, I think that to make sure that the incentives are for sufficient and economical payments that the State should be sharing in the cost of the payment.

Mr. SCHRADER. Yes, but who cares if it comes from the local government or a private enterprise or the State? Who cares?

Ms. IRITANI. The concern around the reliance on providers and local governments for financing the non-Federal share is when the burden on financing Medicaid rests with, for example, the providers who are serving the beneficiaries. From the providers' standpoint, the payment they receive from Medicaid is the net payment. It is not the full payment, it is the payment less the taxes or other contributions they might be making for the payment that they receive.

Mr. SCHRADER. Mr. Chair, I would just respectfully suggest we are micromanaging and should let the States do what they do best and just regulate the outcomes. I think that would be a smarter proposal. And I yield back. Thank you, sir.

Mr. PITTS. The Chair thanks the gentleman. I now recognize the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. BUCSHON. Thank you, Mr. Chairman. I would agree with what you just said and I think we are micromanaging. And I can tell you why CMS wants to know the information, because they want to decrease payments to the Medicaid program. They want to save money. And I was a provider before I was a surgeon, and you can't have access if you continue to decrease Medicaid payments. Because you have a program that needs fundamentally restructured in my view. You can't have both.

And so now, States, including Indiana with the Healthy Indiana Plan 2.0, which is a HSA-based way to manage the Medicaid population, now what basically your testimony is telling me that, wow, you guys came up with a great system but we don't want you to do it because we are concerned it is going to cost the Federal Government more money and we are trying to save money here.

So the question—I mean, I am playing a little devil's advocate here. The question I have is, Why does the Federal Government care? I mean, for example, Healthy Indiana Plan 2.0 uses hospital taxes to, as you probably know, to help fund the expanded State share of the expansion under the Affordable Care Act.

Why does that matter to the Federal Government? Because what they are doing then is they are reimbursing providers at a higher level than traditional Medicaid. Guess what that does? It gets the providers to take Medicaid patients so that we get access so low-income people actually can see a doctor. So why does that matter to the Federal Government? Does that cost the Federal Government any more money than it would if they did it in a traditional way?

Ms. SCHWARTZ. I think the most fundamental reason that the Federal Government pays is that when you look at the financing—Federal, non-Federal—the Federal Government is still paying on average 57 percent of the cost of the Medicaid program and much more than that in many States—

Mr. BUCSHON. So?

Ms. SCHWARTZ [continuing]. Notwithstanding how —

Mr. BUCSHON. So what?

Ms. SCHWARTZ. So the interest is ensuring that that amount of money is being used consistent with the aims of the statute.

Mr. BUCSHON. OK, so they want to micromanage the Medicaid program just like Dr. Schrader said. The basic, and what I am getting is that the reason is, is because the Federal Government wants to micromanage the States. I mean that is my view on that and again I am all for reporting, and I think States should be compliant with coverage and make sure people are getting adequate coverage.

But other than that, I mean the question I have is why does it matter to the Federal Government? That is why I support fundamental Medicaid reform that gives the States a certain amount of money and let them do what they need to do with it versus having all these strings attached. I mean, I think we are just finding today with this hearing why we need to fundamentally restructure the Medicaid program, because people are spending literally thousands of hours trying to figure all this stuff out.

Like I said, I don't have a problem with needing to be reporting if it has an impact on patient access. I mean, if there is a concern that based on States using local or State funding for the non-Federal portion is having an impact on access and people are not getting the services that is one thing. If it is just because the Federal Government wants to say, well, look, we don't have to pay you as much because you have found a way to use local money or State money to help yourself, then I am against that.

And so why does it matter if a State reports, for example, in the aggregate versus an individual provider? Why would the Federal Government care? It is the same amount of money.

Ms. IRITANI. Well, as you point out, we want to make sure that Medicaid payments are going for Medicaid purposes and improve access to Medicaid beneficiaries.

Mr. BUCSHON. And I agree with that.

Ms. IRITANI. Without knowing the amount that an individual provider is contributing to the payment that they are receiving, we can't actually understand whether or not the payment is being used basically for fiscal relief for the State or actually serving to improve access for Medicaid beneficiaries.

Mr. BUCSHON. That is fair enough. But that there what you just said is making the assumption that States are purposely violating Federal law for their own benefit. If you make—I am just saying that CMS needs to know this because they want to prevent States from purposely violating the law by using Medicaid dollars for non-, for example, giving payments to people who are not providing coverage to Medicaid patients. Is that true or not true?

Ms. IRITANI. And it is not necessarily even violating the law. States can make payments and receive Federal matching up to the upper payment limit, and there is no limit on Medicaid payments in relation to costs. But this data is really needed to understand the extent that payments are going to providers who are actually financing the non-Federal share, therefore reducing the net payments to the providers because—

Mr. BUCSHON. My time is expired. So again I will just finish by saying who cares? Because it is the same cost to the Federal Government, who cares? I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman. I had a question about—I am very interested in these demonstration projects to explore alternative venues or settings for long-term care and the financing of those. So I guess the obvious example of experimenting with this is there are some waiver and demonstration programs that have allowed for Medicaid reimbursement for placement in, say, assisted living facilities as opposed to long term in nursing care facilities. I don't know that there has been, but you would know, I imagine, demonstration projects that are reimbursing through Medicaid for placement in somebody's home where they are getting some home care.

But my question is, as those kinds of alternatives are being explored are there also alternative kind of financing structures or formulas being looked at at the same time? So obviously you would

be looking at different kinds of reimbursement amounts depending on this setting, but is there any reason, for example, to look at some of these asset thresholds and other things depending on—my instinct would say no, but I am just wondering, has that kind of analysis accompanied the experimenting of just where you might reimburse for this kind of care?

Ms. IRITANI. We have work planned to look at Medicaid payments for assisted living. We have not done work looking at financing of Medicaid payments necessarily directed to long-term care, if that is your question.

Mr. SARBANES. OK. And are there, is it in your bailiwick to tell me whether there are demonstrations that are actually looking at Medicaid reimbursement for home care where somebody is actually staying in the home?

Ms. IRITANI. There are, increasingly, States moving from a fee-for-service type of payment for long-term care services to managed care which would be a capitated payment amount to cover all services including long-term care.

Mr. SARBANES. So in that instance there would be a capitated payment for providing care along a continuum that could include some component of home care along with institutional care; is that what you are saying?

Ms. IRITANI. Correct.

Mr. SARBANES. OK. All right, thank you. I yield back.

Ms. SCHWARTZ. I can just add to that that about half of payments for long-term services supports in Medicaid are now occurring in a noninstitutional setting, and this reflects a very big shift over the past 20 years when it was primarily in institutional settings. And that is primarily through 1915(c) waivers that have allowed States to allow folks to stay in their own homes and receive services if that is something that is valuable to them.

And there have also been grants under the money follows the person program to help States transition people from nursing homes to home settings or to allow people to stay in their homes and not end up in a nursing facility.

Mr. SARBANES. Thank you.

Mr. PITTS. The gentleman yields back. The Chair now recognizes the gentleman from Maryland, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Florida.

Mr. PITTS. I mean Florida, sorry.

Mr. BILIRAKIS. That is OK. No problem. Well, I have a couple questions here, but I wanted to say how much, with the moving the patient from a long-term care facility to the home, obviously quality of life is number one, but are we saving money at the same time?

Ms. SCHWARTZ. Those waivers require a demonstration of savings and so yes. And in the managed long-term services and supports area, I think that is also an area to increase the predictability of the amount that is being spent on long-term services and supports. So fiscal concerns are obviously a part of both of those efforts.

Mr. BILIRAKIS. Very good, thank you. A couple more questions, Ms. Iritani and Ms. Schwartz. In your testimony you talk a lot about non-State sources being used to fund Medicaid. Can you ex-

plain what these non-State sources are such as provider taxes and how they fund State Medicaid programs?

Ms. IRITANI. States are allowed to use up to certain sources of funds apart from State general revenues to finance Medicaid. Provider taxes are an increasing method that States use to fund Medicaid which would be a broad-based uniform tax on healthcare providers, and it could be Medicaid providers, to fund Medicaid.

And intergovernmental transfers and certified public expenditures are other methods that are increasingly used to finance the non-Federal share of Medicaid. These would be methods that local governments or a local government provider such as county hospitals might use to, for example, in the case of certified public expenditures, to certify that they had expended a certain amount on Medicaid for purposes of getting Federal matching for the payment or the fund.

Mr. BILIRAKIS. Do you have anything else to add, please?

Ms. SCHWARTZ. No, I don't have anything else to add to that.

Mr. BILIRAKIS. OK, all right. OK, Federal law requires that provider taxes must be broad based and uniformly imposed and must not hold the providers harmless and cannot provide a direct or indirect guarantee those providers will receive all or part of the tax payment back.

How does the use of non-State funding sources such as provider taxes reconcile with Federal law?

Ms. SCHWARTZ. It is permissible under Federal law, and changes have been made over time to clarify the circumstances under which it is possible and the ones you just named are examples of that. But it is a permissible activity. There is no intimation that something shady is going on with these taxes and they are clearly important in many States as a source of funds to support the Medicaid program.

Mr. BILIRAKIS. OK, next question. Ms. Iritani, in 2014 you asked CMS to ensure States report accurate and complete information on all sources of funds used to finance the non-Federal share of Medicaid. What data did you want to capture and what was CMS' response to your recommendations?

Ms. IRITANI. Yes, we suggested that CMS come up with a data strategy for obtaining complete and reliable information on sources of funds. Currently CMS does not collect specific sources of funding. CMS agreed that they needed better data for oversight purposes, but disagreed with our suggestion that they needed this data at the provider level for in particular institutional providers.

We felt like the data is needed at the institutional level so that a net payment to the provider could be understood. For example, if a hospital is getting 200 million from CMS in a supplemental payment that CMS would also know that that provider was being asked to finance a non-Federal share, a hundred million or more, whatever the non-Federal share of the payment would be.

This is important not only for understanding the trends in financing and the net impact on the provider, but whether it would be helpful to understand the extent the payments are actually going to improve access to the beneficiaries as opposed to cost shifting to the Federal Government or providing fiscal relief to the States.

Mr. BILIRAKIS. So one final question, if I may, Mr. Chairman.

Mr. PITTS. You may proceed.

Mr. BILIRAKIS. OK, thank you. Ms. Iritani, Medicaid is listed by GAO as a high-risk program. Can you explain why this program is listed as high-risk?

Ms. IRITANI. Yes. There are multiple contributing reasons based on our body of work over the last years, but Medicaid is a significant program in terms of size, in terms of the number of enrollees now, the largest healthcare program in the country. It is a diverse program. The Federal-State nature of it makes it very difficult for oversight. Our work has identified concerns with gaps in oversight including the transparency of supplemental payments and many other types of issues that contributed to our putting Medicaid on our high risk list.

Mr. BILIRAKIS. Thank you. Thank you very much. I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Thank you, Mr. Chairman. And I want to thank our panel for being here. I think examining Medicaid programs is very important and we have kind of been doing it many ways today. I guess I would like to start by standing with Dr. Bucshon in saying if we could block grant Medicaid back to the States I don't even think there would be a need for today's hearing. But unfortunately we haven't done that so that is one of the reasons we are having this hearing, which I think is timely.

And maybe to respond a little bit to Mr. Guthrie's comments earlier, Medicaid is all over the place when it comes to how States administer them. And maybe to sum up a little bit, I am from New York, which New York with 20 million Americans spends as much on Medicaid as California and Texas combined with 60 million people. That shows you how crazy this program is. Thirty six or so States, as I understand it, absorb the Medicaid cost at the State level and there is no local share. It is about 36 out of 50.

Well, the 14 States, of which New York is certainly one, pushed this back to the county level. In the case of Erie County where I am from, Buffalo, I was the county executive, and 100 percent of our property tax did not even cover our Medicaid share at the county level; 100-plus percent of our county tax covered Medicaid, which meant the county had to live on sales tax.

Well, when it gets to DSH it is worse. In New York State, when the Federal Government makes a DSH payment the State pays nothing. They force 100 percent of the match for DSH payments down to the local level for the county. Erie County, Erie County Medical Center, we are talking about \$40 million in a year.

Now under the ACA, to speak to the folks on the other side that was, the DSH payments were supposed to be reduced dramatically by the expansion of Medicaid and Affordable Care. Well, it hasn't happened. As I understand it now just maybe we will see a DSH reduction in 2018, but that may go the same way as SGR and just kicked down the road. And I just bring this up to put into context how Medicaid is all over the place through the country, and if you are living in Erie County, New York, it doesn't get much worse when it comes to what we are having to bear for that burden.

So briefly, the bill that I have put forth, H.R. 2151, really addresses the non-DSH supplemental payments. And this came from the GAO's own report on we need transparency. I have a sign in my office, "In God we trust, all others bring data." We don't have the data on the non-DSH supplemental payments.

And so, Ms. Iritani, I am assuming the bill that I am putting forth, I am simply asking States, or not asking, requiring States to do audits and CMS to do audits on non-DSH supplemental payments as something GAO would support.

Ms. IRITANI. Yes, we would agree that that bill is consistent with our recommendations.

Mr. COLLINS. And really in learning from that I think all of us would support payments going where they are supposed to, but do you also have any data on the 50 States? I understand it is very inconsistent from State to State. And the crazy thing I have heard is I don't think New York does as much non-DSH supplemental. Is that true? Do you know?

Ms. IRITANI. I cannot speak to that right now, but be happy to—

Mr. COLLINS. Yes, if you could get back to us it would be interesting just to see as a percentage or absolute or both on the non-DSH supplemental payments, and then that would also beg the questions, and I think we would see, why variances from one State to the other? And it would beg the question, why is one State doing one thing and another doing something else, but without the audits how do we know?

Ms. IRITANI. There are great variations among States in how they finance their programs and the extent of supplemental payments.

Mr. COLLINS. And just from a commonsense standpoint it doesn't make any sense to me. So I would certainly urge all my colleagues to support that bill, H.R. 2151, which is simply trying to gather data in a way that would help us all better understand State by State even what is going on. So again, Mr. Chairman, thank you for holding this hearing, and I yield back the balance of my time.

Mr. PITTS. The Chair thanks the gentleman. Ms. Schwartz, did you want to add anything to that?

Ms. SCHWARTZ. Well, I have some data here that show that nationally supplemental payments as a share of inpatient and outpatient hospital payment is about 44 percent, and in New York it is 36.8 percent so it is below the national average. But the figures go all over the place from two percent to there is several States in the '80s and one or two in the '90s. So you are slightly below the average, but like all things Medicaid, it varies by State.

Mr. COLLINS. And I think again we could use some data to understand why that variation would be what it is. Thank you very much.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Mr. Griffith for 5 minutes.

Mr. GRIFFITH. Thank you very much, Mr. Chairman. As we have discussed in some of the prior testimony, the State may impose a broad-based healthcare tax on providers and use the revenue raised from that tax to pay for the Medicaid program. Virginia looked at that a couple of decades ago and it was rejected because

it was considered a sick tax or a bed tax and why would we want to put more burden on those people who are already sick by having a broad based tax on folks who are in the hospital?

But because of the way the FMAP works, the Federal Medicaid Assistance Percentage, the effect of this is that a State can draw down more and more Federal spending in its Medicaid program. Currently these provider taxes are permissible, as we talked about earlier, if they are applied at a rate that produces revenues less than or equal to six percent of the provider's net patient revenues.

Now I know, Ms. Schwartz, you said that is not cheating, but from a Virginia perspective even though it is legal it seems a little bit dicey that you get more money because you charge your sick people more taxes, therefore you can get more money drawn down from the Federal Government.

Can you talk about any work that either MACPAC or GAO has done to explore provider taxes to see how they are utilized by the States and how they drive up the spending or how provider taxes can create what we believe in Virginia is a perverse incentive in Medicaid? Either of you all want to tackle that one?

Ms. SCHWARTZ. We have written about provider taxes and described the statute as you have, and there has been an expression of interest in learning more. But it is a topic that is difficult to study because you are having to look at the finances of the entire State and their tax structure. So it is not one that we have a lot to offer now, but I am hopeful that in the future we will have more information to be able to share on that.

Mr. GRIFFITH. Well, as Mr. Bucshon said earlier, maybe we would be better off if we just decided what was the right amount for each State and sent it back to them, and then you don't have all these little games being played about we are going to charge our people a sick tax so that we can then draw down more money.

I have introduced a bill, the Medicaid Tax Fairness Act, which is co-sponsored by some of my colleagues on the committee, Blackburn, Bucshon and Guthrie. It doesn't get to the whole problem, but it does reduce the current provider-tax threshold from 6 percent to 5.5 percent which is what it was just a few years ago. What do you all think of that concept? And there is a follow-up question too.

Ms. IRITANI. We have looked at States' uses of provider taxes at a broad level, at a national level, and have found that States are increasingly relying on provider taxes as a source of the non-Federal share of Medicaid. And we looked in three States' financing arrangements where indeed there was an increase in the Medicaid payments and some sort of contribution, for example, through provider taxes, from the same providers that were receiving payments.

And so we would agree that there needs to be much more transparency on what is reported. And with regard to your proposal about reducing the provider tax threshold that I would just note that there have been several bodies including CMS in its budget that have also suggested reducing provider taxes as a way to improve the fiscal integrity of Medicaid.

Mr. GRIFFITH. Yes, my bill is actually the first step, I think, but it is H.R. 1400 and then we can go forward from there. And what is interesting is, as folks on the other side of the aisle will recog-

nize, is oftentimes I am in conflict with the administration. But in December 2010, President Obama's Fiscal Commission said Congress and the President should eliminate State gaming of Medicaid tax gimmick. They recommended restricting and eventually eliminating this practice.

While this policy would obviously need to be phased in incrementally, does GAO or MACPAC, and I think you have already answered it in part, but do either of you have a position on that policy, and if not can you comment on benefits of reducing the use of the provider taxes over time?

And you may have already answered it in your previous answer and I recognize that but did want to get it out there that this is a bipartisan thought. It is not something that we own just on the Republican side or just on the Democrat side. But gaming the system moves money around but it doesn't really help the sick folk. Comments? Agree, disagree?

Ms. SCHWARTZ. I would just say that from the Commission's perspective that interest at the moment has been on transparency and you need those data to be able to then evaluate different policy options. The Commission as of this time has no position on that.

Mr. GRIFFITH. And I would just say at some point, and I haven't introduced a bill and maybe I should, but at some point we need to look at helping folks out. I had a little concept when I was in the State legislature in Virginia that would allow folks who needed medical care maybe not as intense as a nursing home, but needed at least two things a day that were of assistance, and we passed a law that—North Carolina has a similar law—that would allow a medical cottage to be placed, a temporary to be placed in a family member's backyard, side yard, whatever, worked under the regular laws but it created a zoning exemption for that.

It might be a way that we can save money for folks all the way around because it is cheaper than a nursing home but the person is still getting care and they are with their family. I appreciate it, Mr. Chairman. I appreciate the time, and I yield back.

Mr. PITTS. The Chair thanks the gentleman, and that concludes the questions of the Members present. As usual, Members who are in other hearings on our committee may have questions who will submit those too in writing along with any follow-up questions. We ask that you please respond promptly. And I remind Members that they have 10 business days to submit questions for the record, so Members should submit their questions by the close of business on Tuesday, November 17th.

Very interesting hearing examining various Medicaid programs, a very complex issue. Thank you very much for your time and testimony today. Without objection, the subcommittee is adjourned.

[Whereupon, at 11:54 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Good morning, thank you Mr. Chairman for holding this hearing to discuss a variety of bills related to healthcare in our Medicare and Medicaid program.

I'm pleased that we will be discussing draft legislation today on the Quality Care for Moms and Babies Act. Given that Medicaid finances roughly half of all births in this country, it is critical that we continue to advance the quality of care our Medicaid beneficiaries receive. This bill not only develops quality of care metrics for

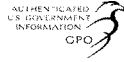
pregnancy and infancy, but would also develop maternity care quality collaboratives. I look forward to working in a bipartisan manner to advance this important bill.

I do have some concerns over several of the other bills under discussion today. H.R. 1362 and H.R. 2151 work in tandem to increase reporting and auditing requirements on States' Medicaid payments relating to non-DSH supplemental payments and the non-Federal share of State Medicaid spending. I agree that transparency in these areas is important to ensure that payments to providers are sufficient in Medicaid. But these bills are duplicative of ongoing CMS initiatives and add a burdensome layer of administrative bureaucracy. We need a more nuanced approach here, and rather than improving our ability to ensure that Medicaid dollars go towards Medicaid beneficiaries, I fear these bills will instead do the very opposite of that.

H.R. 1361, the Medicaid HOME Improvement Act eliminates State flexibility in determining home equity levels for the determination of long-term care assistance. Unfortunately, our country has yet to provide a meaningful solution to our country's long-term care crisis. Yet this bill limits State flexibility to determine the right eligibility threshold for long-term care in their own Medicaid programs. In short, the bill does not address the underlying issues in our long-term care system, but only serves to restrict access to critical services.

Finally, H.R. 2878 provides an extension on CMS' decision to temporarily suspend the enforcement of supervision requirements for outpatient health services in critical access and small rural hospitals through the end of the calendar year. While these hospitals certainly face different workforce staffing issues than those in urban areas, I hope my colleagues will work to address concerns that this bill may not adequately balance patient safety and access to care. I hope that we can work in a bipartisan fashion to address this issue.

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



I

114TH CONGRESS
1ST SESSION

H. R. 2878

To provide for the extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2015.

IN THE HOUSE OF REPRESENTATIVES

JUNE 24, 2015

Ms. JENKINS of Kansas (for herself and Mr. LOEBACK) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for the extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2015.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. EXTENSION OF ENFORCEMENT INSTRUCTION**
2 **ON SUPERVISION REQUIREMENTS FOR OUT-**
3 **PATIENT THERAPEUTIC SERVICES IN CRIT-**
4 **ICAL ACCESS AND SMALL RURAL HOSPITALS**
5 **THROUGH 2015.**

6 Section 1 of Public law 113–198 is amended—

7 (1) in the section heading, by striking “**2014**”
8 and inserting “**2015**”; and

9 (2) by striking “calendar year 2014” and in-
10 serting “calendar year 2015”.

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 (Original Signature of Member)

114TH CONGRESS
 1ST SESSION

H. R. _____

To amend title XIX of the Social Security Act to require States to submit a report at least once a year on sources of funds used to finance the non-Federal share of expenditures under such title, and for other purposes.

 IN THE HOUSE OF REPRESENTATIVES

M. _____ introduced the following bill; which was referred to the
 Committee on _____

A BILL

To amend title XIX of the Social Security Act to require States to submit a report at least once a year on sources of funds used to finance the non-Federal share of expenditures under such title, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicaid Requiring
 5 Expenditures for Public Objectives to be Reflective of
 6 Total Spending Act” or the “Medicaid REPORTS Act”.

1 **SEC. 2. REQUIREMENT FOR STATES TO SUBMIT REPORTS**
 2 **ON SOURCES OF FUNDS USED TO FINANCE**
 3 **THE NON-FEDERAL SHARE OF MEDICAID.**

4 (a) IN GENERAL.—Section 1903(w)(6) of the Social
 5 Security Act (42 U.S.C. 1396b(w)(6)) is amended by add-
 6 ing at the end the following new subparagraphs:

7 “(C) The Secretary shall require each State to submit
 8 a report, at least once during 2016 and each year there-
 9 after, using formats and standards established and up-
 10 dated as necessary by the Secretary, identifying each
 11 source of funds specified in subparagraph (D) (and the
 12 amount of funds from each such source) used by the State
 13 to finance the non-Federal share of expenditures under
 14 this title for such year. Such report also shall—

15 “(i) identify each entity providing the funds
 16 used by the State to finance the non-Federal share
 17 of expenditures under this title; and

18 “(ii) provide such additional information as the
 19 Secretary determines is sufficient to ensure the
 20 State’s compliance with the requirements of this title
 21 applicable to financing such non-Federal share.

22 “(D) A source of funds specified in this subparagraph
 23 includes each of the following:

24 “(i) A state appropriation or transfer to the
 25 State agency administering the State plan under this
 26 title, or to any other State agency or government en-

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1 tity that is used to finance such non-Federal share
2 of expenditures under this title.

3 “(ii) A bona fide provider-related donation (as
4 defined in paragraph (2)(B)) and donation revenue
5 (as described in paragraph (2)(C)).

6 “(iii) A broad-based health care related tax (as
7 defined in paragraph (3)(B)).

8 “(iv) An intergovernmental transfer from a unit
9 of local government within the State.

10 “(v) A certified public expenditure from a unit
11 of local government within the State.

12 “(vi) The general revenue of the State.

13 “(vii) Any other source as determined necessary
14 by the Secretary.

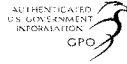
15 “(E) Not later than 6 months after the date on which
16 a report required under subparagraph (C) is submitted,
17 the Secretary shall make the information included in such
18 report publicly available on the website of the Centers for
19 Medicare & Medicaid Services.”.

20 (b) CONFORMING AMENDMENT.—Section
21 1903(w)(6)(A) of such Act (42 U.S.C. 1396b(w)(6)(A))
22 is amended by inserting before the period at the end the
23 following: “or the transferred funds are not reported as
24 required under subparagraph (C)”.

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1 (c) TECHNICAL AMENDMENT.—Section 1903(w) is
2 amended by striking “unit of government” each place it
3 appears and inserting “unit of local government”.



114TH CONGRESS
1ST SESSION

H. R. 2151

To amend title XIX of the Social Security Act to improve the calculation, oversight, and accountability of non-DSH supplemental payments under the Medicaid program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 30, 2015

Mr. COLLINS of New York introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend title XIX of the Social Security Act to improve the calculation, oversight, and accountability of non-DSH supplemental payments under the Medicaid program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 This Act may be cited as the “Improving Oversight
5 and Accountability in Medicaid Non-DSH Supplemental
6 Payments Act”.

1 **SEC. 2. IMPROVING CALCULATION, OVERSIGHT, AND AC-**
 2 **COUNTABILITY OF NON-DSH SUPPLEMENTAL**
 3 **PAYMENTS UNDER THE MEDICAID PROGRAM.**

4 (a) GUIDANCE FOR STATES ON NON-DSH SUPPLE-
 5 MENTAL PAYMENTS; STATE REPORTING AND AUDITING
 6 REQUIREMENTS.—Section 1903 of the Social Security Act
 7 (42 U.S.C. 1396b) is amended by inserting after sub-
 8 section (k) the following new subsection:

9 “(l)(1) Not later than 180 days after the date of the
 10 enactment of this subsection, the Secretary shall—

11 “(A) issue guidance to States that identifies
 12 permissible methods for calculation of non-DSH sup-
 13 plemental payments to providers to ensure such pay-
 14 ments are consistent with section 1902(a)(30)(A)
 15 (including any regulations issued under such section
 16 such as the regulations specifying upper payment
 17 limits under the State plan in part 447 of title 42,
 18 Code of Federal Regulations (or any successor regu-
 19 lations));

20 “(B) establish annual reporting requirements
 21 for States making non-DSH supplemental payments
 22 that include—

23 “(i) with respect to a provider that is a
 24 hospital, nursing facility, intermediate care fa-
 25 cility for the mentally retarded, or an institu-
 26 tion for mental diseases, or any other institu-

1 tion, an identification of each provider that re-
2 ceived a non-DSH supplemental payment for
3 the preceding fiscal year, the type of ownership
4 or operating authority of each such provider,
5 and the aggregate amount of such payments re-
6 ceived by each provider for the preceding fiscal
7 year broken out by category of service;

8 “(ii) with respect a provider that is not de-
9 scribed in clause (i), any information specified
10 in the preceding paragraph, as determined ap-
11 propriate by the Secretary; and

12 “(iii) such other information as the Sec-
13 retary determines to be necessary to ensure
14 that non-DSH supplemental payments made to
15 providers under this section are consistent with
16 section 1902(a)(30)(A); and

17 “(C) establish requirements for States making
18 non-DSH supplemental payments to conduct and
19 submit to the Secretary an annual independent cer-
20 tified audit that verifies—

21 “(i) the extent to which non-DSH supple-
22 mental payments made in the preceding fiscal
23 year are consistent with the guidance issued
24 under subparagraph (A);

1 “(ii) that payments made under the State
2 plan (or under a waiver of the plan) are only
3 for the provision of covered services to eligible
4 individuals under the State plan (or under a
5 waiver of the plan); and

6 “(iii) any other information the Secretary
7 determines is necessary to ensure non-DSH
8 supplemental payments are consistent with ap-
9 plicable Federal laws and regulations.

10 “(2) For purposes of this subsection, the term ‘non-
11 DSH supplemental payment’ means a payment, other
12 than a payment under section 1923, that—

13 “(A) is identified by the Secretary through
14 guidance described in paragraph (1)(A);

15 “(B) is made by a State to a provider under the
16 State plan (or under a waiver of the plan) for an
17 item or service furnished to an individual eligible for
18 medical assistance under the State plan (or under a
19 waiver of the plan); and

20 “(C) is in addition to any base or standard pay-
21 ments made to a provider under the State plan (or
22 under a waiver of the plan) for such an item or serv-
23 ice, including any additional payments made to such
24 provider that are not more than any limits imposed
25 pursuant to section 1902(a)(30)(A) (including the

1 regulations specifying upper payment limits under
2 the State plan in part 447 of title 42, Code of Fed-
3 eral Regulations (or any successor regulations)).”.

4 (b) STATE REPORTING AND AUDITING OF NON-DSH
5 SUPPLEMENTAL PAYMENTS.—Section 1903(i) of the So-
6 cial Security Act (42 U.S.C. 1396b(i)) is amended—

7 (1) in paragraph (25), by striking “or” at the
8 end;

9 (2) by redesignating paragraph (26) as para-
10 graph (27); and

11 (3) by inserting after paragraph (25) the fol-
12 lowing new paragraph:

13 “(26) with respect to amounts expended to
14 make any non-DSH supplemental payment (as de-
15 fined in subsection (l)(2)), unless the State complies
16 with the reporting and auditing requirements under
17 subparagraphs (B) and (C) of subsection (l)(1); or”.

○

1 **SEC. ____ . ELIMINATING STATE OPTION TO REDUCE MED-**
 2 **ICAID HOME EQUITY EXEMPTION AMOUNT**
 3 **FOR PURPOSES OF DETERMINING ELIGI-**
 4 **BILITY FOR LONG-TERM CARE ASSISTANCE.**

5 (a) IN GENERAL.—Section 1917(f)(1) of the Social
 6 Security Act (42 U.S.C. 1396p(f)(1)) is amended—

7 (1) in subparagraph (A), by striking “subpara-
 8 graphs (B) and (C)” and inserting “subparagraph
 9 (B)”;

10 (2) by striking subparagraph (B);

11 (3) by redesignating subparagraph (C) as sub-
 12 paragraph (B); and

13 (4) in subparagraph (B), as so redesignated, by
 14 striking “dollar amounts specified in this para-
 15 graph” and inserting “dollar amount specified in
 16 subparagraph (A)”.

17 (b) EFFECTIVE DATE.—

18 (1) IN GENERAL.—The amendments made by
 19 subsection (a) shall apply with respect to eligibility
 20 determinations made after the date that is one year
 21 after the date of the enactment of this section.

22 (2) EXCEPTION FOR STATE LEGISLATION.—In
 23 the case of a State plan under title XIX of the So-
 24 cial Security Act that the Secretary of Health and

1 Human Services determines requires State legisla-
2 tion in order for the respective plan to meet any re-
3 quirement imposed by amendments made by this
4 section, the respective plan shall not be regarded as
5 failing to comply with the requirements of such title
6 solely on the basis of its failure to meet such an ad-
7 ditional requirement before the first day of the first
8 calendar quarter beginning after the close of the
9 first regular session of the State legislature that be-
10 gins after the date of the enactment of this Act. For
11 purposes of the previous sentence, in the case of a
12 State that has a 2-year legislative session, each year
13 of the session shall be considered to be a separate
14 regular session of the State legislature.

.....
(Original Signature of Member)

114TH CONGRESS
1ST SESSION

H. R. _____

To amend title XI of the Social Security Act to improve the quality, health outcomes, and value of maternity care under the Medicaid and CHIP programs by developing maternity care quality measures and supporting maternity care quality collaboratives.

IN THE HOUSE OF REPRESENTATIVES

Mr. ENGEL (for himself and Mr. STIVERS) introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XI of the Social Security Act to improve the quality, health outcomes, and value of maternity care under the Medicaid and CHIP programs by developing maternity care quality measures and supporting maternity care quality collaboratives.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Quality Care for Moms and Babies Act”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

- Sec. 1. Short title; table of contents.
- Sec. 2. Quality measures for Maternal and Infant Health.
- Sec. 3. Quality collaboratives.
- Sec. 4. Facilitation of increased coordination and alignment between the public and private sector with respect to quality and efficiency measures.

SEC. 2. QUALITY MEASURES FOR MATERNAL AND INFANT HEALTH.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1139B the following new section:

“SEC. 1139C. MATERNAL AND INFANT QUALITY MEASURES.

“(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR MATERNAL AND INFANT HEALTH.—

“(1) IN GENERAL.—The Secretary shall identify and publish a recommended core set of maternal and infant health quality measures for infants, pregnant women, breastfeeding women, and postpartum women (as such terms are defined in section 17(b) of the Child Nutrition Act of 1966) in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1139A, including with respect to identifying and publishing existing maternal and infant health quality measures that are in use under public and pri-

1 vately sponsored health care coverage arrangements,
2 or that are part of reporting systems that measure
3 both the presence and duration of health insurance
4 coverage over time, that may be applicable to Med-
5 icaid and CHIP eligible mothers and infants.

6 “(2) ALIGNMENT WITH EXISTING CORE SETS.—
7 In identifying and publishing the recommended core
8 set core set of maternal and infant health quality
9 measures required under paragraph (1), the Sec-
10 retary shall ensure that, to the extent possible, such
11 measures align with and do not duplicate—

12 “(A) the core set of child health quality
13 measures identified, published, and revised
14 under section 1139A; or

15 “(B) the core set of adult health quality
16 measures identified, published, and revised
17 under section 1139B.

18 “(3) PROCESS FOR MATERNAL AND INFANT
19 QUALITY MEASURES PROGRAM.—In identifying gaps
20 in existing maternal and infant measures and estab-
21 lishing priorities for the development and advance-
22 ment of such measures, the Secretary shall consult
23 with—

24 “(A) States;

1 “(B) physicians, including physicians in
2 the fields of general obstetrics, maternal-fetal
3 medicine, family medicine, neonatology, and pe-
4 diatrics;

5 “(C) nurse practitioners and nurses;

6 “(D) certified nurse-midwives and certified
7 midwives;

8 “(E) health facilities and health systems;

9 “(F) national organizations representing
10 mothers and infants;

11 “(G) national organizations representing
12 consumers and purchasers of health care;

13 “(H) national organizations and individ-
14 uals with expertise in maternal and infant
15 health quality measurement; and

16 “(I) voluntary consensus standard-setting
17 organizations and other organizations involved
18 in the advancement of evidence-based measures
19 of health care.

20 “(b) DEADLINES.—

21 “(1) RECOMMENDED MEASURES.—Not later
22 than January 1, 2018, the Secretary shall identify
23 and publish for comment a recommended core set of
24 maternal and infant health quality measures that in-
25 cludes the following:

1 “(A) Measures of the process, experience,
2 efficiency, and outcomes of maternity care, in-
3 cluding postpartum outcomes.

4 “(B) Measures that apply to childbearing
5 women and newborns who are at lower risk, in-
6 cluding measures of appropriately low-interven-
7 tion birth, and those at higher risk.

8 “(C) Measures that apply to care during
9 pregnancy, the intrapartum period, and the
10 postpartum period.

11 “(D) Measures that apply to a variety of
12 settings and provider types, such as clinics, fa-
13 cilities, health plans, and accountable care orga-
14 nizations.

15 “(E) Measures that address disparities,
16 care coordination, and shared decisionmaking.

17 “(2) DISSEMINATION.—Not later than January
18 1, 2019, the Secretary shall publish an initial core
19 set of maternal and infant health quality measures
20 that are applicable to Medicaid and CHIP eligible
21 mothers and infants.

22 “(3) STANDARDIZED REPORTING.—Not later
23 than January 1, 2020, the Secretary, in consultation
24 with States, shall develop a standardized format for
25 reporting information based on the initial core set of

1 maternal and infant health quality measures and
2 create procedures to encourage States to use such
3 measures to voluntarily report information regarding
4 the quality of health care for Medicaid and CHIP el-
5 igible mothers and infants.

6 “(4) REPORTS TO CONGRESS.—Not later than
7 January 1, 2021, and every 3 years thereafter, the
8 Secretary shall include in the report to Congress re-
9 quired under section 1139A(a)(6) information simi-
10 lar to the information required under that section
11 with respect to the measures established under this
12 section.

13 “(5) ESTABLISHMENT OF MATERNAL AND IN-
14 FANT QUALITY MEASUREMENT PROGRAM.—

15 “(A) IN GENERAL.—Not later than 12
16 months after the release of the recommended
17 core set of maternal and infant health quality
18 measures under paragraph (1), the Secretary
19 shall establish a Maternal and Infant Quality
20 Measurement Program in the same manner as
21 the Secretary established the pediatric quality
22 measures program under section 1139A(b).

23 “(B) REVISING, STRENGTHENING, AND IM-
24 PROVING INITIAL CORE MEASURES.—Beginning
25 not later than 24 months after the establish-

1 ment of the Maternal and Infant Quality Meas-
2 urement Program, and annually thereafter, the
3 Secretary shall publish recommended changes
4 to the initial core set of maternal and infant
5 health quality measures that shall reflect the
6 results of the testing, validation, and consensus
7 process for the development of maternal and in-
8 fant health quality measures.

9 “(C) EMEASURES.—

10 “(i) IN GENERAL.—An entity awarded
11 a grant or contract by the Secretary to de-
12 velop emerging and innovative evidence-
13 based measures under the Maternal and
14 Infant Quality Measurement Program shall
15 work to advance eMeasures that are
16 aligned with the measures developed under
17 the Pediatric Quality Measures Program
18 established under section 1139A(b) and
19 the Medicaid Quality Measurement Pro-
20 gram established under section
21 1139B(b)(5).

22 “(ii) DEFINITION.—For purposes of
23 this subparagraph, the term ‘eMeasure’
24 means an electronic measure for which
25 measurement data (including clinical data)

1 will be collected electronically, including
2 through the use of electronic health
3 records and other electronic data sources.

4 “(D) AMOUNT AVAILABLE FOR GRANTS
5 AND CONTRACTS.—The aggregate amount of
6 funds that may be awarded as grants and con-
7 tracts under the Maternal and Infant Quality
8 Measurement Program for the development,
9 testing, and validation of emerging and innova-
10 tive evidence-based measures shall not exceed
11 the aggregate amount of funds awarded as
12 grants and contracts under section
13 1139A(b)(4)(A).

14 “(c) CONSTRUCTION.—Nothing in this section shall
15 be construed as supporting the restriction of coverage,
16 under title XIX or XXI or otherwise, to only those services
17 that are evidence based, or in any way limiting available
18 services.

19 “(d) MATERNITY CONSUMER ASSESSMENT OF
20 HEALTH CARE PROVIDERS AND SYSTEMS SURVEYS.—

21 “(1) ADAPTION OF SURVEYS.—Not later than
22 January 1, 2020, for the purpose of measuring the
23 care experiences of childbearing women and
24 newborns, where appropriate, the Agency for
25 Healthcare Research and Quality shall adapt Con-

1 sumer Assessment of Healthcare Providers and Sys-
2 tems program surveys of—

3 “(A) providers;

4 “(B) facilities; and

5 “(C) health plans.

6 “(2) SURVEYS MUST BE EFFECTIVE.—The
7 Agency for Healthcare Research and Quality shall
8 ensure that the surveys adapted under paragraph
9 (1) are effective in measuring aspects of care that
10 childbearing women and newborns experience, which
11 may include—

12 “(A) various types of care settings;

13 “(B) various types of caregivers;

14 “(C) considerations relating to pain;

15 “(D) shared decisionmaking;

16 “(E) supportive care around the time of
17 birth; and

18 “(F) other topics relevant to the quality of
19 the experience of childbearing women and
20 newborns.

21 “(3) LANGUAGES.—The surveys adapted under
22 paragraph (1) shall be available in English and
23 Spanish.

24 “(4) ENDORSEMENT.—The Agency for
25 Healthcare Research and Quality shall submit any

1 Consumer Assessment of Healthcare Providers and
2 Systems surveys adapted under this paragraph to
3 the consensus-based entity with a contract under
4 section 1890(a)(1) to be considered for endorsement
5 under section 1890(b)(2).

6 “(5) CONSULTATION.—The adaption of (and
7 process for applying) the surveys under paragraph
8 (1) shall be conducted in consultation with the
9 stakeholders identified in paragraph (6)(A).

10 “(6) STAKEHOLDERS.—

11 “(A) IN GENERAL.—The stakeholders
12 identified in this subparagraph are—

13 “(i) the various clinical disciplines and
14 specialties involved in providing maternity
15 care;

16 “(ii) State Medicaid administrators;

17 “(iii) maternity care consumers and
18 their advocates;

19 “(iv) technical experts in quality
20 measurement;

21 “(v) hospital, facility and health sys-
22 tem leaders;

23 “(vi) employers and purchasers; and

1 “(vii) other individuals who are in-
 2 volved in the advancement of evidence-
 3 based maternity care quality measures.

4 “(B) PROFESSIONAL ORGANIZATIONS.—
 5 The stakeholders identified under subparagraph
 6 (A) may include representatives from relevant
 7 national medical specialty and professional or-
 8 ganizations and specialty societies.

9 “(e) ANNUAL STATE REPORTS REGARDING STATE-
 10 SPECIFIC MATERNAL AND INFANT QUALITY OF CARE
 11 MEASURES APPLIED UNDER MEDICAID OR CHIP.—

12 “(1) IN GENERAL.—Each State with a plan or
 13 waiver approved under title XIX or XXI shall annu-
 14 ally report (separately or as part of the annual re-
 15 port required under section 1139A(e)) to the Sec-
 16 retary on the—

17 “(A) State-specific maternal and infant
 18 health quality measures applied by the State
 19 under such plan or waiver, including measures
 20 described in subsection (b)(5)(B);

21 “(B) State-specific information on the
 22 quality of health care furnished to Medicaid and
 23 CHIP eligible mothers and infants under such
 24 plan or waiver, including information collected
 25 through external quality reviews of managed

1 care organizations under section 1932 and
2 benchmark plans under section 1937.

3 “(2) PUBLICATION.—Not later than September
4 30, 2021, and annually thereafter, the Secretary
5 shall collect, analyze, and make publicly available the
6 information reported by States under paragraph (1).

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated \$16,000,000 to carry
9 out this section. Funds appropriated under this subsection
10 shall remain available until expended.”.

11 (b) TECHNICAL AMENDMENT.—Section
12 1139B(d)(1)(A) of the Social Security Act (42 U.S.C.
13 1320b–9b(d)(1)(A)) is amended by striking “subsection
14 (a)(5)” and inserting “subsection (b)(5)”.

15 **SEC. 3. QUALITY COLLABORATIVES.**

16 (a) GRANTS.—The Secretary of Health and Human
17 Services (in this section referred to as the “Secretary”)
18 may make grants to eligible entities to support—

19 (1) the development of new State and regional
20 maternity and infant care quality collaboratives;

21 (2) expanded activities of existing maternity
22 and infant care quality collaboratives; and

23 (3) maternity and infant care initiatives within
24 established State and regional quality collaboratives
25 that are not focused exclusively on maternity care.

1 (b) ELIGIBLE ENTITY.—The following entities shall
2 be eligible for a grant under subsection (a):

3 (1) Quality collaboratives that focus entirely, or
4 in part, on maternity and infant care initiatives, to
5 the extent that such collaboratives use such grant
6 only for such initiatives.

7 (2) Entities seeking to establish a maternity
8 and infant care quality collaborative.

9 (3) State Medicaid agencies.

10 (4) State departments of health.

11 (5) Health insurance issuers (as such term is
12 defined in section 2791 of the Public Health Service
13 Act (42 U.S.C. 300gg-91)).

14 (6) Provider organizations, including associa-
15 tions representing—

16 (A) health professionals; and

17 (B) hospitals.

18 (c) ELIGIBLE PROJECTS AND PROGRAMS.—In order
19 for a project or program of an eligible entity to be eligible
20 for funding under subsection (a), the project or program
21 must have goals that are designed to improve the quality
22 of maternity care delivered, such as—

23 (1) improving the appropriate use of cesarean
24 section;

- 1 (2) reducing maternal and newborn morbidity
- 2 rates;
- 3 (3) improving breast-feeding rates;
- 4 (4) reducing hospital readmission rates;
- 5 (5) identifying improvement priorities through
- 6 shared peer review and third-party reviews of quali-
- 7 tative and quantitative data, and developing and car-
- 8 rying out projects or programs to address such pri-
- 9 orities; or
- 10 (6) delivering risk-appropriate levels of care.
- 11 (d) ACTIVITIES.—Activities that may be supported by
- 12 the funding under subsection (a) include the following:
- 13 (1) Facilitating performance data collection and
- 14 feedback reports to providers with respect to their
- 15 performance, relative to peers and benchmarks, if
- 16 any.
- 17 (2) Developing, implementing, and evaluating
- 18 protocols and checklists to foster safe, evidence-
- 19 based practice.
- 20 (3) Developing, implementing, and evaluating
- 21 programs that translate into practice clinical rec-
- 22 ommendations supported by high-quality evidence in
- 23 national guidelines, systematic reviews, or other well-
- 24 conducted clinical studies.

1 (4) Developing underlying infrastructure needed
2 to support quality collaborative activities under this
3 subsection.

4 (5) Providing technical assistance to providers
5 and institutions to build quality improvement capac-
6 ity and facilitate participation in collaborative activi-
7 ties.

8 (6) Developing the capability to access the fol-
9 lowing data sources:

10 (A) A mother's prenatal, intrapartum, and
11 postpartum records.

12 (B) A mother's medical records.

13 (C) An infant's medical records since birth.

14 (D) Birth and death certificates.

15 (E) Any other relevant State-level gen-
16 erated data (such as data from the pregnancy
17 risk assessment management system
18 (PRAMS)).

19 (7) Developing access to blinded liability claims
20 data, analyzing the data, and using the results of
21 such analysis to improve practice.

22 (e) SPECIAL RULE FOR BIRTHS.—

23 (1) IN GENERAL.—Subject to paragraph (2), if
24 a grant under subsection (a) is for a project or pro-
25 gram that focuses on births, at least 25 percent of

1 the births addressed by such project or program
2 must occur in health facilities that perform fewer
3 than 1,000 births per year.

4 (2) EXCEPTION.—In the case of a grant under
5 subsection (a) for a project or program located in a
6 State in which less than 25 percent of the health fa-
7 cilities in the State perform less than 1,000 births
8 per year, the percentage of births in such facilities
9 addressed by such project or program shall be com-
10 mensurate with the Statewide percentage of births
11 performed at such facilities.

12 (f) USE OF QUALITY MEASURES.—Projects and pro-
13 grams for which such a grant is made shall—

14 (1) include data collection with rapid analysis
15 and feedback to participants with a focus on improv-
16 ing practice and health outcomes;

17 (2) develop a plan to identify and resolve data
18 collection problems;

19 (3) identify and document evidence-based strat-
20 egies that will be used to improve performance on
21 quality measures and other metrics; and

22 (4) exclude from quality measure collection and
23 reporting physicians and midwives who attend fewer
24 than 30 births per year.

1 (g) REPORTING ON QUALITY MEASURES.—Any re-
2 porting requirements established by a project or program
3 funded under subsection (a) shall be designed to—

4 (1) minimize costs and administrative effort;
5 and

6 (2) use existing data resources when feasible.

7 (h) CLEARINGHOUSE.—The Secretary shall establish
8 an online, open-access clearinghouse to make protocols,
9 procedures, reports, tools, and other resources of indi-
10 vidual collaboratives available to collaboratives and other
11 entities that are working to improve maternity and infant
12 care quality.

13 (i) EVALUATION.—A quality collaborative (or other
14 entity receiving a grant under subsection (a)) shall—

15 (1) develop and carry out plans for evaluating
16 its maternity and infant care quality improvement
17 programs and projects; and

18 (2) publish its experiences and results in arti-
19 cles, technical reports, or other formats for the ben-
20 efit of others working on maternity and infant care
21 quality improvement activities.

22 (j) ANNUAL REPORTS TO SECRETARY.—A quality
23 collaborative or other eligible entity that receives a grant
24 under subsection (a) shall submit an annual report to the
25 Secretary containing the following:

1 (1) A description of the activities carried out
2 using the funding from such grant.

3 (2) A description of any barriers that limited
4 the ability of the collaborative or entity to achieve its
5 goals.

6 (3) The achievements of the collaborative or en-
7 tity under the grant with respect to the quality,
8 health outcomes, and value of maternity and infant
9 care.

10 (4) A list of lessons learned from the grant.

11 Such reports shall be made available to the public.

12 (k) GOVERNANCE.—

13 (1) IN GENERAL.—A maternity and infant care
14 quality collaborative or a maternity and infant care
15 program within a broader quality collaborative that
16 is supported under subsection (a) shall be governed
17 by a multi-stakeholder executive committee.

18 (2) COMPOSITION.—Such executive committee
19 shall include individuals who represent—

20 (A) physicians, including physicians in the
21 fields of general obstetrics, maternal-fetal medi-
22 cine, family medicine, neonatology, and pedi-
23 atrics;

24 (B) nurse-practitioners and nurses;

1 (C) certified nurse-midwives and certified
2 midwives;

3 (D) health facilities and health systems;

4 (E) consumers;

5 (F) employers and other private pur-
6 chasers;

7 (G) Medicaid programs; and

8 (H) other public health agencies and orga-
9 nizations, as appropriate.

10 Such committee also may include other individuals,
11 such as individuals with expertise in health quality
12 measurement and other types of expertise as rec-
13 ommended by the Secretary. Such committee also
14 may be composed of a combination of general col-
15 laborative executive committee members and mater-
16 nity and infant specific project executive committee
17 members.

18 (I) CONSULTATION.—A quality collaborative or other
19 eligible entity that receives a grant under subsection (a)
20 shall engage in regular ongoing consultation with—

21 (1) regional and State public health agencies
22 and organizations;

23 (2) public and private health insurers; and

1 (3) regional and State organizations rep-
 2 resenting physicians, midwives, and nurses who pro-
 3 vide maternity and infant services.

4 (m) AUTHORIZATION OF APPROPRIATIONS.—There
 5 are authorized to be appropriated \$15,000,000 to carry
 6 out this section. Funds appropriated under this subsection
 7 shall remain available until expended.

8 **SEC. 4. FACILITATION OF INCREASED COORDINATION AND**
 9 **ALIGNMENT BETWEEN THE PUBLIC AND PRI-**
 10 **VATE SECTOR WITH RESPECT TO QUALITY**
 11 **AND EFFICIENCY MEASURES.**

12 (a) IN GENERAL.—Section 1890(b) of the Social Se-
 13 curity Act (42 U.S.C. 1395aaa(b)) is amended by insert-
 14 ing after paragraph (3) the following new paragraph:

15 “(4) FACILITATION OF INCREASED COORDINA-
 16 TION AND ALIGNMENT BETWEEN THE PUBLIC AND
 17 PRIVATE SECTOR WITH RESPECT TO QUALITY AND
 18 EFFICIENCY MEASURES.—

19 “(A) IN GENERAL.—The entity shall facili-
 20 tate increased coordination and alignment be-
 21 tween the public and private sector with respect
 22 to quality and efficiency measures.

23 “(B) ANNUAL REPORTS.—The entity shall
 24 prepare and make available to the public its
 25 findings under this paragraph in its annual re-

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21

1 port. Such public availability shall include post-
2 ing each report on the Internet website of the
3 entity.”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) shall take effect on the date of the enact-
6 ment of this Act.

Energy & Commerce Health Subcommittee Hearing

November 3, 2015

On behalf of the American College of Obstetricians and Gynecologists:

"The Perinatal Quality Collaborative of North Carolina has done a broad variety of important work, but one critical focus has been an initiative to increase breastfeeding rates. The American College of Obstetricians and Gynecologists recommends breastfeeding because of a number of maternal and infant benefits, including improved protection from infection, reduced risk of obesity and cardiovascular disease, even a decrease in postpartum blood loss. Our collaborative collected data to assess the gap between intention to breastfeed and rate of actual infants exclusively breastfed, and then implemented solutions to reduce that gap.

Over the course of about two and a half years, or 29 months, the Perinatal Quality Collaborative of North Carolina was able to increase breastfeeding support by 78%, reduce pacifier use by 53%, and achieve a 20% increase in exclusive breastfeeding rates. Over 50% of births in North Carolina are covered by Medicaid, so any cost savings realized through these initiatives has a positive impact on state and federal funds. It is essential that we support the important quality improving and cost-saving work being done by perinatal collaboratives in North Carolina and across the United States, as well as expanding into states that lack them."

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-2927
Minority (202) 225-3841

December 7, 2015

Dr. Anne L. Schwartz
Executive Director
Medicaid and CHIP Payment and Access Commission
1800 M Street, N.W.
Washington, DC 20036

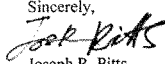
Dear Dr. Schwartz:

Thank you for appearing before the Subcommittee on Health on November 3, 2015, to testify at the hearing entitled "Examining Legislation to Improve Medicare and Medicaid."

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 with a transmittal letter by the close of business on December 21, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@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 Gene Green, Ranking Member, Subcommittee on Health

Attachment

Additional Questions for the RecordThe Honorable Representative G.K. Butterfield

1. Ms. Schwartz, thank you for your testimony on the importance of the Quality Care for Moms and Babies Act. I am especially interested in the expansion of the collaborative activities related to maternity and infant care quality. The Perinatal Quality Collaborative of North Carolina is currently a partner of the Centers for Disease Control on a wide number of initiatives related to postpartum health. Can you describe the impact of partnerships like that on public health in our country?

The Centers for Disease Control and Prevention (CDC) currently fund six states (California, New York, Ohio, Illinois, Massachusetts, and North Carolina) under the state-based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement. The funding is designed to assist the collaboratives in improving the quality of perinatal care in their states. These efforts are targeted at reducing maternal morbidity and mortality, reducing scheduled births without a medical indication, improving breastfeeding rates, and reducing hospital-acquired neonatal infections and neonatal morbidity.

The Commission has not specifically evaluated the PQCs. However, our June 2013 report to Congress (<https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-613/>) provides an examination of eligibility and coverage for pregnant women in Medicaid and the State Children's Health Insurance Program (CHIP), and describes some of the efforts in states targeting maternal and child health. A copy of the chapter is attached. Commission staff would be happy to brief you or your staff on this work.

2. Can you highlight some of the innovations which have come about through existing perinatal collaborations?

As described in the Commission's June 2013 report to Congress (<https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-613/>), collaborative quality improvement initiatives generally establish health care processes and procedures to discourage elective inductions and cesarean deliveries, with many initiatives focused primarily on deliveries before 39 weeks of gestation. (See Table 1-6 in the report for details.) Common elements of these initiatives include internal audit and feedback procedures, patient and provider education, policies limiting circumstances under which elective deliveries prior to 39 weeks can take place (for example, only when medically indicated or after peer review), and changes in scheduling processes for labor and delivery.

Quality improvement initiatives have been implemented by statewide collaboratives, state agencies (including Medicaid), and health systems. Some of these collaboratives are supported by state legislation or occur within a learning network, where hospitals or other organizations learn from their peers while implementing systems changes at the same time. The Louisiana Institute for Healthcare Improvement, for example, is working with 28 of the state's 58 maternity hospitals to engage providers in quality improvement programs.

At the federal level, the Strong Start for Mothers and Newborns Initiative is a joint effort between the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services Administration, and the Administration on Children and Families. It aims to reduce

preterm births and improve outcomes for both newborns and pregnant women. The initiative is made up of two strategies – a public-private partnership and awareness campaign to reduce early elective deliveries and a funding opportunity to improve prenatal care among women enrolled in Medicaid and CHIP with the goal of reducing premature births.

3. Can you describe how the provisions of the Quality Care for Moms and Babies Act will expand those partnerships and how that expansion would benefit millions of people across the country?

The Quality Care for Moms and Babies Act requires development of a core set of health care quality measures for maternal and infant health, and would facilitate increased coordination and alignment between the public and private sector with respect to quality and efficiency measures. Regarding expanded perinatal collaborative partnerships, the legislation would authorize the Secretary of Health and Human Services to make grants to eligible entities to support the development of new state and regional maternity and infant care quality collaboratives, expand activities of existing collaboratives, and expand maternity and infant care initiatives within established collaboratives that are not focused exclusively on maternity care.

Entities that will be eligible for the grants include state Medicaid agencies, state departments of health, health insurance issuers, provider organizations, entities seeking to establish a maternity and infant care quality collaborative, and existing quality collaboratives that focus entirely or in part on maternity and infant care initiatives.

Funding could also be used to support other activities including developing quality collaborative infrastructure; providing technical assistance; developing, implementing, and evaluating protocols to foster evidence-based practice; developing, implementing, and evaluating programs that translate into recommendations for clinicians; facilitating performance data collection and feedback reports; and developing access to and analyzing blinded liability claims data to improve practice.

The bill would authorize \$15 million for such grants. An additional \$16 million would be authorized to develop and implement the core set of health care quality measures for maternal and infant health. The Congressional Budget Office (CBO) estimates that implementing the legislation would cost the amount appropriated (\$31 million) over the 2016-2020 period, and would not affect direct spending or revenues (CBO 2015).

While MACPAC does not have estimates of how many people would benefit from quality collaborative grants authorized in the bill, the Centers for Disease Control and Prevention (CDC) reports that perinatal quality collaboratives currently exist or are being formed in 38 states, 6 of which are funded by the CDC (CDC 2015). Grants authorized by the Quality Care for Moms and Babies Act would likely support many of these existing programs, and may be the catalyst to create perinatal collaboratives in additional states.

- 4. With nearly one out of every two births covered by Medicaid, it seems that the Quality Care for Moms and Babies act has an opportunity to benefit millions of people across the country. Can you describe some potential quality measures and how they would directly benefit beneficiaries?**

MACPAC last examined the use of quality measures for prenatal and maternity services in its June 2013 report to Congress (<https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-613/>). There we found that while the use of quality measures in health care has expanded rapidly, there are still relatively few valid measures of labor and delivery care processes and outcomes. In addition, performance reporting on maternity care remains relatively limited and inconsistent across the country and among various entities, including health plans, health systems, and facilities. However, some notable efforts have been made in recent years to develop and promote reporting on measures of elective deliveries. (See Table 1-7 in the report.)

For example, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required HHS to identify a set of core quality measures related to children's health which states can report on a voluntary basis. The 2015 core set of children's quality health measures for Medicaid/CHIP (also known as the child core set) includes six measures related to maternal and perinatal health. The core set includes the frequency and timeliness of ongoing prenatal and postpartum care (including a behavioral risk assessment), as well as the rates of cesarean sections, low-birthweight babies, and bloodstream infections among infants in intensive care.

Additionally, the National Quality Forum (NQF) endorsed a set of 14 clinical quality measures related to perinatal care. Some of these measures have been adopted by the Joint Commission, the Leapfrog Group, and CMS (as part of the core set of 25 children's health care quality measures discussed above). In August of 2012, the American College of Obstetricians and Gynecologists (ACOG) convened the reVITALize conference to assist in clarifying existing data definitions and in streamlining measurement for obstetrical outcomes nationwide.

MACPAC will continue to monitor quality measure development and update information and its impact on Medicaid and CHIP enrollees in future reports to Congress.

- 5. Can you discuss how national evidence-based measures can benefit providers and potentially lead to better health outcomes for mothers and babies?**

Highlighted as a success by the CDC, the California Maternal Quality Care Collaborative built a data center to establish rapid-cycle performance measures about maternity services and outcomes and has used the data center to reduce both maternal morbidity and non-medically indicated early deliveries.

Specifically, the state used the California Maternal Data Center as a data source and reporting application for its Preeclampsia Collaborative, a statewide hospital-level learning and quality improvement initiative. From February 2013 through June 2014, 13 hospitals participating in the Preeclampsia Collaborative showed a 12 percent reduction in severe

complications among women with severe preeclampsia/eclampsia. When women who experienced hemorrhage or had a blood transfusion (which comprises the majority of the complications) were excluded, there was a more dramatic reduction of 36 percent in severe complications.

Non-medically indicated deliveries before 39 weeks gestation are also declining among hospitals actively enrolled in the California Maternal Data Center. Between January 2012 and May 2014, hospitals using the center's quality improvement tools demonstrated a 57 percent reduction in the percentage of non-medically indicated deliveries performed in the 37- and 38-week gestational period.

6. Can you describe the projected financial impact that quality measures would have for Medicaid and CHIP programs?

The Commission does not develop cost estimates for pending legislation. Like Congress, we rely on estimates of legislative proposals developed and made public by the CBO.

7. Would you agree that investing in this legislation will benefit patients and also reduce the likelihood of costly or potentially dangerous medical procedures?

The Commission has not specifically evaluated the impact of this bill on enrollees or the federal budget. As its published work on Medicaid and CHIP policies concerning maternity care and children's coverage issues highlights, the Commission is committed to learning from and sharing knowledge about program improvements that benefit enrollees.

